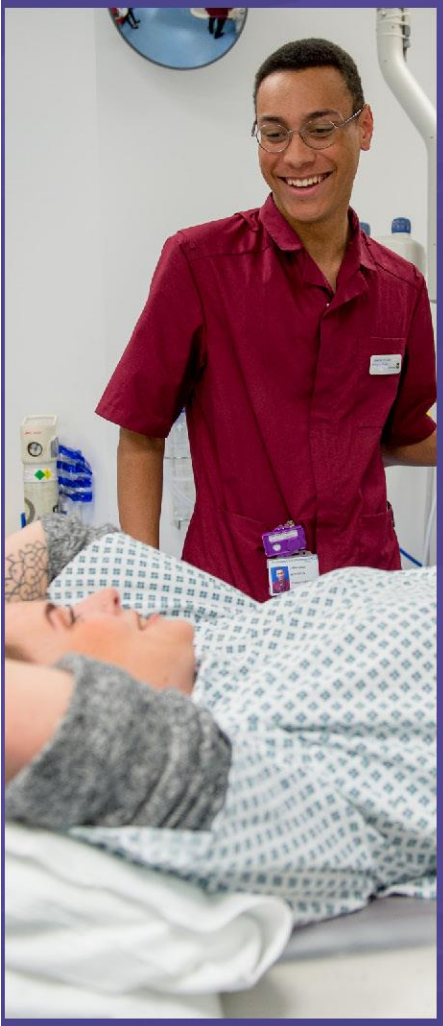
Integrated Care System

Shropshire, Telford and Wrekin



TRANSFORMING THE ROYAL SHREWSBURY HOSPITAL AND THE PRINCESS ROYAL HOSPITAL

STRATEGIC OUTLINE CASE

NHS

The Shrewsbury and Telford Hospital NHS Trust

Foreword

We welcome the opportunity to present this Strategic Outline Case (SOC). It is a crucial step in our plans to address critical challenges at the Princess Royal and Royal Shrewsbury Hospital sites. It reflects our commitment, as a system, to resolve longstanding challenges of duplicated and fragmented services in an ageing infrastructure that is not fit for delivery of twenty-first century healthcare – issues that have only been amplified by the COVID-19 pandemic.

The right care in the right place for the right people

We cannot continue to operate a clinical model that is fragile and from buildings that do not have the space or flexibility for modern healthcare. This is creating growing challenges to the services in the local health system, and we're committed to addressing them as soon as possible.

We have an agreed solution that invests in healthcare infrastructure to improve care for patients across Shropshire, Telford & Wrekin and Powys. In 2019 the Government's Independent Reconfiguration Panel recommended implementation without delay, which was supported by the Secretary of State for Health and Social Care. We now need to deliver this solution.

The preferred way forward described in this Strategic Outline Case will improve both hospital sites, increase flexibility to respond to future changes in demand and population need, and provide a better environment for both staff and patients. A centre for planned care will be located at the Princess Royal Hospital site, which will also offer urgent care to patients who need it through an A&E Local model. The Royal Shrewsbury Hospital site will become a centre for emergency care, offering leading emergency and critical care. These investments will make tangible improvements to the quality, accessibility and experience of the care available to all of our communities.

A significant opportunity

This proposal represents a significant opportunity to invest in our region and contribute to the national Levelling Up agenda. We've made sure that the proposal offers great value for taxpayers – more than many other public sector investments – in an area with a history of underinvestment.

We recognise that this development is critical to our success as an integrated care system. The Hospitals Transformation Programme (HTP) forms a key part of our overarching vision to transform health and care services across Shropshire, Telford and Wrekin. The SOC has the full support of the Shropshire, Telford and Wrekin Integrated Care System; Shropshire, Telford & Wrekin CCG; and The Shrewsbury and Telford Hospital NHS Trust. Together, we have resolved to take action to make the changes that were agreed in 2019 following public consultation. The quality and service changes included in this proposal are critical to support our recovery from COVID-19 and in helping us to build towards a sustainable health and care system.

Implementing this proposal will allow us to make substantial improvements to the care we provide for our patients. We now need to honour the commitments we have made and take forward the preferred way forward outlined in this SOC.

[Signatures to be added]

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Contents page

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Document sign-off

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Executive summary

The current configuration and layout of acute services in Shrewsbury and Telford will not support future population needs and will present an increasing challenge to the staffing, quality and continuity of services. We completed a public consultation (Future Fit) in 2018 which concluded that the recommended solution should be implemented without delay.

In 2019, following extensive public consultation, we made a strong, public commitment to reconfigure our services and resolve longstanding issues. These challenges prevent us from delivering the quality of care and safe, robust services our patients deserve and from attracting and retaining the best staff. At the time, the Independent Reconfiguration Panel recommended implementation 'without further delay' and the findings were supported by the Secretary of State. The DHSC agreed to invest the capital required to deliver the proposed solution.

Since then, COVID-19 has further highlighted the urgent need to reconfigure, and the Care Quality Commission has highlighted significant quality and safety challenges linked to our estate and the configuration of our services. These issues present an increasing risk to the staffing, quality and continuity of services.

Delivering the agreed clinical model is essential for providing long term sustainable, high quality care and will also achieve a range of significant benefits for all of our local communities. The planned reconfiguration will deliver a step change in clinical care for patients by delivering the improvements in emergency and planned care we committed to in 2019. It will provide quicker access to specialist consultants, improve the quality of the care we can provide, and help to address our workforce gaps by bringing fragmented teams together.

We will reconfigure the estate within the two hospital sites serving our population and patients, with an emergency care centre at the Royal Shrewsbury Hospital and a planned care centre at the Princess Royal Hospital (Telford).

Our proposal will improve the environment to deliver modern, safe and effective healthcare. This will lead to better outcomes for patients and improve their experience of care, as well as creating a more attractive place to work. We will enhance the physical environment and substantially reduce the estates risk, ensuring services have the right clinical configurations, adjacencies and layouts for excellent healthcare.

We will be better able to meet future healthcare challenges. New facilities will improve accessibility and be more resilient against the impact of community and healthcare-acquired infections such as COVID-19. They will incorporate dedicated capacity for planned care to reduce waiting lists and help integrate care pathways across Shropshire and Telford & Wrekin as set out in the NHS Long Term Plan. The reconfigured services will provide more single rooms and the capacity to meet the needs of a complex and ageing patient population, including dedicated planned care facilities.

This SOC appraises a number of strategic options that will deliver the service reconfiguration agreed through the Future Fit consultation, thereby addressing a number of the health system's most pressing acute challenges. These challenges arise principally from two inadequately sized Emergency Departments, split site delivery of key clinical services (including critical care), insufficient physical capacity (particularly impacting elective services), mixing of planned and unplanned care pathways and poor clinical adjacencies.

In assessing the available strategic options, this SOC seeks to explore the most appropriate way to balance a number of competing priorities and objectives:

- delivering the full ambition behind the extensive public consultation (Future Fit)
- implementing new national standards (for example around COVID-19 requirements, increased proportion of single rooms and Net Zero)
- establishing a sustainable infrastructure to support the delivery of excellent healthcare
- the funding available to achieve those changes - the current allocation of funding for this scheme is based on costings, inflation assumptions and national standards from 2016

Our preferred way forward involves investing £312m in Royal Shrewsbury Hospital and Princess Royal Hospital to provide improved facilities that will better meet the needs of our patients. It will put in place the core elements of the service reconfiguration described in the Future Fit consultation, help us to address our most pressing clinical challenges, and establish solid and sustainable foundations upon which to make further improvements. A number of significant challenges will remain, particularly in relation to the standard of patient accommodation at the RSH site, and whilst these can be managed over the medium term, they will need to be addressed in the long term.

The preferred way forward is also fully aligned with local health system objectives and is one of a number of strategic initiatives that will transform the health and wellbeing of the population of Shropshire, Telford & Wrekin and Powys. One of the core local health system assumptions underpinning the design of the Hospitals Transformation Programme relies on the transformation of out of hospital services, which will be delivered through the Integrated Care Systems Local Care programme and is expected to lead to a much lower increase in acute bed requirements over the medium to long term.

Our proposals offer excellent value for money for taxpayers, with a higher benefit-cost ratio than many public sector schemes (3.7) and a significant positive net present social value. We will continue to test the value for money of this scheme and identify ways to improve it, through the business case process.

