

The Shrewsbury and Telford Hospital  
NHS Trust



# **The Future Configuration of Hospital Services**

**Securing High Quality, Safe and Sustainable  
Hospital Services in Shrewsbury and Telford**

**Volume 2: Executive Summary**

**19 September 2011 – amended version**

# 1.0 Executive Summary

## 1.1 Introduction

The investment set out within this Outline Business Case (OBC) supports the reconfiguration of a number of hospital services in Shrewsbury and Telford in 2014: acute surgery; inpatient head and neck services; and women's and children's services. It details the capital investment required to provide accommodation to support the Future Configuration of Hospital Services (FCHS) at both the Royal Shrewsbury Hospital (RSH) in Shrewsbury and the Princess Royal Hospital (PRH) in Telford.

This Executive Summary should be read alongside the Outline Business Case Volume 1 – Main Body. However, it can also be read as a stand-alone document.

The overarching objective for the reconfiguration is to secure high quality, safe and sustainable hospital services for the population we serve. With this in mind and in the development of this OBC, the Trust has reviewed the different options for where services could be located on each of the two acute sites. Particular consideration has been given to delivering a clinically safe model of care, maintaining key clinical adjacencies, minimising disruption to existing services, supporting longer term strategic service developments and providing value for money whilst ensuring affordability in the immediate and longer term.

The FCHS Programme was established in the summer of 2010 with the overarching objective described above. The first stage of this work launched a renewed clinically-led debate on the shape of services. This debate focused on three dilemmas:

- Making sure the Trust continues to provide 24 hour acute surgery in the county
- Making sure the range of inpatient children's services are maintained within the county
- Planning to move out of the deteriorating maternity and children's services building at the RSH site before this building fails for clinical care.

These dilemmas needed to be considered in the context of a wide range of current and future challenges including clinical safety and sustainability risks; the needs of the different communities served by the Trust across Shropshire, Telford and Wrekin and mid Wales; maintaining important clinical linkages between hospital services (e.g. the clinical links between obstetrics and neonates); a drift of services out of county for example patients with ST elevation myocardial infarction and some cancer services; medical workforce issues such as restrictions in working hours for junior doctors, subspecialisation and earlier specialisation in medical training; increasing external scrutiny of health services from regulators and of course the availability and affordability of capital funding in the current economic climate.

However the development of the options for addressing these dilemmas and meeting these essential requirements has had the commitment and support from our local commissioners, NHS Telford and Wrekin and Shropshire County PCT and from our Local Authorities through the Joint Health Overview and Scrutiny Committee. All parties have agreed that the work is to be framed by three reconfiguration principles:

- Keeping two vibrant, well balanced successful hospitals in the county
- A commitment to having an Accident and Emergency Department on both sites
- Access to acute surgery from both sites.

These essential requirements and principles have therefore formed the basis of the work that has got us to the solutions outlined in this OBC.

## 1.2 Public Consultation and Assurance

### 1.2.1 Strategic Options

The Trust initially identified four strategic options for appraisal:

**Do nothing and maintain all services as they are.** This option would neither address the clinical challenges faced by local hospital services nor extricate services from the deteriorating women and children's building at the RSH. This would result in risks that services would decline and possibly

reach crisis point, in which case emergency changes would need to be made to services. Other implications could include further services drifting out of the county or a risk of losing our "licence" to operate certain services.

**Concentrate all services on one site – either a new single site or one of the existing hospitals.** There was strong clinical support for concentration of services onto a single site. However, the capital costs and revenue implications of this option were not considered affordable in the current economic climate.

**Major and emergency work on one site and planned activity on the other.** This model also had strong clinical support. However, the Trust undertakes much more urgent and emergency activity than elective planned activity, and this also represents the majority of patient bed days in hospital. Given that one site would handle much reduced levels of activity and the other would require significant expansion (both in terms of beds, and in related services such as A&E, critical care and diagnostics), this would not meet with reconfiguration principles and would require significant capital investment which was considered neither feasible nor affordable.

**Move some services from PRH to RSH and some services from RSH to PRH.** Given that the options discussed above would neither address the risks faced by hospital services nor would be feasible or affordable, the development of a safe and sustainable model of care focused on:

- Using existing resources as best as possible on both sites
- Achieving the highest possible standards of clinical safety and sustainability
- Feasible delivery within the human, financial and other resources available
- Maximising acceptability to patients and communities, including continuing to provide services where they are now where this is clinically safe, feasible and appropriate.

The Trust Board at its meeting on 2 December 2010 therefore approved proposals for consultation with regards to reconfiguring surgery (including head and neck), maternity, gynaecology, neonatology and children's inpatient services between the two sites.

### ***1.2.2 The Proposals***

#### *Surgery*

- All inpatient general surgery, both planned and emergency, for vascular, colorectal and upper gastro-intestinal surgery would be carried out at RSH
- Breast, gynaecological and head and neck surgery would be carried out at PRH
- All trauma surgery would continue to be carried out at RSH as now
- Orthopaedic surgery would continue to be carried out at both sites as now
- Head and neck services transferred from RSH to PRH
- Most outpatients and day cases would continue to take place at the same hospital as they do now.

#### *Maternity/Gynaecology/Neonatology*

- The consultant-led maternity unit currently on the RSH site would move to PRH. Both sites would continue to provide midwifery-led units (MLU). The MLU accommodation at RSH would be improved
- The neonatal intensive care unit would move to the PRH site so that it is on the same site as the consultant led maternity unit and inpatient services
- Pregnant women would continue to have their outpatient antenatal care, including scans at the same hospital they go to now
- All pregnant women assessed as likely to have a low risk of complications in the later stages of pregnancy and during delivery would still have the opportunity to have their baby in an MLU or at home
- All pregnant women assessed as likely to have a high risk of complications would have their baby in the consultant led unit at PRH

- Gynaecology inpatient services for women would be concentrated within the women's and children's centre at the PRH. Most outpatient care would continue to be at the same hospital as now.

#### *Children's Services*

- Concentrating inpatient services for children on the PRH site with Paediatric Assessment Units on both sites
- Children attending outpatients to go to the same hospital as now
- Head and Neck services transferred from RSH to PRH.

#### **1.2.3 "Keeping It In The County"**

The public consultation 'Keeping It In The County' was a 14 week period of extensive sharing of information, debate and media reporting. It enabled lead clinicians and officers of the Trust and health economy to hear, first hand, the views and opinions of the population who use SaTH's services. Much of the discussion focused on the changes to maternity and paediatrics (including neonatology) and in particular, concerns around the increased travel time for some pregnant mothers and newborns'. Increased travel time as a result of the plans to consolidate the inpatient children's ward at the PRH site, and the impact this would have on children and their families was also raised as concern. The Trust has responded to these concerns in the development of the proposals through ongoing communication and engagement and a robust assurance process. This will continue into the implementation phase of the programme. The Trust has worked in partnership with both the WMAS and WAS in mitigating the risks of additional travel time for some patients and has developed safe clinical pathways that will be implemented across organisational boundaries.

#### **1.2.4 The Assurance Framework**

The FCHS programme has been developed within a robust assurance framework. During Assurance and Consultation, there were six formal key aspects to the assurance element. These were:

- **Local Assurance Panel** - enabled the PCTs and other key stakeholders, advised by independent experts, to test the clinical proposals put forward for acute hospital reconfiguration by local clinicians. It gave assurances around the Government's four key tests for service configuration based on a 'test of reasonableness' and also whether proposals were clinically safe, robust and sustainable and were financially viable and affordable. The panel supported the proposals in principle and confirmed the four key tests were met
- **Office of Government Commerce** - The OGC visited the Trust for Gateway Review 1: Business Justification in June 2011. They reported sound progress of the reconfiguration programme since Gateway 0 in October 2010 and the Trust received a delivery confidence rating of AMBER – "successful delivery appears feasible but issues require management attention. The issues appear resolvable at this stage of the programme/project if addressed promptly"
- **National Clinical Advisory Team** - The National Clinical Advisory Team (NCAT) provided an independent pool of clinical experts to support, advise and guide us through independent assessment of local service reconfiguration proposals. Prior to consultation they confirmed 'the single proposed option seems logical and we believe could deliver safer and more sustainable service across the county and beyond. The model for maternity care is an excellent example of this. An opportunity to achieve much needed capital investment for the people served seems to be available. The option appears to be widely supported by stakeholders in primary and secondary care. However it is critical that the clinical leaders and senior managers continue to work together...."
- **Joint Health Overview and Scrutiny Committee** - The Committee indicated that they were supportive of the proposals for children's services, maternity services and surgery subject to some additional assurances and have developed a work programme for the Trust to support their own monitoring of progress against recommendations and requests for further information/assurance
- **Clinical Assurance Group** - This group involves Trust clinicians (medical, nursing/midwifery and therapies), GPs (from Shropshire County PCT, NHS Telford and Wrekin and Powys

Teaching Health Board), ambulance service representatives from West Midlands and Wales, PCT Directors of Public Health and Trust executives. This group is responsible for: the overarching clinical advice and assurance of the proposed pathways; understanding and checking the development of existing and new clinical interfaces and co-dependencies; working with and feeding back to the clinical working groups to identify and mitigate future risks

- **Equality Impact Assessment** – NHS Telford and Wrekin and Shropshire County PCT commissioned Step Up Consulting (UK) Ltd. to carry out an Equality Impact Assessment (EqIA) on the "Keeping It In The County" proposals.

### **1.2.5 The Outcome of Consultation and the development of the OBC**

The outcome of the consultation and assurance process approved by the Trust Board on 24 March 2011 has formed the basis of this OBC.

At PRH, the OBC has assessed the different options for:

- A consultant-led maternity and neonatology unit, co-located with gynaecology and paediatric inpatient services (including head and neck), and a Paediatric Assessment Unit
- Enhancing the current antenatal service through relocation of gynaecology outpatients to the main outpatients department (OPD), releasing additional accommodation for the antenatal clinics
- Establishing a Women's Service to include inpatient gynaecology and breast surgery, gynaecology assessment/fit to sit service, an Early Pregnancy Assessment Service (EPAS) located on one ward, relocation of gynaecology outpatients to the main OPD with new provision of a colposcopy suite. (Fertility services will be retained at RSH in their current location)
- Adult inpatient head and neck services being co-located near theatres and critical care. The relocated head and neck outpatient facility with audiology booth being within children's outpatients and a dedicated head and neck treatment room in the A&E department
- Relocated and improved accommodation for paediatric outpatients and paediatric assessment and re-provision of the gardens for oncology patients (currently provided at RSH) and improved day case facilities to provide a child friendly environment within the existing day surgery unit.

At RSH, the OBC has assessed the different options for:

- All inpatient general surgery, both planned and emergency, for vascular, colorectal, bariatric surgery, urology and upper gastro-intestinal being co-located near theatres and critical care
- Relocating and improving accommodation for paediatric outpatients and a Paediatric Assessment Unit (PAU) with the PAU being co-located with A&E
- Relocating and improving accommodation for the antenatal services, Pre Antenatal Day Assessment unit (PANDA) and Midwifery-Led Unit (MLU). This will be enabled by the release of medical space through improved models of care and new ways of working in medicine and urgent care at RSH
- The relocation of surgery to RSH requires the staffing of two<sup>1</sup> additional intensive care unit (ITU) beds.

## **1.3 The Strategic Case**

The Trust has recently developed its wider strategy across four balanced strategic domains to focus on what it will take to create the financial strength to enable investment in the quality of services; to focus on what has to be done to meet the needs of patients and GPs; to focus on the internal processes in which the Trust must excel if the quality and safety of care is to be improved and finally to focus on the learning and growth that will prepare the Trust for the future through developing staff, the technology used and the innovation created.

'Putting Patients First' is the Trusts organising principle. The role of individuals and the organisation is to provide the safest possible care at the highest level of quality we can afford, using the best evidence of what provides the greatest benefit to patients.

The case for change therefore is fundamentally based on three drivers: safety and viability of current clinical services, workforce challenges of providing the right skills in the right place at the right time, and the condition of the facilities for women and children at RSH.

### **1.3.1 Safety and Viability of Services**

There are currently a number of challenges in delivering safe and timely hospital care. The main risks associated with the future viability of clinical services are:

- Sustaining acute surgery on two sites, with prompt access to senior clinical input to ensure the best possible outcomes of care. Across the country vascular surgery is being focused into bigger centres as part of a nationwide drive to improve survival rates for major surgery. Holding onto services in Shropshire would only be achievable if the teams who provide these services are brought together onto a single site
- Sustaining inpatient paediatric services on two sites, providing 24-hour senior paediatric input and maintaining accreditation for doctors in training

### **1.3.2 Workforce Challenges**

Ensuring that the right people with the right skills are always in the right place to meet the needs of patients is a real challenge to the Trust. The current workforce has seen a number of changes, which impact on the ability to provide 24 hour emergency services on both sites. These are:

- Changes to the training of medical staff; the training programme for doctors is significantly different. In the past, a general surgeon would have probably carried out large volumes of abdominal, breast and vascular surgery whilst in training. Now, consultants will have specialised in one of these branches of surgery much sooner. Therefore, they will not have the necessary skills to perform techniques they have not been trained to deliver. This leads to a situation where a surgeon who does not operate on the abdomen in the day time may have to perform such surgery at night
- Reduction in middle grade doctors; due to the changes in medical training described above, traditional 'middle grade' doctors are a disappearing workforce. The Trust will have to increasingly rely on consultants to 'fill this gap'
- Changes to staff working hours; introduced by the European Working Time Directive, still presents a challenge for the Trust as it needs to recruit more doctors than in the past to sustain a 24-hour rota across 2 sites
- Challenges in recruiting medical staff; the number of doctors who the Trust can recruit fluctuates on a regular basis. This leads to occasions when there are not enough medical staff to cover all the departments. This is happening for two reasons. Firstly, doctors can choose where to work and some are deciding not to come to the Trust. Secondly the Trust has experienced a reduction in the availability of some doctors from overseas.