The Trust has established rigorous governance arrangements (which also involve system colleagues) to support the successful delivery of this project and has a track record of delivering complex infrastructure developments to time and budget. Project timelines are dependent on securing timely progress though approval-to-proceed gateways. If there are delays in delivery timelines, inflationary pressures are likely to impact capital costs and increase the funding required to deliver the preferred way forward.

This document seeks approval to progress to the Outline Business Case (OBC) with the Core DMBC ('Do Minimum') option as the preferred way forward, with a capital funding requirement of £312m.

Timely regulatory review and approval processes will be essential to maintaining the timescales for implementation outlined in this SOC and to minimising additional inflationary impacts on the capital funding requirement.

This document also seeks approval for the drawdown of additional capital funding totalling £9.9m to support the development of the OBC, including the detailed design work.

This document is the latest stage in implementing the Future Fit consultation decision to reconfigure services across the Royal Shrewsbury Hospital (RSH) and the Princess Royal Hospital (PRH) sites.

We have carefully considered the strategic context and case for change to make sure that the targeted hospital investment is aligned to the configuration confirmed by the Future Fit consultation. Based on this, we have worked through a range of options to meet the aims for this investment and deliver the agreed configuration of services. We have agreed an affordable and deliverable way forward.

This strategic outline case (SOC) seeks approval to proceed with our preferred way forward to outline business case (OBC) stage. It has been developed in line with relevant guidance and with the standard gateway process for NHS investment. Our preferred way forward will generate significant benefits for our patients, improving the quality, safety and experience of care while generating efficiency and sustainability benefits.

The need for investment in our existing hospital sites (strategic case)

Our urgent case for change

As a system and a Trust, we face multiple long-running challenges that mean we need to change how services are configured and supported. The current clinical service configuration does not meet the needs of patients. There are two inadequately sized emergency departments, split site delivery of key clinical services (including critical care), insufficient physical capacity (particularly affecting elective services), mixing of planned and unplanned care pathways, and poor clinical adjacencies.

There is a pressing need to tackle these issues, which has only increased in the three years since we made a strong public commitment to address the problems by reconfiguring services. COVID-19 has further highlighted the need to reconfigure, and the Care Quality Commission (CQC) have also highlighted the adverse impact that our current service configuration is having on the quality and safety of our services. If we cannot make changes, there is an increasing risk to the staffing, quality and continuity of core clinical services at both sites.

"If we continue the way we are now, we do not believe that all of our patients will receive safe, high-quality care and treatment all of the time. The only way that we can make the improvements that we need is by changing the way we deliver services at our two hospitals. Doing nothing and staying as we are, is simply not an option."

Future Fit Consultation Document (2018)[1]

In 2019, the Independent Reconfiguration Panel and the Secretary of State for Health and Social Care endorsed this proposed configuration and clinical model. This validated the need for these changes and the urgency of implementing them "without further delay". As part of this SOC, we have progressed the plans by considering options for delivering the clinical model agreed as part of Future Fit.

As a system, we committed to making these changes. NHSEI and DHSC also agreed to make the required capital investment.

"The Panel's view is that the proposal to establish a single emergency centre at Royal Shrewsbury Hospital with a full range of complementary services at Princess Royal Hospital, Telford, is in the interests of health services in Shropshire, Telford and Wrekin and should proceed without further delay."

Independent Reconfiguration Panel, supported by Secretary of State (2019)

Our critical issues

- **The clinical model is not fit for purpose because of an outdated service configuration that prevents us from addressing quality and operational issues, contributing to an 'inadequate' CQC rating**

  The current model offers two admission routes for emergency patients across two sites, with some services duplicated and others with over complex, ineffective pathways, disrupted flow and consequential ambulance waits. As a result, access to appropriate care can be slow, complex and inefficient – leading to poor quality care and increased risk to patients.

[1] https://nhsfuturefit.org/key-documents/draft-public-consultation-documents/full-consultation-document-1/506-public-consultation-document-english/file

The current hospitals do not provide sufficient capacity or dedicated facilities for emergency care. This means patients are at risk of healthcare-acquired infections and, during busy periods, planned care patients are cancelled to create emergency capacity. This goes against the national direction of travel towards dedicated planned care facilities and shorter waiting times for treatment.

As a result, we struggle to achieve quality standards, with 4-hour A&E waits, 62-day cancer waits and referral-to-treatment all considerably below target.[2] Our CQC rating has deteriorated from 'requires improvement' (2015) to 'inadequate' (2021). The CQC identified significant issues associated with the estate and its configuration, which adversely impact medical staffing recruitment/retention and contribute to a poor patient experience. We cannot fully address these issues without changing our service model and investing in an improved environment.[3]

- **The workforce situation is not sustainable if we continue to duplicate services across both sites**

  We are unable to meet NHS Seven Day Services Clinical Standards and professional guidance for consultant-led care, partly because there is duplication of services across the two sites. There are also significant long-term recruitment challenges leading to agency use of c. £30m p.a.

  Delays in implementing the new configuration are having an increasing adverse impact on recruitment and retention of our staff as well as having a negative impact on staff morale. Certain emergency department and anaesthesia vacancies have been unfilled for over five years – and this is directly linked to the model of care. Currently, only 38% of staff would recommend the Trust as a place to work.

- **Our population is older than most areas – creating additional pressure on our services**

  Shropshire's over-65 population is set to grow from c. 25% (2018) to c. 33% (2043) of the total population. Telford & Wrekin is similarly growing from c. 18% to c. 23%.[4] These are both higher than national averages and contribute to expected growth in demand for inpatient care of c. 10% by 2024/25 – requiring c. 109 extra beds. This ageing population profile means we need to provide care differently by responding to complex care needs and health inequalities in a more integrated way.

- **Our buildings do not give us the capacity, space or layout we need for modern healthcare – and do not provide adequate support for infection control**

  With our current buildings, we do not have the capacity we need to deliver emergency care. Our accident and emergency departments are too small for modern emergency care and our wards, especially at RSH, have structurally poor layouts.

  We cannot recover planned care capacity or implement the national planned care backlog requirements without dedicated capacity to improve performance. The current clinical and operational model inhibits our ability to sustainably ring-fence planned care capacity.

  COVID-19 has highlighted the need for improved infection control, better hygiene facilities and separation of planned and emergency flows. There are no dedicated isolation rooms at RSH/PRH (we installed emergency pods temporarily for COVID- 19) and RSH has only 23 single rooms across its c. 400 beds (c. 5%) – which is far lower than peer comparators and latest national standards (70%). The RSH site is poorly configured, with patient pathways fragmented across a large site with poor clinical adjacencies.

  We have an ageing estate which will require investment of c. £96m over the coming five years. Sixty-eight per cent of RSH is considered poor/expired (including critical care, theatres, inpatient wards, pathology, pharmacy, imaging, outpatients). Twenty-eight per cent of PRH is considered poor (including theatres, A&E, imaging, outpatients, pathology, pharmacy).[5]

  Delays in implementing solutions to these issues have meant we have resorted to a range of temporary, ad hoc solutions, including modular accommodation. This contributes to fragmented pathways (particularly at RSH) and an unsustainable long term development strategy.

  We need a new clinical model, with dedicated emergency and planned care facilities.

- **The local health system has one of the largest financial recovery challenges in the NHS and there is a risk that the financial position will deteriorate further if we do not change the way we operate**

  In 2021/22, Shropshire, Telford & Wrekin Integrated Care System (STW) had a projected deficit of c. £115m, that will grow to c. £172m by 2026/27 if action is not taken. Our worsening deficit is driven by demand, agency spend and service costs; our current service configuration costs us c. £14.6m a year (last estimated 2019, Drivers of the Deficit Report).

  To overcome the challenges described above, we urgently need to change how services are configured across our sites and invest in appropriate facilities to support this – and we have an agreed solution. The Future Fit

[2] NHS Digital; Care Quality Commission; Model Hospital
[3] https://api.cqc.org.uk/public/v1/reports/540c3e74-b764-4915-9728-e99c444348d8?20210330144607
[4] Office of National Statistics
[5] Six Facet Survey; ERIC return

consultation looked at the issues, consulting the public on a new configuration of services in 2018. In 2019, our commissioners confirmed the decision to reconfigure services and invest in RSH as an emergency site and develop a planned care centre at PRH.

Given the pressing urgency of our challenges, we need to move quickly – implementing these changes cannot wait any longer.