### **1.3.3 Facilities for Women's and Children's Services**

The current maternity building on the RSH site is over forty years old; it is the Trust's oldest building and does not provide an appropriate environment for patients, who are increasingly choosing where to give birth. There is inadequate and substandard space built to now out-dated construction standards providing poor clinical functionality. It is poorly sited and is not connected adequately to the rest of the hospital. A condition report in 2007 emphasised the need to address high and significant risk items as a priority as part of the Trust's estate investment planning process. It is estimated that extensive work (in the order of approximately £14million) would need to be undertaken just to provide an adequate solution that would resolve the building deficiencies and provide decent facilities.

The following table summarises how the proposals set out in this business case will mitigate these risks:

<i>Current risk</i>	<i>Anticipated benefit from service reconfiguration</i>
Sustainability of acute surgery on two sites including: delays of transfer into appropriate units/beds; delays in access to specialised senior clinical input; a lack of confidence to manage patients out of own surgical expertise	A single inpatient site for emergency and elective surgery would enable patients to be managed in the right subspecialty by appropriately trained and experienced medical staff via separate rotas for vascular and general surgery. Training places for junior doctors will be more attractive and locum dependency would be reduced.
Sustainability of inpatient paediatric services on two sites including: challenge of providing 24-hour senior paediatric input; maintaining the accreditation for doctors in training; a reliance on staff/middle grades; and an inability to develop services such as high dependency care	A single inpatient site would enable a sustainable medical rota to be implemented. The unit would be run at optimum efficiency with space allocated for high dependency care. The majority of children would continue to be seen in-hours and in the PAUs as now. Children requiring inpatient care who attend RSH would be stabilised and transferred.
Poor physical environment in the women and children's department at RSH, as well as the need to provide additional obstetric theatre capacity to support the number of births in the county	A new, fit for purpose women's and children's centre is created. An additional obstetric theatre mitigates the current risks associated with single theatre provision. Low risk, midwifery-led care would continue to be provided at both sites along with antenatal and outpatient clinics. Improved accommodation would be provided for the midwifery-led unit at the RSH site.
Future sustainability of a local vascular surgery service if the Trust is not accredited as a centre for AAA screening	A single rota for vascular surgery, with enhanced training provision would help towards safe guarding a local AAA screening service.
Ensuring access to 24-hour thrombolysis for hyperacute stroke services	Establishment of a 24/7 thrombolysis service at both sites will resolve service risk.
Changing training programme for doctors resulting in earlier specialisation, a lack of skills in techniques doctors which have not been trained to deliver and a disappearing middle grade workforce	The consolidation of services onto a single site would enable single specialty rotas and enhanced senior clinician cover.
Medical staff recruitment challenges and the implications of the EWTD are exacerbated through difficult working environments, on-call commitments and numbers of patients to be managed	Single site provision is more attractive than split site services for training, working and development.

### **1.3.4 Constraints and Risks**

The current and future economic climate means that significant capital funding is not available as it has been in the past to support major building or renovation programmes. The Trust has looked at options which optimise the use of existing accommodation to minimise capital investment to deliver an affordable scheme. The models of care that have been developed within the FCHS programme include opportunities to improve efficiency and achieve best practice. The Trust has reviewed benchmark performance for other similar acute hospitals and this has been used to inform the future capacity plans for the services affected by the reconfiguration proposal. Affordability and the non-financial benefits criteria defined have equally been weighted in driving the option appraisal.

The Trust is currently scheduled to present its Foundation Trust application to Monitor during the latter part of 2013. When the Trust makes its application, an external firm of accountants will undertake a historical due diligence, which will provide an account of the Trust's financial health and liabilities. The Women and Children's building at RSH is one of the Trust's biggest liabilities. Monitor

will require the Trust to demonstrate that a plan is in place which is affordable and deliverable to deal with these liabilities before the Trust can be authorised.

The highest risks currently being reported within the FCHS programme are:

- Capacity within SaTH to deliver a significant change programme alongside the challenges of delivering improvement of performance and financial recovery
- Affordability within the context of a financially challenged health economy
- The implications for making clinical services safe and sustainable in the more immediate term if the programme is significantly delayed.

These risks are being mitigated through the programme's governance arrangements and will continue to be reviewed.

## **1.4 Planning Assumptions in Developing the Options**

### **1.4.1 Clinical Pathways and Service Briefs**

Since January 2011 meetings of the three clinical working groups have taken place (Maternity, Gynaecology and Neonatology; Children's Services; and Surgery, including Urology and Head and Neck). Over 50 different clinicians have participated directly in the discussions on the care pathways, estates implications, travel needs and the issues, risks and concerns of the proposed reconfiguration. This has included clinicians who bring a wide range of views and opinions on the proposed changes, including clinicians who have spoken publicly both in support of and with concerns about the impact the changes may bring for some patients.

A total of 23 pathways have been agreed and signed off by the clinical groups. The clinical pathways have all been developed to address the risks to clinical safety and sustainability that drive the FCHS programme, now and following the service changes. The pathways have been shared with a wider network of clinicians and staff for their input and comment.

Detailed planning assumptions and service briefs by specialty have been developed with clinicians and external planners who have provided some challenge in using external benchmarks in the development and agreement of future efficiency assumptions. For example it has assumed a movement towards upper quartile length of stay for all specialties and 90% occupancy rates for all inpatients with the exception of paediatrics which is modelled at 80%. The Trust has also sought the involvement of the Royal Colleges where clarification and external opinion was necessary. This was particularly important in developing the paediatric service brief.

### **1.4.2 Wider Capacity Planning Assumptions**

The Trust has also undertaken a Trust-wide detailed assessment of the longer term strategic bed capacity requirements to inform the OBC and the wider strategic and estate planning agenda for the next 5-10 years. The assumptions within the modelling have included: demographic changes, realistic but challenging length of stay targets based on moving progressively towards the national upper quartile benchmark; reduction in occupancy rates currently at 97% to a more realistic 90%, PCT commissioning plans, where these impact on the requirement for inpatient beds, including policies concerning procedures of limited clinical value, avoidable non-elective admissions and other condition-specific protocols and pathways; planned changes to models of care for example the British Association of Day Surgery (BADs) guidance on potential delivery options for elective and day case activity and the NHS Institute for Innovation and Improvement guidance on ambulatory emergency care for adults.

The projected demographic change across Shropshire, Telford and Wrekin shows a very significant increase in the number of older people: 18% change in the 65-79yr age group and the 80+ age group over the next 5 years and 27% and 44% respectively over the next 10 years. The significance of this is that these age groups account for much of the demand for inpatient beds, and make up a high proportion of the patients who need to stay in hospital for lengthy periods. The net impact for the projected demographic changes suggest that without any change to ways of working and models of care, an additional 185 beds would be required to meet the increase in demand by 2021.