To address the challenges outlined in the case for change, we have established an ambitious and achievable Hospitals Transformation Programme (HTP).

Scope of this business case

This SOC builds on the work completed previously and the agreed configuration of services and intends to move the trust towards the outcome agreed within the Decision-Making Business Case (DMBC; Appendix A). This previous work identified PRH would be a centre for planned care and RSH would become the centre for emergency care. It considered alternative configurations (including single-site options) and discounted them as not offering the right solution for our patients and the taxpayer.

We are not planning to review this decision, this has already been determined following the consultation and the subsequent review by the Independent Reconfiguration Panel. In 2019, it was recommended that this solution should be implemented without further delay. COVID-19 and recent challenges have only underlined the need to move quickly to the agreed solution.

Feedback from wider NHSEI colleagues has confirmed that we must consider an option that only utilises the allocated funding. As this will not enable the delivery of all of the wider Future Fit ambitions (due to the impact of inflation in the past three years), this SOC assesses the options against their delivery of the core DMBC requirements and how much of the wider Future Fit ambitions they deliver. A number of the options explore the additional benefits that would be realised with a larger investment.

A number of parallel developments are supporting these changes. The scope of this SOC complements the Trust's and the local health system's wider strategic goals that will deliver elements of the DMBC and/or wider Future Fit ambitions, including:

- Targeted Investment Fund 2 (TIF2) funding for a regional day case hub at PRH – this will deliver the day case components of the Future Fit consultation
- Public Sector Decarbonisation Scheme (PSDS) funding for the Energy Centre at RSH – this will deliver critical components of the strategic estates plan
- capital funding for renal dialysis at Telford – this will deliver critical components of the strategic estates plan linked to a more recent public engagement
- funding for the health system's digital transformation plans

These are not included in the options considered in this SOC as they are separate developments but the interdependencies with this programme will be rigorously and continually managed.

Delivering the core DMBC requirements and moving towards the wider Future Fit ambitions is the priority investment objective of this SOC. This underpins the development of the options, and as such all SOC options (except business-as-usual) must support the Trust in the delivery of the outputs of the consultation (see Economic Case).

The benefits for the population of Shrewsbury, Telford & Wrekin and Powys (strategic case)

In our new service model, we consolidate specialist services onto single sites (with the required clinical adjacencies). That means when patients need specialist care, they will get the best care available at the right time, in the right place from the right clinicians. Both hospital sites will provide 24/7 urgent care, and routine services like outpatients and diagnostics, so most people will continue to be cared for at their local hospital site.

Benefits of investment

- **Significant improvement in the quality of care**

  Consolidating expertise will address a number of problems associated with our existing clinical model.

  We plan to consolidate the emergency department and critical care onto a single site, co-located with speciality assessment areas, urgent treatment and same day emergency care. This will enable a greater amount of timely consultant-delivered decision-making and care, and improved access to key multi-disciplinary teams which will lead to improved patient experience and outcomes.

  This systemic change will reduce morbidity, mortality, and harm, and reduce length of stay with a better patient experience while meeting operational targets. Dealing with a greater critical mass of cases, will help our clinicians

develop their skills further and contribute to a more collaborative environment for specialists and for education, supporting improved staff recruitment and retention.

- **Appropriate capacity, well-designed facilities and more space**

  We will have two, significantly refreshed hospital sites at the Royal Shrewsbury and Princess Royal Hospitals (the preferred way forward also addresses over £16m of our existing maintenance backlog, which is primarily linked to the enabling works associated with the new build infrastructure at RSH).

  Modern, fit-for-purpose facilities will improve clinical adjacencies and flows through the hospitals and offer greater capacity and space in all departments – contributing to an enhanced patient experience, along with the provision of more efficient and effective care. Providing more single rooms will improve privacy, dignity and infection control.

  This will be a substantial investment in healthcare for the people of Shropshire, Telford & Wrekin and Powys – making a positive impact to the health and well-being of all of our communities and contributing to the Government's levelling up agenda.

- **Improved access to services**

  Improved flow and dedicated capacity will help reduce waiting times for services (urgent, emergency and planned), improve overall access to care and address the national planned care backlog. Patients will not need to wait as long for treatment, and we can treat more patients, more quickly.

  This is aligned to the national direction of travel. The new model will enhance support for long-term conditions, through better integrated working, and contribute to efforts to reduce health inequalities, aligned to both the NHS Long Term Plan and our local health system plans.

- **Fewer cancellations, shorter waiting times and reduced infection rates**

  Separating emergency and planned care will ensure there is appropriate reliable planned care capacity which will reduce cancellations and waiting times and improve throughput and bed utilisation. This will enhance both the patient experience, quality and performance of services.

  Managing planned care flows separately will also improve infection control, reducing rates of healthcare-acquired infections and improving patient safety. Dedicated planned care facilities will offer enhanced access to rehabilitation and better-quality care, improving surgical outcomes and reducing complications. The COVID-19 pandemic has highlighted the need to make these changes.

- **Becoming an employer of choice within the local health system**

  Consolidating the current fragmented and duplicated services will make clinical posts more attractive by offering the opportunity for better working arrangements, as well as an enhanced professional and teaching environment. Developing new roles to enhance the workforce with leading models of care will also contribute to a more sustainable workforce, especially where there are continued national and local recruitment issues.

  Our hospital sites will offer unique and exciting employment opportunities and support our ambition to become an employer of choice.

- **Improved performance and efficiency**

  The HTP is one of six key system priorities, is critical to the clinical and financial sustainability of STW and is a core part of the STW recovery plan.

  Consolidating services will lay the foundations for improved efficiency and contribute to a more sustainable system. Improved performance and delivery will cover the costs of the necessary capital investment and support reductions in both the Trust and system deficits.

Given the current and pressing need to improve care for our patients we need to achieve these benefits as soon as possible.

Table 1: Benefits of transforming our hospitals

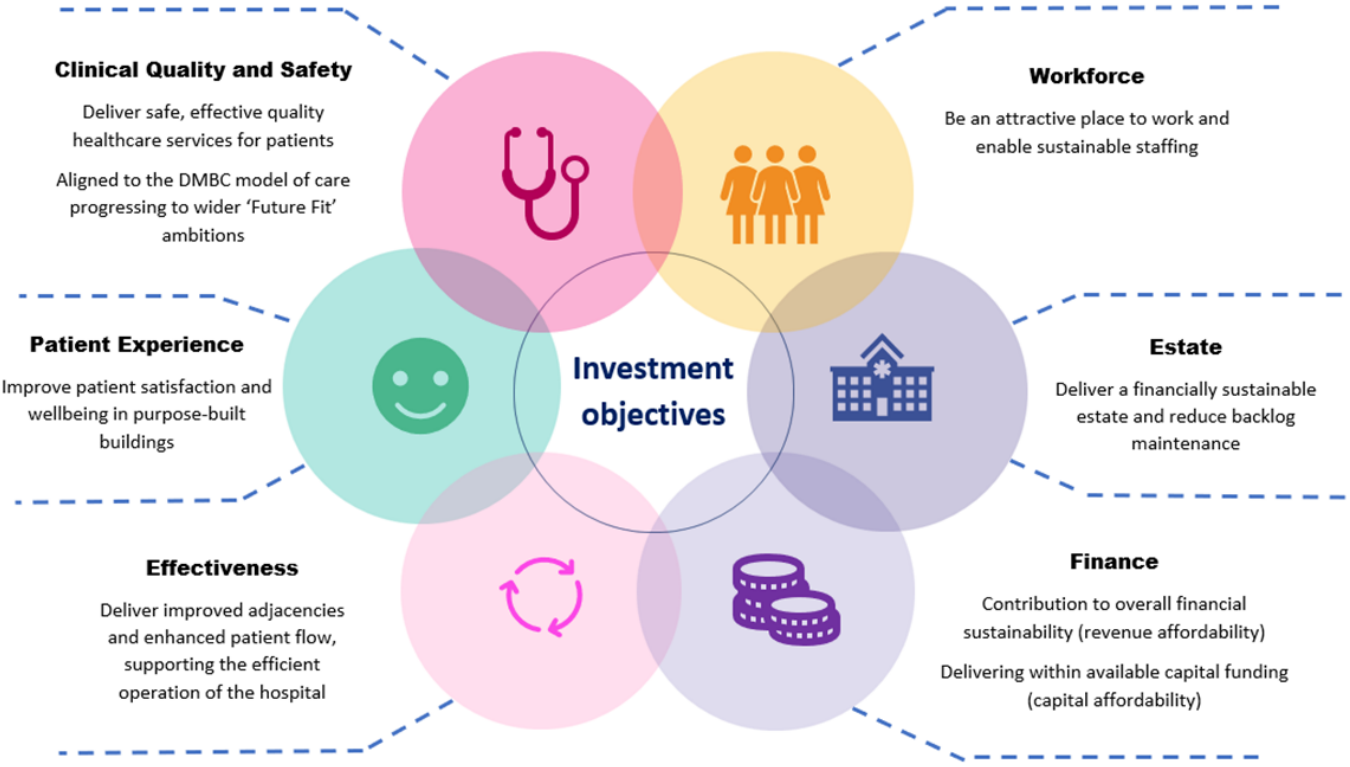
Princess Royal Hospital: Planned care centre	Royal Shrewsbury Hospital: Emergency care centre
• Planned care centre - optimising care pathways • Leader in day case development • Refined inpatient medical care • Better access to rehabilitation and wellness services • Much improved patient experience – including lowering infection risks, reducing cancellations, reducing patient waits • Improved operational performance – including Referral to Treatment, reduced waiting lists • 24/7 urgent care model that maintains local services for most patients through an A&E local model • Improved recruitment and retention of staffing	• Improved quality of care – immediate access to appropriate senior clinical decision-maker, supported by clinical adjacencies – delivering better outcomes for patients • Right-sized critical care facilities, consolidated on a single site • Better patient experience – including privacy and dignity, shorter waits, shorter hospital stays • Improved patient flow and operational performance – including eliminating of 12-hour breaches and considerably reducing delayed ambulance handovers • 24/7 urgent care model that maintains local care for most patients that currently attend A&E • Improved recruitment and retention of staffing

Assessing the best value option for delivering the clinical model outlined in the consultation (economic case)

Delivering the required changes will require investment in appropriate facilities and services. This SOC considers the options for this investment, building on the options analysis completed as part of Future Fit. Future Fit agreed how we should configure our services and we have taken this as our starting point.

Our analysis is based on a set of clear investment objectives, summarised below, which define what we want to achieve by investing in our hospitals. Our primary objective is to rapidly move towards the commissioner configuration decision in the DMBC and model of care, as this is the most urgent change needed to how we operate. The delivery options have been assessed against how well they achieve our HTP investment objectives.

Figure 1: HTP investment objectives



We have considered a range of options for reconfiguring services and improving care for our patients. We have appraised them against our critical success factors and identified a preferred way forward.

In developing these plans, we have learned from new hospital developments across the NHS (including the New Hospitals Programme), innovations in digital, technology and opportunities to utilise modern methods of construction.

Critical success factors

Based on our investment objectives, we defined a range of critical success factors for assessing the options. These are all the factors an option must pass for us to give them further consideration. We have also identified where an option is preferred (most favourable) against each of the critical success factors.

Options for delivering our commitments and investing in our hospitals

Based on the HM Treasury options framework, we considered a wide range of options and generated a long list. These options build on the conclusions of Future Fit and the DMBC and consider ways to implement the agreed clinical model to support the delivery of improved services for all of our population across Shropshire, Telford & Wrekin and Powys.

The clinical model delivered by the options we explored is consistent with the acute components of the agreed Future Fit model of care which we consulted on, and which was supported by the Secretary of State:

- an emergency care centre at RSH comprising an emergency department, a critical care unit and women and children's inpatients (with all the required acute medical and surgical specialities co-located),
- a planned care centre at PRH,
- urgent treatment services at both sites (implementing an A&E Local model at PRH),
- local planned care – outpatients and diagnostics on both hospital sites.

Most patients will continue to receive their care at their local site and all of our communities will benefit from improvements to the quality of care they receive.

Comparing the options

In line with guidance, we have considered multiple ways we can implement the agreed clinical model and achieve the targeted aims for our population and patients.

We reviewed all opportunities for value engineering to minimise the capital requirement. This included reviewing inflation[6], the impact of modern methods of construction, opportunities for standardised and repeatable design, and key benchmarks (including New Hospital Programme developments).

Following the appraisal of the long-list option, we reached the following short-list options and comparator:

- **Business-as-usual (c. £72m):** Continuation of current arrangements, including the Trust's baseline annual capital programme over the appraisal period.
- **Core DMBC ('Do minimum') (c. £312m):** The minimum capital investment required to deliver the priority Investment Objective" (DHSC/HMT guidance) – i.e. deliver the core DMBC requirements and move towards wider 'Future Fit' ambitions.
- **Core DMBC + key estates risks (c. £481m):** This allows us to deliver the core DMBC requirements and some of the wider Future Fit ambitions. It seeks to expand the opportunity for redevelopment whilst improving overall sustainability. This is a fuller development – including additional new wards, theatre refurbishment, improving the physical environment and substantially reducing the estates risk.
- **Core DMBC + key estates risks + integration (c. £534m):** Seeks to maximise the opportunity for redevelopment and improvements to overall sustainability. Delivers the core DMBC requirements and most of the wider Future Fit ambitions – including additional new wards, theatre refurbishment, improving the physical environment, substantially reducing the estates risk, optimising estate layout across both sites and facilitating more integrated health and wellbeing services.

We have reviewed these options against our critical success factors and undertaken a full qualitative and quantitative appraisal of the costs and benefits, including the net present social value, benefits-cost ratio, and revenue and capital affordability of the options and comparator. We have summarised conclusions about the merits of each option below. This is based on significant engagement and appraisal with clinical, operational and financial leads.

1.1.1.1 Business-as-usual (c. £72m)

Continuing with business-as-usual is not a viable way forward, as the core investment objective is to deliver the DMBC requirements and move towards the wider Future Fit ambitions, which would not be achieved.

The business-as-usual option fails on several critical success factors, will not support future population needs and will present an increasing risk to the staffing, quality and continuity of services. This option does not deliver the changes to services that are critical for clinical and financial sustainability and increases longer term risk.

This option is required as the economic comparator, so will be included in the appraisal process.

[6] Inflation is included in all capital estimates based on the estimated completion date and build profile, in line with the latest PUBSEC indices.

1.1.1.2 Core DMBC ('Do minimum') (c. £312m)

This scenario considers what can be achieved for the original £312m of allocated funding, which was the estimated cost of implementing the core DMBC requirements and wider Future Fit ambitions in 2016.

Due to inflation in build costs and additional mandatory build requirements (including Net Zero and single room requirements), £312m would now only enable the core clinical model to be delivered (core DMBC requirements) and would not allow other elements of the previous scope to be included.

This option would deliver the core DMBC requirements including the over-arching clinical model, which includes:

- new consolidated emergency department facilities, consolidated critical care, core women and children's developments and some additional ward capacity at RSH
- consolidating planned care at PRH (when considered alongside day case hub investments)
- 24/7 urgent care at both PRH and RSH (through an A&E local model at PRH)
- ongoing medical wards and rehabilitation wards at PRH
- required expansion of pathology and pharmacy (sufficient to support increased activity levels)

Qualitatively this option meets all the CSFs defined for the scheme, however, it does not deliver the further benefits associated with addressing key estates risks and further integration of health services.

Quantitatively, this option delivers a significant portion of the potential benefits driven largely by the new clinical model and changes in the configuration of services. This results in the strong benefit-cost ratio (3.7) and a strong net present social value (£424m). The option provides a small I&E improvement relative to BAU, demonstrating revenue affordability and is within the original allocated capital funding of £312m.

1.1.1.3 Core DMBC + key estates risks (c. £481m)

This option allows us to progress beyond the core DMBC requirements towards some of the wider Future Fit ambitions; this includes enactment of the clinical model along with addressing the highest risk estates issues.

It seeks to maximise the opportunity for redevelopment and improvements to overall sustainability. This is a fuller development – including additional new wards, theatre refurbishment, improving the physical environment and substantially reducing the estates risk.

This option would include:

- new consolidated emergency department facilities, consolidated critical care, core women and children's developments and some additional ward capacity at RSH
- consolidating planned care at PRH (when considered alongside day case hub investments)
- 24/7 urgent care at both PRH and RSH (through an A&E local model at PRH)
- ongoing medical wards and rehabilitation wards at PRH
- required expansion of pathology and pharmacy (sufficient to support increased activity levels)
- new ward accommodation at RSH that meets current standards (including 70% single rooms) – improving the physical environment and reducing estates risk
- redeveloping the ward block to repatriate off-site support services, administration, and education, and
- upgrading theatres - improving the physical environment and reducing estates risk.