The Trust's objective is to be able to make immediate improvements to allow current activity levels to be managed as efficiently and effectively as possible, and then to absorb future population-driven demand increases through a continuous programme of service improvement. Achievement of these

improvements will enable the Trust to manage more clinical activity with fewer inpatient beds. In practical terms, the Trust's aim is to reduce the requirement for inpatient beds during 2011/12 and 2012/13, following which continuous improvement will allow further demand pressures to be managed.

A strategy therefore moving 35% to upper quartile could be summarised as follows:

		<i>Inpatient Activity (Spells)</i>	<i>Inpatient Beds Required (95% occupancy)</i>	<i>Inpatient Beds Required (90% occupancy)</i>
Current		55,495	821	821
Short term (0-2 years)	Scenario Ai: 25% shift towards median length of stay	55,495	684	717
Short term (0-2 years)	Scenario Bi: 20% shift towards upper quartile length of stay	55,495	674	706
5 years	Scenario Cii: 35% shift towards upper quartile length of stay	59,160	671	704

### **1.4.3 Efficiency Assumptions for the Reconfigured Services**

This scenario planning exercise and the demonstration of the potential for reduction in the Trust's current bed base has informed the options appraisal in examining options where existing estate may be freed up on both sites rather than complete new build options.

The table below outlines the impact of target LOS and beds for the relevant specialities. The proposed bed capacity requirements that have emerged from the clinical pathway groups for the specialties forming part of the reconfiguration reflect the direction of the Trust to reduce LOS and move towards upper quartile performance, to reduce its occupancy rates and are broadly in line with the short term scenarios set out above 0-2 year timeframe.

### **1.4.4 Physical Solutions for RSH and PRH**

The capacity modelling exercise and the defined models of care from the clinical pathway groups have been used as a basis for agreeing the facility requirements. The new build requirements have been based on current recommended HBN space standards; refurbishment solutions are based on original contemporaneous standards with some enhanced provision. Schedules of accommodation have been developed for all elements of the scheme. A requirement for additional car parking spaces has been identified at PRH.

The Trust has engaged with the Local Authority, specifically in connection with Development Control and Highways, and they are broadly supportive of the proposals. On this basis the OBC assumption is that a Full Town Planning Application would be approved, subject to making a complete and accurate submission and undertaking the recommended level of detail consultation.

## **1.5 Workforce Assumptions**

The workforce baseline used is the budgeted establishment for each service for 2011/12. The plan has taken account of clinical adjacencies and the efficiencies that this will promote whilst also recognising the need for a minimal investment in paediatrics. The workforce summary is shown below.

Reference to	2012/13		2013/14	
	Wte	£000	Wte	£000
<b>Paediatrics</b>				
Consultants			0.4	45
Reduction in junior doctor banding supplement		(25)		(25)
Reduction in Associate Specialist PA requirements			(0.6)	(45)
SHOs			(2.0)	(88)
APNP	4.0	258		
Qualified nurses			4.19	263
Unqualified staff			1.8	15
<b>Neonates</b>	-	-	-	-
<b>Women's Services</b>	-	-	-	-
<b>Surgery</b>				
Qualified nurses			(4.12)	(160)
Unqualified staff			(1.14)	(24)
<b>Head and Neck</b>				
Qualified nurses			(0.88)	(36)
Unqualified staff			0.5	9
<b>Total</b>	4.00	233	-1.85	(46)

Key assumptions underpinning this plan are:

- In paediatrics, exploration of the possibilities of sharing staff and facilities with co-located clinical services such as A&E have been important. In paediatrics, exploration of the possibilities of sharing staff and facilities with co-located clinical services, such as A&E have been important. It has also been important to consider the recent recommendations from the Royal College of Paediatrics and Child Health (RCPCH) concerning consultant presence at times of peak activity, as well as the risks identified during the public consultation relating to availability and sustainability of middle grade medical rotas. Detailed work on Consultant job plans and new ways of working will be required as the FCHS Programme progresses. A small increase in consultant PAs (0.4 WTE) as directly attributable to the FCHS programme has been identified. This reflects the net effect of a requirement for increased Consultant availability. Further detailed work to assess and change job plans, including the potential to reallocate PAs amongst the Consultant body, will be carried out as the FCHS programme progresses
- The paediatric middle grades (Associate Specialists and Speciality Registrars at ST4-8) currently operate a combined rota to provide medical cover to all Children's Services. Detailed rota modelling has been carried out and this work has demonstrated the requirement to split the Associate Specialist and Speciality Registrar teams in order to deliver the service requirements of the FCHS programme. This means that the decision-making doctor present within the RSH PAU will be an Associate Specialist, with Consultant opinion available through an on-call mechanism. The detailed rota modelling carried out has demonstrated that these changes will not only enable the Trust to provide a high quality RSH PAU service, but will also reduce the total number of Associate Specialist PAs by 6
- The requirement for training grades to have Consultant presence at all times means that the Specialty Registrar team must be rostered to cover all of the other parts of the Children's Service, where Consultants will be present during normal day time hours. One advantage of the reconfiguration of children's services is the expectation that training places will be easier to fill as the unit will be relatively large, with a consolidated paediatrician workforce and be able to provide robust and wide-spread training opportunities
- It is intended to introduce a new role of Advanced Paediatric Nurse Practitioner (APNP) which will ultimately (once competent) form part of the middle grade medical rota. These posts will

address the risks around the sustainability of middle grade rotas and also provide an additional career step for the paediatric nursing team. Consequently the workforce plan for Children's Services includes provision for the training of 4.00 wte APNPs from September 2011 in order that they can be available for service delivery from June 2014

- Detailed rota modelling and discussion with the Consultant body has demonstrated that the current levels of service and adequate training opportunities can be provided whilst reducing the numbers of junior doctors (Foundation Years 1&2 and Speciality Registrars at ST1-3) by 2.00 wte. Additionally, it is possible to produce a rota which will produce a reduction in rota banding from a 2b (50% supplement) to a 1b (40% supplement).
- Following a skill-mix review the paediatric nursing establishment has been identified for the current service model. The proposed nursing workforce have been agreed with the development of much closer collaboration between the RSH PAU and A&E, which will be co-located and share a single portal of entry for the emergency services
- For surgery the drive towards reductions in LOS and the bed base and more effective theatre utilisation together with discussions regarding co-location of services, has resulted in nursing workforce reductions being proposed. This has achieved a reduction of 0.88 wte qualified nurses and 1.30 wte unqualified staff within the Head and Neck workforce, and a reduction of 4.12 wte qualified and 1.14 wte unqualified staff within Surgery
- The efficient and effective operation of theatres underpins service delivery for all of the reconfigured services. At this stage it is expected that theatre staff will remain in their present locations and, following a Skills Assessment, be provided with any relevant additional skills required. Although there is much work underway – and much change expected - in identifying and making more effective use of theatre capacity, there are no anticipated changes in workforce numbers as a direct result of the FCHS programme

As at 30 April 2011, SaTH employed 1,539 staff (1,338.6 WTE) in the core services affected by the FCHS programme. It is estimated that of these, approximately 575 staff will be directly affected by the programme and required to change work base. At this stage a detailed implementation plan has not been finalised. However it is possible to give an indicative time scale for the management of change and some suggestions of the key tasks that will require completion prior to that time.