Qualitatively this option meets all the Critical Success Factors and provides some further incremental improvement compared to the Core DMBC ('do minimum') option.

Quantitatively, the option also delivers substantial benefits and a strong benefit-cost ratio (3.3), however, it is marginally below that for the Core DMBC ('do minimum'). The option makes a positive revenue contribution but is not affordable within the allocated capital envelope.

1.1.1.4 Core DMBC + key estates risks + integration (c. £534m)

Seeks to maximise the opportunity for redevelopment and improvements to overall sustainability. Delivers the core DMBC requirements and most of the wider Future Fit ambition – including additional new wards, theatre refurbishment, improving the physical environment, substantially reducing the estates risk, optimising estate layout across both sites and facilitating more integrated health and wellbeing services.

This option would include:

- new consolidated emergency department facilities, consolidated critical care, core women and children's developments and some additional ward capacity at RSH

- consolidating planned care at PRH (when considered alongside day case hub investments)
- 24/7 urgent care at both PRH and RSH (through an A&E local model at PRH)
- ongoing medical wards and rehabilitation wards at PRH
- required expansion of pathology and pharmacy (sufficient to support increased activity levels)
- new ward accommodation at RSH that meets current standards (including 70% single rooms) – improving the physical environment and reducing estates risk
- redeveloping the ward block to repatriate off-site support services, administration, and education
- upgrading theatres - improving the physical environment and reducing estates risk
- developing and expanding elective centre services
- further redeveloping and upgrading pathology and pharmacy (focusing on improved workflow)
- redeveloping and upgrading outpatient departments (increasing effectiveness and improving patient and staff experience)
- developing estate to support wider system integration plans and health and wellbeing services, and
- further optimising site layout to improve flow, adjacencies and utilisation.

Qualitatively, this option provides the most benefits to the trust.

Quantitatively this option delivers a strong benefit-cost ratio (3.6) which is marginally lower than the Core DMBC ('do minimum') and has a strong net present social value. It provides a positive revenue contribution, but like option 3, is not affordable within the allocated capital envelope.

Summary of the appraisal

As outlined above, all the do-something options pass the CSFs, with the larger investments delivering greater qualitative benefits for the trust and the local health system and as a result option 4 is preferred qualitatively. This is demonstrated in the table below.

Table 2: Qualitative benefits by option

Investment Objective	Description	Option (2)	Option (3)	Option (4)
Clinical Quality and Safety	Improve **cancer waiting times** as a result of ringfenced elective capacity/facilities and more effective pathways (improve cancer waiting times against peer trusts from lowest quartile 1 to highest quartile 4)	●	●	●
	Support **elective restoration and recovery** in medium-term with additional, pandemic resilient, ringfenced elective capacity (helping to deliver 130% of pre-pandemic elective activity by 2024/25)	●	●	●
	Reduce average **elective LoS** by 0.5 days as a result of improved adjacencies and separation of emergency flows	◑	◕	●
	Eliminate **delayed transfers (longer than 2 hours) from critical care**	◑	●	●
	Increase **weekend discharges** from 35% of the average weekday discharges to 75%	◑	◕	●
	Increase adoption of **zero length of stay pathways** (meeting Directory of Ambulatory Emergency Care upper recommended levels for patients deemed suitable for AEC treatment)	●	●	●
	Eliminate **mixed-sex breaches**	◑	◕	●
Patient Experience	Eliminate **'day before' and 'on day' elective cancellations** resulting from emergency escalation	●	●	●
	Improve patient experience (increase Friends and Family uptake from 13% to 20% and maintain 99% positive outcomes)	◑	◕	●
Effectiveness	Improve **referral-to-treatment performance** (exceeding national target of 90%)	◕	●	●
	Eliminate **12-hour breaches**	●	●	●
	Reduce **4-hour emergency wait breaches** (exceeding NHSE/I A&E target of 85%, upper quartile performance vs peer NHS Trusts)	◕	●	●
	Improve **general and acute bed occupancy** (from an average of 92%, peaking at 98% during winter escalation, to a target of 89% across the year)	●	●	●
	Ensure 95% of patients are **admitted to ward** within 45 minutes of decision to admit time (including resus)	◕	●	●
	Reduce **ambulance handover times** (95% of handovers within 30 mins)	●	●	●
Workforce	Positive impact on **staff experience** leading to improvements in recruitment and retention (increase staff recommending SaTH as a place to work into the upper quartile of peer NHS Trusts, reduce staff turnover by 5%)	◑	◕	●
Estate	Improve the standard of the hospital estate, **reducing overall estate risk and improving experience** (for patients, familiies and staff)	◑	●	●

Key

○ No improvement ◔ Minor improvement ◑ Moderate improvement ◕ Major improvement ● Significant improvement ● Achieved through elective restoration initiative

A summary of the qualitative appraisal of the options is outlined below.

Figure 2: Summary of appraisal conclusions[7]

		CSF1: Clinical model	CSF2: Quality & Experience	CSF3: Workforce	CSF4: Effectiveness	CSF5: Commercial viability	CSF6: Build deliverability
1	**Business as Usual**	× **Will not deliver the DMBC decision**, as it is a continuation of current activities	× Substantial issues with quality and safety **not addressed** × **Risk** of further **deterioration** and **threat** to **patient safety** × **No improvement** in experience	× **No improvement** in workforce availability and sustainability	✓ No change in **travel time** × No improvement in **waiting times**	✓ **BAU Trust procurement** can apply	× **Unlikely to be supported** – does not deliver system aims
2	**Core DMBC ('Do minimum')**	✓ Delivers the core DMBC requirements and moves **towards the outputs of the Future Fit ambitions by 2029.**	✓ Improvements in quality, safety & experience driven by consulted **clinical model** ✓ Provides **improvements to some pathways and facilities** × Continued use of the **existing ward accommodation in the tower block**	✓ Improvements in workforce availability and sustainability driven by **clinical model** ✓ Improvements in workforce availability and sustainability driven by **enhanced build environment**	✓ Increases in **travel time** mitigated through DMBC actions planned care/IPC ✓ Reductions in **waiting times** for hospital services delivered through clinical model ✓ Improved access to appropriate specialists	✓ **Several procurement routes** are available	✓ **Expected to be supported –** delivers core DMBC requirements ✓ Future capacity needs met (new wards) ✓ Deliverable by **2026**
3	**Core DMBC + key estates risks**	✓ Delivers the core DMBC requirements and some of the wider **Future Fit ambitions by 2029.** ✓ Improved adjacencies	As Option 2, plus: ✓ Improvements in quality and safety driven ✓ Provides **improvements to most pathways** ✓ Mitigation of **all significant clinical risks** ✓ Provides enough new bed capacity to **vacate the ward block** (mitigated IPC risk) × Lack of redevelopment of OPD **impacts on improvements to flows**	As option 2, plus: ✓ Further improvements in workforce availability and sustainability driven by **enhanced build environment** (morale, wellbeing), **with some limitations** (OPD, not all wards)	✓ Reductions in **waiting times** for hospital services delivered through clinical model ✓ Improved access to appropriate specialists ✓ Improved staff access to patients	✓ **Same as option 2**	✓ **Expected to be supported –** delivers core DMBC requirements and moves towards the wider future fit ambitions ✓ Future **capacity needs** met (new wards) ✓ Deliverable by **2028**
4	**Core DMBC + key estates risks + integration**	✓ Delivers the **core DMBC requirements and most of the wider Future Fit ambitions by 2029** ✓ Further improvement in adjacencies, wider improvements in the experience of the service	As Option 3, plus: ✓ Further improvements driven by **estate optimisation**, **additional upgrades** (OPD, wards) and integrated Health & Wellbeing services	As option 3, plus: ✓ Further improvements in workforce availability and sustainability ✓ Increased staff engagement and role attractiveness as a result of better integration of services that will deliver enhancements to the **Health and Wellbeing of the population**	✓ Reductions in **waiting times** for hospital services delivered through clinical model ✓ Improved **access** to appropriate **specialists** ✓ Improved **staff access** to patients	✓ **Same as option 2**	✓ **Expected to be supported –** delivers core DMBC requirements and moves towards the wider future fit ambitions ✓ Future **capacity needs** met (new wards) ✓ Deliverable by **2029**

[7] Note: Business-as-usual must be taken forward, but it is still important they are assessed and any areas where they do not meet CSFs identified.

However, when considering the quantitative components of the appraisal, the Core DMBC ('Do minimum') is preferred. The option drives a strong benefit-cost ratio and is the only do-something option that is affordable within the allocated capital envelope. The economic appraisal therefore concludes that, taking into account both qualitative and quantitative factors, the Core DMBC ('do minimum') option is the preferred way forward, as per the table below.

Table 3: Summary of the appraisal against the CSFs

Appraisal Section	CSF	1 Business-as-usual (comparator)	2 Core DMBC ('Do minimum')	3 Core DMBC + key estates risks	4 Core DMBC + key estates risks + integration
Qualitative	Clinical Quality and Patient Experience	Fail	Pass	Pass	Preferred
	Workforce	Fail	Pass	Pass	Preferred
	Effectiveness	Fail	Pass	Pass	Preferred
	Clinical Model	Fail	Pass	Pass	Preferred
	Commercial Viability	Pass	Pass	Pass	Pass
	Build Deliverability	Fail	Pass	Pass	Pass
Quantitative	Value for money	Fail	Pass	Pass	Pass
	Revenue affordability	Fail	Pass	Pass	Pass
	Capital affordability	Pass	Pass	Fail	Fail
CONCLUSION		Carry forward as BAU	Preferred way forward	Explore if further capital became available	Explore if further capital became available

Preferred Way Forward

Based on our analysis of the options, our preferred way forward is the Core DMBC ('Do minimum'). This option meets the primary investment objective to deliver the core DMBC requirements and move towards the wider Future Fit ambitions before 2029. It does so by delivering the new clinical model and all the associated benefits, within the original allocated capital funding. It therefore delivers a strong return on investment (benefit-cost ratio of 3.7) in addition to the significant qualitative benefits of the new clinical model.

The preferred way forward also positions the trust strongly to address further key infrastructure issues and deliver health integration in the future should further capital become available.

Procuring the required services (commercial case)

Several procurement options are available to build the new sites, including a framework procurement, a design-and-build approach and a traditional procurement. At this stage, framework procurement (e.g., NHS ProCure23) is expected to offer best value for money and help us move quickly to implementation and build, while also aligning with guidance from NHSEI.

We will investigate these further during the OBC before deciding the right procurement route.

Affording the investment in our hospitals (financial case)

Implementation of the Preferred Way Forward requires capital investment of £312m over 2022/23 – 2026/27. As described in the economic case, this investment is essential to delivering the clinical model, necessary improvements to quality and safety, dedicated capacity, and pandemic resilient hospital facilities.

The trust's financial challenges include c. £14.6m p.a. of revenue costs driven by duplication and inefficiencies in our clinical model. This contributes to a growing Trust and system deficit that has led to national intervention to support rapid improvement.

The phasing of the capital requirement has been aligned where possible to existing commitments and is estimated at c. £6m in 2022/23, £57m in 2023/24 and £83m per annum until 2026/27, totalling £312m as per the commitment in the Hospitals Upgrade Programme.

This capital will incur revenue costs of c. £15.8m a year (by 2031/32) because of depreciation and PDC charges. The option will generate financial revenue benefits of c. £15.8m a year (by 2031/32). This includes the benefits of a more efficient workforce, improved layout and patient pathways, improved patient flow and reduced length of stay, and a better quality estate.

This means the overall scheme is affordable and contributes c. £3.3m p.a. more than business-as-usual, which creates costs from required investments.

Through the outline business case, there will be a focus on further improving the affordability of the scheme within the local health and social care system. This will include further consideration of benefits linked to modern methods of construction and repeatable design elements to reduce capital cost; further validating the size of the development and identifying other areas of opportunity with system partners.

Delivering the investment in our hospitals (management case)

Governance

We have a clear governance structure and risk management approach as part of the HTP, which builds on the learnings from many other large NHS capital schemes. The trust has appointed a Senior Responsible Officer (SRO) who is accountable for delivery of the project.

We have established clear roles and responsibilities within the trust executive team and local health and care system, and we have mobilised governance groups to continue into the OBC phase. We have an HTP Medical Director and set up a Clinical Working Group to provide clinical leadership of the design process.

Delivery plan

The Core DMBC ('Do minimum') will be delivered in a single phase of work commencing in December 2023 and completing in December 2026. If further funding became available for options 3 and/or 4, they are planned to be phased incrementally to the Core DMBC option and could be undertaken in two further phases.

With rapid approvals and availability of capital, we could commence works at the end of 2023 and begin seeing benefits in 2027, including reduced cancellations and elective waiting times, additional emergency and elective capacity, and improved clinical quality.

Following the completion of the Core DMBC option, we would have delivered the core DMBC requirements including the clinical model and configuration of services. Options 3 and 4 would enable us to deliver more of the wider Future Fit ambitions, address key estates issues, and further facilitate improved health integration – bringing more benefits to our patients and the population of Shropshire, Telford & Wrekin and Powys.

The project relies on maintaining an ambitious delivery schedule supported by timely approvals, summarised below.

Table 4: Key milestones for preferred way forward

KEY DECISION/APPROVAL	KEY DATES
SOC Submission	Q1 2022/23
Joint Investment Committee approval of SOC and agreement to proceed to OBC	Q2 2022/23
Appoint PSCP	Q4 2022/23
Completion of OBC	Q1 2023/24
Joint Investment Committee approval for OBC	Q1 2023/24
Completion of FBC (Including Principal Supply Chain Partner (PSCP) Guaranteed Maximum Price (GMP))	Q2 2023/24
Joint Investment Committee approval of FBC	Q3 2023/24
Begin implementation of the Preferred Way Forward	Q3 2023/24

KEY DECISION/APPROVAL	KEY DATES
Completion of the Preferred Way Forward	Q3 2026/27

These ambitious timelines are dependent on the Joint Investment Committee (JIC) giving approval to the overall SOC and approval to proceed with the Core DMBC option ('Do minimum') in July 2022, as well as authorising the drawdown of the £9.9m capital necessary to undertake the design works and complete the OBC (further detail on the breakdown of the £9.9m is outlined in the finance and management cases). In addition, and in advance of the JIC approval of the OBC, we will be seeking to utilise the existing drawdown allocation to put in place the resources required to prepare for the next phase of this development. If these timescales cannot be met, then works would be likely to start later in 2024, following a more traditional OBC and FBC approval timeline, which would result in delays in project delivery and additional capital funding requirements as a result of inflation.

Managing key dependencies

The successful delivery of this project is dependent on the timely delivery of a number of outputs included in other key health system programmes of work. Collaborative working arrangements have been established with each of those programmes to ensure that the impact of any changes to assumptions and/or timings can be assessed and mitigated as quickly as possible.

Key inter-dependent programmes are described below:

- Transformation of Local Care Pathways
- Implementation of a Day Case Unit at PRH
- Development of a new Energy Centre (zero carbon)
- Digital transformation programme

Stakeholder engagement

We will roll out our plan to engage and involve local people and local stakeholders in the next steps to deliver the proposed service reconfiguration. There is a statutory requirement to involve patients and other service users in any service change, and this will be vital to ensure we design future acute hospital services in a way that works for them. The patient panels already created provide a starting point for this, and a much broader communications and engagement plan will now support them.

We continue to engage with local stakeholders through the Implementation Oversight Group and we will continue this through the OBC stage to ensure ongoing engagement and support.

Conclusions and next steps

This case clearly outlines the urgent need to address the challenges presented by the current configuration and layout of acute services in Shrewsbury and Telford and to support the provision of long term sustainable, high-quality care for our communities.

This is a significant milestone in the development of major plans to invest in healthcare facilities for the people of Shropshire, Telford & Wrekin and Powys. Delivery of the preferred way forward will enable us to provide modern, safe and effective emergency and planned care from dedicated facilities, leading to improvements in the health of our population and their experience of care. It will also make our Trust and our health system a much more attractive place for our staff to work within.

Our preferred way forward represents an appropriate balance between the full ambition behind the Future Fit consultation, delivering to modern healthcare standards and the availability of capital funding. It will put in place the core elements of the service reconfiguration described in the Future Fit consultation, help us to address our most pressing clinical risks, and establish solid and sustainable foundations upon which to make further improvements. A number of significant risks will remain, particularly in relation to the standard of patient accommodation at the RSH site, and whilst these can be managed over the medium term, those risks will need to be addressed in the long term.