<i>Action</i>	<i>Length</i>	<i>Proposed Date</i>
Internal consultation on FCHS with stakeholders (staff side, affected staff, all staff)		■ July 2011 until implementation
Development of iterative plans for implementation and transformation		■ July 2011 until implementation
Transformational change programme		■ OBC – December 2012
Line manager briefings & preparation for formal consultation	■ 1 month	■ February 2013
Notification of Department of Business, Innovation and skills		■ March 2013
Formal TNCC, group and 1:1 consultation	■ 4 months	■ March – June 2013
Recruitment process if required	■ 2 months	■ July – August 2013
Notice periods	■ 3 months	■ September – November 2013
Trial periods if required	■ 1 month	■ December 2013
Shadow operation/recruitment to gaps	■ 3 months	■ January – March 2014
Go Live		■ April 2014

In order to successfully implement and sustain the changes identified as part of the FCHS programme, it is essential that the Trust takes all staff, especially those who are directly affected, with it. The transformational change programme will not only include the mechanics of consultation

and formal processes but also staff involvement and engagement in the design and delivery of their services in the new setting. The approved OBC has been shared with the Trust Negotiation and Consultative Committee (TNCC) in August 2011 in order to begin formal consultation and also formally seek the involvement of the Trade Unions and Professional Associations in the process.

## **1.6 Development of the Options**

A long list of options to deliver the agreed proposals for the configuration of surgery, women's and children's services for both sites has been generated in accordance with best practice contained within the Capital Investment Manual and the Treasury Green Book. The do nothing option has been considered as a comparator for the merits of the other options. This option involves investing in backlog maintenance costs only together with the significant revenue consequence of increased medical staffing in order to meet necessary quality and safety requirements and maintain safe medical rotas. This option does not meet the Trust investment objectives or critical success factors.

In terms of the level of new build, an intermediate scope option was selected by the Trust rather than maximum new build. This was due to a number of reasons:

- greater alignment with the wider Trust objectives in terms of ensuring the full utilisation of resources
- ensuring appropriate levels of available capacity in the future whilst supporting a stronger financial position
- reducing capital costs and associated revenue costs.

The investment will deliver existing standards for refurbishment areas and latest standards for all new build components. Any legislative backlog requirements will be met.

Clear investment objectives and critical success factors were used to shortlist options and move from a long list of six options for each site. A shortlist of four options for PRH and three options for RSH were taken forward into the options appraisal process.

## **1.7 Economic Case**

### ***1.7.1 Qualitative benefits scoring***

A key component of any option appraisal is the assessment of the non-financial benefits that are likely to accrue from the options under consideration. For PRH, the results of the benefits appraisal took place within a clinical workshop.

This analysis shows that with both raw and weighted scores, Option P2 was the preferred option against the non-financial benefits criteria and option P4 second. Option P2 had more new build whilst P4 assumes that one ward will be released from the existing bed stock and will be refurbished to accommodate either inpatient obstetric or head and neck beds. Sensitivity testing was applied to these scores including reversing the weighting of each; this did not affect the outcome of the benefits appraisal i.e. Option P2 continued to be the preferred option, and Option P4 was always second.

At the time of the identification of the non-financial criteria and application of weightings, the Trusts wider bed capacity analysis had not been concluded. The impact that adopting the strategies for efficiency this modelling work provides was therefore not available. To maintain the integrity of the process, a future proof adjustment index has been applied in light of this wider bed capacity analysis (section 9) and the Trust's strategy to reduce its inpatient bed base in line with moving to upper quartile performance. This future proof index (ensuring flexibility for the future) ranges between 0 and 1.0 with 1.0 being perfect coherence with this strategy.

In both situations, this did not affect the outcome of the benefits appraisal i.e. Option P2 continued to be the preferred option, and Option P4 was always second. In addition, it would require a 21% increase in the total raw and weighted scores of Option P4 to become level with P2 but when comparing the post future proof index score this reduces to 3%.

The options for RSH were assessed against these criteria and with both raw and weighted scores, option R6 was the preferred option. Sensitivity testing was applied to these scores and it would

require a 5% increase in the raw score and 4% increase in the weighted score of option R3 to become level with R6.

### 1.7.2 Capital Cost Estimates

The Trust's quantity surveyors, Holbrow Brooks, have prepared a full set of OB forms for each of the short-listed options. The capital costs for the economic analysis are based on (BIS) PUBSEC for a projected start date of second quarter 2012 for PRH options and a projected start date of fourth quarter 2013 for RSH options. As detailed within the Treasury's Green Book, the costs used within the economic analysis exclude the effect of VAT.

The table below details the level of on-costs, the level of optimism bias and the total capital cost (excluding VAT). There are no capital implications for options P0.

Cost Item	Option P0	Option P1	Option P2	Option P3	Option P4	Option R0	Option R3	Option R4	Option R6
On- costs	-	56.24%	57.44%	57.23%	52.87%	20.00%	23.13%	19.66%	16.90%
Optimism bias	-	20.46%	20.15%	20.15%	19.84%	24.00%	26.40%	24.00%	24.00%
Total (£000s)	-	£29,344	£26,313	£25,427	£25,092	£14,250	£10,414	£6,319	£5,608

### 1.7.3 Revenue cost Estimates

The following recurrent income and expenditure assumptions have been used within the economic appraisal for the PRH options:

- Option P0 would result in the loss of the vascular surgery service and an associated loss of income of £285,000 has been recognised
- Options P1, P2, P3 and P4 allow the Trust to retain vascular surgery and as such allow the Trust to become a AAA screening site. An estimated income stream of £200,000 has been recognised
- Options P1, P2, P3 and P4 allow the Trust to perform certain paediatric elective work that currently goes out of the county to other providers. An estimated income stream of £100,000 has been recognised
- Option P0 would require additional staff costs to ensure rota compliance, cross site working and additional theatre and support staff. A staff cost amount of £2,443,000 has been recognised
- Options P1, P2, P3 and P4 allow for staff cost reductions within the Surgical centre. These are driven by the consolidation of services onto the RSH site. The impact is based on the more efficient usage of ward staff and equates to a reduction of 5.64 whole time equivalents (wte) with a cost saving of £211,000 being recognised
- Options P1, P2, P3 and P4 require staff cost increases within the Women and Children's centre and are driven by changes in the mix of type of staff within the Paediatric team. The recurring increase is 7.79 wte with a cost of £398,000 being recognised
- Options P1, P2, P3 and P4 increase the overall size of the estate and therefore incur additional running costs of cleaning and heat and light. The additional running costs have been costed from the Trust's ERIC data at rates of £19.95sqm for cleaning and £21.83sqm for heat and light