The preferred way forward is fully aligned with local health system objectives and is one of a number of initiatives that will transform the health and wellbeing of the population of Shropshire, Telford & Wrekin and Powys. One of the core local health system assumptions underpinning the design of the HTP relies on the transformation of local care ('out of hospital') services, which will be delivered through the ICS's Local Care programme and is expected to lead to a much lower increase in acute bed requirements over the medium to long term.

Our proposals offer excellent value for money for taxpayers, with a higher benefit-cost ratio than many public sector schemes (3.7) and a significant positive net present social value. We will continue to test the value for money of this scheme and identify ways to improve it, through the business case process.

The Trust has established rigorous governance arrangements (which also involve system colleagues) to support the successful delivery of this project and has a track record of delivering complex infrastructure developments to time and budget. Project timelines are dependent on securing timely progress though approval-to-proceed gateways. If there are delays in delivery timelines, inflationary pressures are likely to impact capital costs and increase the funding required to deliver the preferred way forward.

This document seeks approval to progress to the Outline Business case (OBC) with the Core DMBC ('Do Minimum') option as the preferred way forward, with a capital funding requirement of £312m.

Timely regulatory review and approval processes will be essential to maintaining the timescales for implementation outlined in this SOC and to minimising additional inflationary impacts on the capital funding requirement.

This document also seeks approval for the drawdown of additional capital funding totalling £9.9m to support the development of the OBC, including the detailed design work.

About this document

This strategic outline case (SOC) has been developed as the next stage of implementing of Future Fit; reconfiguring Acute services for Shropshire, Telford & Wrekin, and Powys; and investing in Royal Shrewsbury Hospital and Princess Royal Hospital.

The SOC has been developed by The Shrewsbury and Telford Hospital NHS Trust (the Trust) Hospitals Transformation Programme (HTP), working closely with the Shropshire, Telford & Wrekin Integrated Care System (STW) and system partners, including Shropshire Community Health Trust, The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, and Shropshire, Telford & Wrekin Clinical Commissioning Group (CCG).

It follows the Future Fit decision-making business case (DMBC), which decided the preferred clinical model for hospital services in the area. In 2019, the Independent Reconfiguration Panel (IRP) and the Secretary of State for Health and Social Care endorsed this decision and the proposed configuration and clinical model.

This SOC examines the options for delivering this business case and recommends a preferred way forward. The preferred way forward is an indication of the Trust Board's preference, which will inform detailed design work and appraisal at the next business case stage – outline business case (OBC). The preferred way forward could be subject to change at OBC stage as detailed design work and more detailed appraisal of the short-listed options may cause the Board to select a different option.

This SOC incorporates feedback from NHSEI and DHSC in preparation for the Joint Investment Committee meeting in July 2022. Through the next stages of the business case process, including OBC development, we will continue to refine and improve our proposals and respond to feedback on this SOC.

This is a technical document intended to support the approval of the scheme by the NHS and HM Government and follows the five-case structure mandated by HM Treasury Green Book.

This document is not intended for a public audience. Some elements of this document may be placed in the public domain for transparency purposes. As this document relates to significant potential capital expenditure, some elements of the SOC may be commercially sensitive and therefore redacted if placed in the public domain.

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Integrated Care System
Shropshire, Telford and Wrekin

1 Strategic Case

1 Strategic case

Our local healthcare system has faced and continues to face long-standing challenges that place significant limits on the quality and quantity of care that we can provide.

The current configuration and layout of acute services will not support future population needs and presents an increasing risk to the staffing, quality and continuity of services. Services are duplicated and fragmented, leading to complex patient pathways that increase the risk of harm to patients. Emergency medicine and critical care services are fragile, with significant workforce challenges, and require urgent change and consolidation.

We have an agreed way forward to resolve these challenges involving significant changes in service configuration and need to move quickly to implement them. We have consulted the public on a clinical model that will address these challenges by reconfiguring services at Royal Shrewsbury Hospital and Princess Royal Hospital. We have agreed that Royal Shrewsbury Hospital will become an emergency care centre and that a planned care centre will be located at the Princess Royal Hospital. Both hospital sites will continue to provide 24/7 urgent care, and routine services such as outpatients and diagnostics, meaning most people will continue to receive care at their local site.

Delivering the agreed clinical model is essential for providing long term sustainable, high-quality care and will also realise a range of significant benefits for all local communities. The planned reconfiguration will deliver a step change in clinical care for patients by delivering the improvements in emergency and planned care we committed to in 2019. It will provide quicker access to specialist consultants, improve the quality of the care we can provide, and help us to address our workforce gaps by bringing teams together more effectively.

Our strategic estates plan leverages the sources of capital we have available, that includes investment in a planned care centre at PRH (partly funded by the Targeted Investment Fund), a new energy centre at RSH (utilising expected Public Sector Decarbonisation Scheme funding) and the agreed reconfiguration of renal dialysis. This strategic plan includes a phased approach to the delivery of our long-term goals enabling us to build on these foundations as capital becomes available.

The proposals included in this document are a key part of the local health system's strategic plan and will improve the right environment for delivering modern, safe and effective healthcare from dedicated, fit-for-purpose buildings. This will lead to significant improvements in our population's health and their experience of care, as well as making us an employer of choice. We will develop both PRH and RSH while reducing our estates risks and ensuring services have the right clinical configurations, adjacencies and layouts for excellent healthcare.

Through this investment, we are seeking to deliver the changes we consulted on which are fully aligned with our organisational strategy and long-term vision, including:

- **ensuring we can provide safe and high-quality emergency and planned care** by consolidating services and improving access to specialists – meaning patients will see the right clinician at the right time when they need specialist care,
- **separation of emergency and planned patient flows**, reducing cancellations and improving infection control,
- **modern, fit-for-purpose facilities**, including increased capacity and departments, better layouts, and more single rooms,
- **offering a more attractive place to work**, with sustainable staffing models, suitable working environments and an effective clinical model,
- **quicker access to care**, with reduced waiting times for emergency and planned care, and
- **enhanced resilience and infection control**, including fit for purpose facilities to isolate infectious patients.

This SOC appraises a number of strategic options that will deliver the service reconfiguration agreed through the Future Fit consultation, thereby addressing a number of the health system's most pressing acute challenges. These challenges arise principally from two inadequately sized emergency departments, split site delivery of key clinical services (including critical care), insufficient physical capacity (particularly impacting elective services), mixing of planned and unplanned care pathways and poor clinical adjacencies.

In 2019, rapid implementation of these proposals was supported by the Independent Reconfiguration Panel and the Secretary of State for Health and Social Care. Since then, the need for this change has increased as a result of the growing demand for services, compounded by the impact of the COVID-19 pandemic. **If the reconfiguration does not progress, there is an increasing risk to the staffing, quality and continuity of core clinical services at both sites.**

The strategic case provides a compelling case for change in terms of existing and future operational needs and explains how the scope of the proposed scheme fits with national, regional, and local priorities and our existing business strategies.

1.1 Case for change

1.1.1 Clinical strategy

The current clinical service configuration does not meet the needs of patients. There are two inadequately sized emergency departments, split site delivery of key clinical services (including critical care), insufficient physical capacity (particularly affecting elective services), mixing of planned and unplanned care pathways and poor clinical adjacencies.

Pathways are unnecessarily complex and often patients are seen in inappropriate clinical settings with poor facilities. We have duplication of some clinical services, and some clinical services are only delivered at a single site, resulting in confusion for patients, their families and staff alike.

One key impact of the current model of care seen in recent years has been difficulties with recruitment and retention and it has become harder to ensure that there are the right number of highly skilled medical, nursing and other healthcare staff at both hospitals to provide the wide range of services for patients. This is evident daily where many of the departments and wards are staffed with a high proportion of agency staff and morale is regularly negatively affected by a lack of progress.

There is a pressing need to address these issues, which has only increased in the three years since we made a strong public commitment to solve our problems by reconfiguring services. COVID-19 has further highlighted the need to reconfigure our services and the CQC continues to highlight our quality and safety challenges. If we cannot make changes, there is a real and increasing risk to both the staffing, quality and continuity of core clinical services at both sites.