The table below summarises recurrent income and expenditure assumptions for PRH:

Cost Item	Option P0 (£000s)	Option P1 (£000s)	Option P2 (£000s)	Option P3 (£000s)	Option P4 (£000s)
Total Income	(285)	300	300	300	300
Total Pay Cost Effect	(2,443)	(187)	(187)	(187)	(187)
Total Non-Pay Cost Effect	-	(307)	(300)	(215)	(219)

The following recurrent income and expenditure assumptions have been used within the economic appraisal for the RSH options:

- Option R0 results in no additional income and expenditure items

- Options R3, R4 and R6 allow the Trust to repatriate and relocate its Finance and HR functions. The rent saving and the opportunity to rent the current HR offices as staff accommodation have been included as a saving of £329,000 and £70,000 respectively
- Options R3, R4 and R6 increase the overall size of the estate and therefore incur additional running costs of cleaning and heat and light. The additional running costs have been costed from the Trust's ERIC data at rates of £19.95sqm for cleaning and £21.83sqm for heat and light.

The table below summarises recurrent income and expenditure assumptions for RSH

<i>Cost Item</i>	<i>Option R0 (£000s)</i>	<i>Option R3 (£000s)</i>	<i>Option R4 (£000s)</i>	<i>Option R6 (£000s)</i>
Total Income	-	-	-	-
Total Pay Cost Effect	-	-	-	-
Total Non-Pay Cost Effect	-	334	393	396

#### **1.7.4 NPV Appraisal and Ranking**

The capital costs and income and expenditure costs for each of the shortlisted options have been subjected to a net present value/cost (NPV/NPC). The Equivalent annual cost (EAC) is calculated and to construct the preferred option, the qualitative benefits scoring merged with the EAC. The preferred option and ranking has then been generated by comparing the 'Cost per benefit point'. The tables below summarise how the preferred options for PRH and RSH are concluded from the cost per benefit point.

	<i>Option P0</i>	<i>Option P1</i>	<i>Option P2</i>	<i>Option P3</i>	<i>Option P4</i>
Weighted Benefit Score	79	270	715	539	695
Equivalent Annual Cost (£000)	2,616	1,586	1,430	1,311	1,299
Cost per benefit point	33.22	5.87	2.00	2.43	1.87
RANKING	5	4	2	3	1
DIFFERENCE (Marginal change required to make Option P4 not preferred)	(1677.8%)	(214.1%)	(7.0%)	(30.2%)	-

	<i>Option R0</i>	<i>Option R3</i>	<i>Option R4</i>	<i>Option R6</i>
Weighted Benefit Score	149	772	742	807
Equivalent Annual Cost/ (Benefit) (£000)	1,101	290	11	(31)
Cost/ (Benefit) (£000) per benefit point	7.39	0.38	0.02	(0.04)
RANKING	4	3	2	1
DIFFERENCE (Marginal change required to make Option R6 not preferred)	(19,388.6%)	(1,079.8%)	(139.9%)	-

The conclusions are that the preferred option is P4 with a 7.3% change required in P2 to make this an equivalent option. For RSH the preferred option is R6 with a 40.6% change required within R4 to make this an equivalent option. These preferred options have then been taken forward for analysis.

## **1.8 The Preferred Option**

### **1.8.1 Description of Preferred Option for PRH**

#### *1.8.1.1 Obstetric and Neonatal Services*

The transfer of obstetric and neonatal Services from RSH to PRH requires significant expansion of the existing estate. The Trust is of the view that such investment should concentrate on providing key clinical space within new build accommodation whilst utilising the limited available refurbished accommodation (vacated HSDU) for support accommodation. The proposed location for obstetrics and neonatology seeks to create clinical adjacencies between the existing paediatric department, imaging and A&E on the ground floor. On the first floor the key adjacencies are with existing theatres, refurbished support accommodation including on-call and relative's overnight stay plus a converted inpatient ward providing the balance of obstetric beds.

#### *1.8.1.2 Midwife Led Unit*

The Midwife Led Unit will remain in its current location and will receive a refresh in respect of appearance, lighting and finishes. The same approach applies to both WANDA (Day Assessment) and the antenatal clinic.

#### *1.8.1.3 Children's Services*

Children's Services are consolidated around the existing accommodation, providing two elements of new build extension, one to accommodate the longer stay oncology inpatients and the other to accommodate Paediatric Assessment Unit and paediatric outpatients. Proposals include enhancing elements of the existing Day Case Unit to create a 'child friendly' patient pathway. The new outpatient facility will make specific provision for discreet scheduling of immuno-compromised patients. A paediatric audiology facility is included. The Paediatric facilities are within close proximity to theatres, imaging and A&E.

#### *1.8.1.4 Women's Services*

Gynaecology outpatients will transfer to General Outpatients but will be zoned around a new Colposcopy Suite within the vacated and converted ophthalmology area. At first floor, Women's Services (Breast, Gynaecology and EPAU) are consolidated within existing ward 12-14, with close proximity to theatres.

#### *1.8.1.5 Head and Neck*

Transferred adult head and neck inpatients are located within ward 12-14, with close proximity to theatres and critical care. Proposals for a head and neck treatment room within the existing A&E are included.

#### *1.8.1.6 Site Works*

A section of the existing site access road and part of the car park to the north of the site will require adjustment, and replacement of displaced parking spaces is included within the proposals to provide a 200-250 place car park extension - subject to final ratification of the travel and traffic impact assessment commissioned by the Trust in connection with this project.

### **1.8.2 Description of Preferred Option at RSH**

#### *1.8.2.1 Midwife-Led Unit*

The proposed location for the Midwife Led Unit is at Level 2 of the main ward block, occupying a refurbished ward area. This location offers good vehicular and pedestrian access for patients and visitors, whilst maintaining a level of separation from other hospital activity.

#### *1.8.2.2 Obstetrics*

A proportion of the existing 'front-of-house' areas next to the new MLU will be converted to provide antenatal clinic and PANDA (Day Assessment) accommodation with the Early Pregnancy Assessment Service occupying a more discreet, but immediately adjacent suite.

### *1.8.2.3 Children's Services*

The retention of a Paediatric Assessment Unit at RSH, after the majority of service transfers to PRH, requires a new location with immediate adjacencies with A&E. The new PAU is planned to occupy the original paediatric head and neck inpatient accommodation that is collocated with A&E.

Children's outpatient facilities are delivered by re-commissioning outpatient consult / exam accommodation at Level 3 above main Outpatients. It is envisaged that paediatric audiology will be delivered in the same way as currently at RSH via existing facilities and booked children's clinic sessions.

### *1.8.2.4 Surgical Inpatients*

The impact of the surgical inpatient capacity at RSH requires an overall increase of 30 surgical beds. The creation of an Integrated Assessment Unit forms part of a wider Trust wide strategy, and the preferred option is realistically aligned with that objective as it allows a proportion of the surgical assessment beds to be integrated with the existing Medical Assessment Unit, the balance of SAU beds is located within the original adult head and neck inpatient accommodation that is immediately adjacent.

### *1.8.2.5 Clinical Support*

In order to expand and integrate assessment services, it is proposed to relocate the medical office support zone in this area in order to increase bed capacity. The management offices at Level 3 above main Outpatients will move to a more remote location in order to accommodate the displaced medical offices that require more immediate adjacency to clinical accommodation.

### *1.8.2.6 Non Clinical Support*

It is proposed to centralise a management suite of offices including Finance and Human Resources, within the vacated Maternity Building in order to 'repatriate' divisions that are currently located off-site. These will integrate with those management functions at RSH that are vacating offices at Level 3 above main Outpatients.

## **1.8.3 Design Strategy**

The PRH site has a very strong development pattern dominated by the original nucleus style development. In addition, the proposed new build site is in fact a gap within the original development control plan and had been earmarked for future development.

There is therefore a strong tendency toward providing new development that respects the cruciform and planning principles of Nucleus design, whilst responding to the modern construction and design drivers such as BREEAM and other current carbon and energy saving initiatives.

The scale of development at RSH is such that it is unlikely that any material external alteration will be required and that any minor works that are required will be in keeping with, and contemporaneous to, the existing estate.

The Trust is committed to a process of engagement and the creation of opportunities that will generate comment and feedback within a time frame that will benefit the design development. This process of engagement recognises various levels of interaction with clinical users, wider staff consultation via meetings, road-shows, newsletters and e-bulletins, patient and public involvement through developing speciality focus groups, encouraging design excellence via the formation of a Design Group and public consultation including local community representation and key stakeholders as part of the Town Planning process.

## **1.9 Commercial Case**

The Trust intends to use P21+ as this process reduces many of the risks to the project cost and timetable and removes much of the traditional adversarial nature of the design/construction management process. This procedure is advocated by the Department of Health unless there are reasonable grounds for following a more traditional route. This project will be funded by central government capital and will not be required to test the Private Finance Initiative.

The Trust will invite potential partners to tender for appointment under P21+ arrangements and will then work with the selected PSCP to develop the project at FBC stage.

## 1.10 Financial Case

### 1.10.1 Capital Funding Requirement

The Trust's quantity surveyors, Holbrow Brooks, have prepared a full set of OB forms for each of the short-listed options. The capital costs for the financial analysis are based on (BIS) PUBSEC for a projected start date of second quarter 2012 for PRH options and a projected start date of fourth quarter 2013 for RSH options. The capital costs include an element of non-recoverable VAT based on an estimated level of recoverable VAT. The estimate of recoverable VAT will require further clarification and ratification.

In the year 2011/12 the Trust is intending to use £1,000,000 of its internally generated capital funds to support all the fee elements directly associated with the production of the OBC and FBC.

	2011/12 (£000)	2012/13 (£000)	2103/14 (£000)	2014/15 (£000)	Total (£000)
<b>Option</b>					
P4	1,000	11,039	11,258	5,363	<b>28,660</b>
R6	-	192	1,762	4,343	<b>6,297</b>
<b>Total</b>	<b>1,000</b>	<b>11,231</b>	<b>13,020</b>	<b>9,706</b>	<b>34,957</b>
Funded by:					
Trust Capital	1,000	-	-	-	<b>1,000</b>
External loan (DH)	-	11,231	13,020	9,706	<b>33,957</b>
<b>Total</b>	<b>1,000</b>	<b>11,231</b>	<b>13,020</b>	<b>9,706</b>	<b>34,957</b>

### 1.10.2 Impact on the Organisation's I&E Account

The preferred options will allow the Trust:

- to retain vascular surgery and as such the Trust is aiming to become a 'AAA' screening site. An estimated income stream of £200,000 has been included from 2012/13 onwards
- to perform certain paediatric elective work that currently goes out of the county to other providers. An estimated income stream of £100,000 has been included to recognise this activity from 2013/14 onwards
- to reduce surgical staff costs driven by the consolidation of services onto the RSH site. The impact is based on the more efficient usage of ward staff and equates to a reduction in 2013/14 of 5.64 whole time equivalents (wte) with a cost saving of £211,000
- to repatriate finance and HR onto the RSH site with a saving of £329,000 and £70,000 respectively.

Staff cost increases are however being planned within the Women and Children's centre over the first two years of the project and are driven by changes in the mix of type of staff within the Paediatric team. The increase in 2012/13 is 4.0 wte at a cost of £233,000 and an additional 3.79wte in 2013/14 at a cost of £165,000.

There is a net increase in the size of the estate by 5318 sqm. The additional running cost number included within the non pay element is £222,000.

A summary of the impact of the financial appraisal is shown below:

	2011/12 (£000)	2012/13 (£000)	2013/14 (£000)	2014/15 (£000)	2015/16 (£000)	2016/17 (£000)	2017/18 (£000)	2018/19 (£000)
Total Income	-	200	200	300	300	300	300	300
Total Pay	-	(233)	(187)	(187)	(187)	(187)	(187)	(187)
Total Non Pay	-	-	(500)	177	177	177	177	177
Total Capital Charges	(18)	(469)	(948)	(2,282)	(2,252)	(2,213)	(2,178)	(2,141)
<b>Total Charge</b>	<b>(18)</b>	<b>(502)</b>	<b>(1,435)</b>	<b>(1,992)</b>	<b>(1,962)</b>	<b>(1,923)</b>	<b>(1,888)</b>	<b>(1,851)</b>

### **1.10.3 Revenue Impact and Affordability**

Key to the affordability of the development is the Trusts recurring cost improvement programme (CIP). The Trust has recently commissioned PriceWaterHouseCoopers (PWC) to assist in the identification and planning of CIP schemes. This has resulted in the identification of 14 work streams that require progression within the Trust. The Trust has prioritised 8 schemes for delivery in 2012/13 and the remaining schemes to delivery in 2013/14. Detailed project plans with clear lines of responsibility and accountability for delivery are in place.

	<b>2011/12</b> <b>(£000)</b>	<b>2012/13</b> <b>(£000)</b>	<b>2103/14</b> <b>(£000)</b>	<b>2014/15</b> <b>(£000)</b>	<b>2015/16</b> <b>(£000)</b>
Income	290,100	287,400	289,300	295,100	301,000
Pay	(199,800)	(201,000)	(206,900)	(214,100)	(222,700)
Non Pay	(76,400)	(81,000)	(84,600)	(88,500)	(92,400)
Finance Costs	(13,900)	(13,900)	(13,900)	(13,900)	(13,900)
<b>Total Before CIP</b>	<b>-</b>	<b>(8,500)</b>	<b>(16,100)</b>	<b>(21,400)</b>	<b>(28,000)</b>
PWC CIP Schemes (see section 16.7)	-	17,000	21,000	21,800	22,700
Trust CIP Schemes	-	-	-	5,900	11,900
<b>Total Post CIP</b>	<b>-</b>	<b>8,500</b>	<b>4,900</b>	<b>6,300</b>	<b>6,600</b>

The top three schemes are medical workforce, nursing workforce and capacity management amounting to £11.5m of the £17m identified in 2012/13. A robust programme management approach has been put in place to ensure the delivery of all schemes through the establishment of a Programme Management Office (PMO) together with external support from PWC.

In concluding on the affordability issue, the cost differential between Reconfiguration and the 'do nothing' option has significant relevance. The increased revenue cost associated with taking forward the preferred reconfiguration option introduces a cost pressure to the Trust amounting to £1.4m per annum in 2014 rising to £1.6m per annum by 2021. However to deliver the 'do nothing' option requires substantial investment in staffing levels across both Surgical and Paediatric specialties. This investment when combined with the increased capital charges associated with essential backlog maintenance results in a cost pressure to the Trust amounting to £2.4m per annum in 2014 rising to £3.2m per annum in 2021. The cost pressure therefore arising from supporting the capital costs required are compensated through the avoidance of significant increased staffing costs as required with the 'do nothing' option.

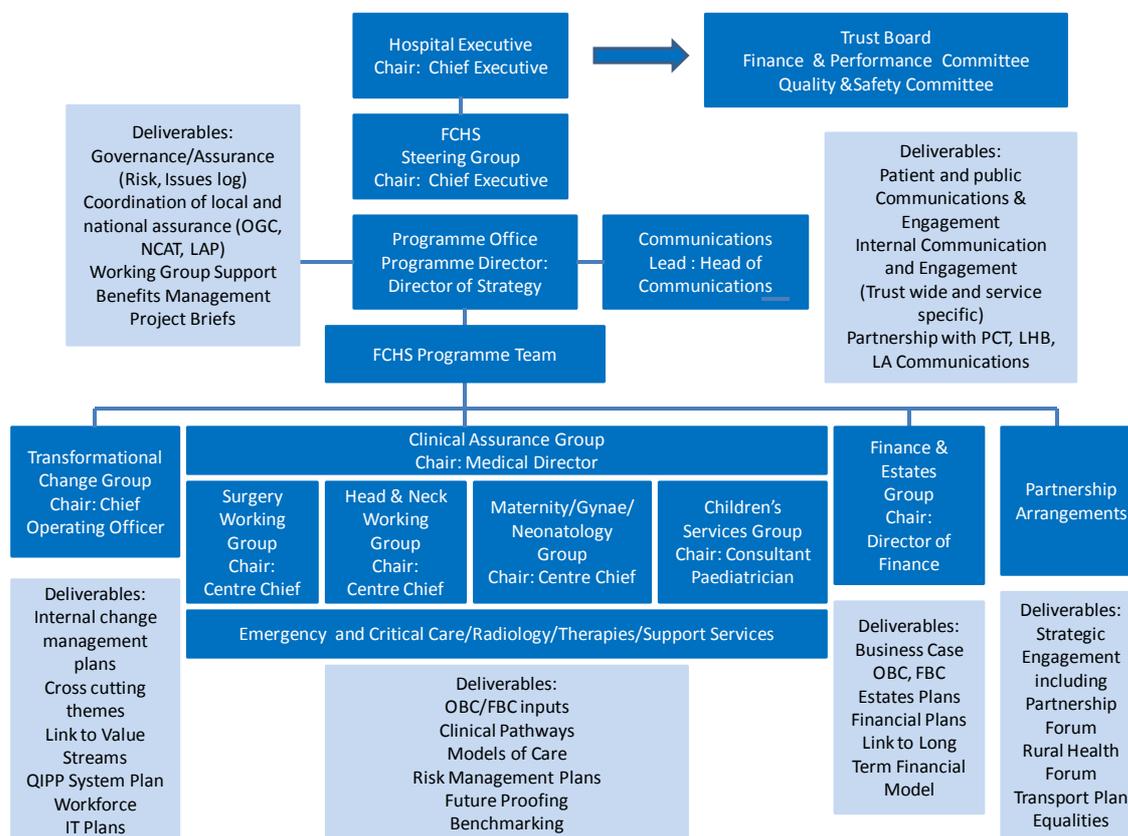
## **1.11 Management Case: Programme Management Arrangements**

### **1.11.1 Programme Governance**

The programme will continue to be managed according to the Project Initiation Plan. It will be clinically-led by local clinicians. Its outputs and developments will be shared widely with partners and will be based on external reviews, on-going PCT assurance testing and full engagement and involvement of the local Health Overview and Scrutiny Committees and Community Health Council.

The programme arrangements are underpinned by a robust structure and agreed levels of accountability to ensure the scheme is delivered successful by the end of 2014. Clinical engagement and leadership with robust management support will be key to a successful implementation.

The programme structure for Phase Two was agreed at the Trust Board meeting on 28 April 2011 and is provided below.



There is a dedicated project manager in place currently reporting to the Director of Strategy. The Programme Team will meet/communicate weekly within the Programme Management Office function (PMO). Progress will be reviewed, risks identified and reassessed and issues and challenges with the deliverables shared.

The Trust will also undertake a comprehensive assessment of the risk associated with the preferred option. The risk appraisal will involve identifying all the possible business and service risks associated with the preferred option and will include risks, other than financial, to the Trust from the development e.g. general project risks, service planning risks, workforce planning risks, capital planning risks, construction risks and operational risks.

It is expected that the implementation phase will start from April 2012. However, due to the current level of clinical risk, a more immediate change may need to be implemented within some services. These include relocating acute surgery onto a single site. The programme structure has been established to implement the necessary changes and clinical leadership remains central to the programme. A detailed programme plan to FBC stage will be approved by the Trust Board in September 2011.

### **1.11.2 Benefits Management Strategy and Post Project Evaluation**

The Trust has developed a Benefits Management Strategy, The high level benefits have been identified and possible measures proposed: This plan will form part of the evaluation stage. The Trust is committed to full evaluation of all major schemes and projects through a formal evaluation methodology that will provide evaluation by the Trust of the capital development, with involvement as necessary from local commissioners and an evaluation of the overall project process by the Trust. Post Project Evaluation will be undertaken as an integral part of the monitoring of benefits realisation. The Trust will also create a 'lessons learned log' which will consider the issues raised and potential solutions to avoid reoccurrence in the future.

## **1.12 Recommendations**

The overarching objective for the reconfiguration of hospital services is to secure high quality, safe and sustainable hospital services in Shrewsbury and Telford. With this in mind the Trust has reviewed the different options set out in this OBC with particular consideration to delivering a clinically safe model of care i.e. maintaining key clinical adjacencies, minimising disruption to existing services, supporting longer term strategic service developments, providing value for money whilst ensuring affordability in the immediate and longer term.

Implementation of these service changes will address the significant challenges to the future safety and sustainability of acute surgery and our local women's and children's services.

It is recommended to approve this OBC and proceed with the development of the full business case for the Future Configuration of Hospital Services.