Clinicians, patients and members of the public have actively participated in the development of the proposed configuration of clinical services since the NHS England's Call to Action in 2013 and continue to recognise pressing issues and challenges faced locally. The clinical strategy is the outcome of more than five years of planning and public consultation; this outcome is supported by the clinical professions within the Trust, the West Midlands Clinical Senate and the Independent Reconfiguration Panel. Investment is now required to accelerate progress and develop and implement the proposed clinical, workforce and estates strategies.

The clinical strategy includes delivery of the model described during consultation (see Section 1.2.4). In our new service model, we consolidate specialist services onto single sites (with the required clinical adjacencies). That means when patients need specialist care, they will get the best care available at the right time from the right clinicians. Both hospital sites will provide 24/7 urgent care, and routine services like outpatients and diagnostics, so most people will carry on being cared for at their local hospital site.

This includes:

- A planned care centre at PRH dedicated to day cases and inpatients, which will minimise the disruptive impact of emergency admissions, which can often lead to the cancellation of planned care and increased risk of infection. The planned care centre includes medical beds with enhanced therapy services for patients recovering from emergency admissions. The planned care centre will provide enhanced 24/7 urgent care services (an A&E Local model), which will ensure c. 65% of patients who would have attended a traditional emergency department can be seen on the site – meeting the recommendation of the IRP and relevant urgent care guidance. This ensures care continues closer to home where clinically appropriate.
- An emergency care centre at RSH, including a dedicated emergency department and critical care unit, supported 24/7 by all the required medical and surgical specialities. Alongside the emergency department will be on-site 24-hour urgent care services and a same day emergency care centre with specialist assessment areas.

The proposed configuration of services will streamline and simplify patient care pathways, leading to improved clinical quality and safety, a better patient and staff experience and enhance our ability to recruit and retain the best NHS talent. Care will be effectively optimised across the two sites. Patients will receive acute care in the most appropriate location and integrated care across the whole patient pathway.

These benefits are defined further in Section 1.1.6.

Our clinical strategy will continue to be refined as we move into implementation and aligned with local, regional, and national priorities (see Section 1.2). For example, these include the integration of diagnostic hubs and regional centres.

1.1.2 Organisational overview

We face clinical, operational and workforce challenges; these result from the current configuration of services, and an estate which is unable to efficiently cope with demand. There is a broad duplication of services across two hospital

sites, as shown in Table 5. The resultant costs and inefficiencies from this further exacerbate other challenges and drives an additional structural cost that contributes to the Trust's financial deficit. Investment in reconfiguring services presents a crucial opportunity to address the longstanding issues that we face.

We are the main provider of acute hospital services for Shropshire, Telford & Wrekin and Powys and work across two main sites: RSH in Shrewsbury and PRH in Telford.

Both hospital sites provide a wide range of acute hospital services including emergency services, critical care services, diagnostics, outpatients, trauma, most inpatient medical services including, for example respiratory medicine, endocrinology and renal dialysis services.

Inpatient urology, abdominal, general surgery, vascular and oncology services are provided at RSH.

Inpatient paediatrics, head and neck, breast surgery, planned orthopaedics, acute stroke and stroke rehabilitation services, cardiology, gynaecology, and consultant-led obstetrics services are provided at PRH.

We also provide community and outreach services such as:

- consultant-led outreach clinics (including the Wrekin Community Clinic at Euston House in Telford).
- renal dialysis outreach at Ludlow Hospital; and
- community services including audiology, heart assessment services, therapies and maternity services.

Additional providers across the ICS include a community trust (Shropshire Community Health Trust), a mental health trust (MPFT) which covers Shropshire and Staffordshire, and the region is served by the West Midlands Ambulance Service University NHS Foundation Trust (WMAS). Wales Ambulance Service NHS Trust serves the Powys region in which we also provide acute hospital services. Services are commissioned largely by Shropshire, Telford & Wrekin Clinical Commissioning Group.

Figure 3: Our geography (average current journey times)

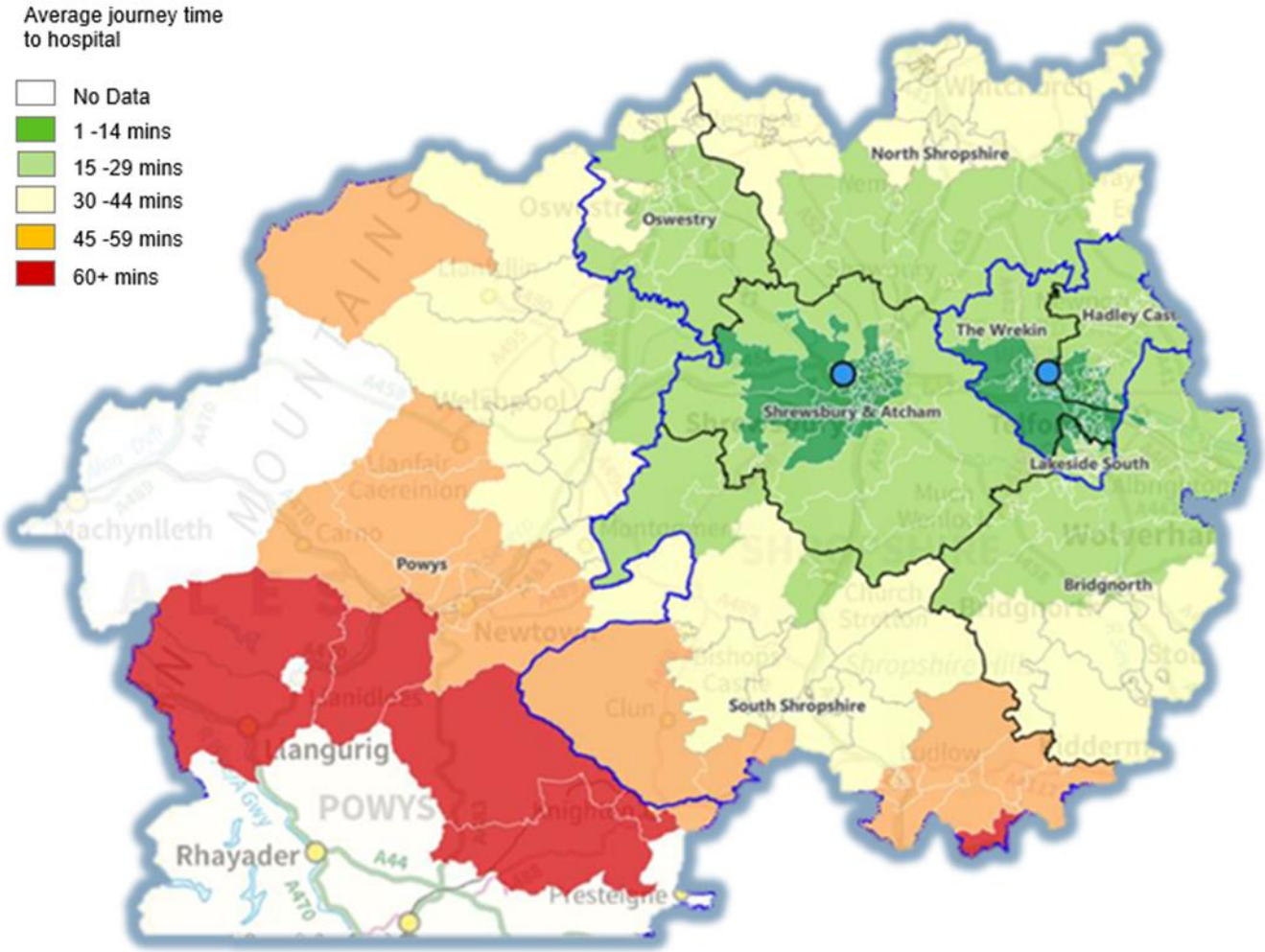


Table 5: Our current service configuration

Service	Princess Royal Hospital (PRH)	Royal Shrewsbury Hospital (RSH)
A&E and Critical Care	✓	✓
Outpatients	✓	✓
Diagnostics	✓	✓
Inpatient Medical Care	✓	✓
Inpatient Head & Neck Surgery	✓	
Inpatient Acute and Elective Surgery (Vascular, urology, abdominal surgery)		✓
Surgical Assessment Unit		✓
Ambulatory Care	✓	✓
Inpatient Women & Children	✓	
Outpatient Children	✓	✓
Children's Assessment Unit	✓	✓
Inpatient Oncology Care		✓
Midwife-Led Maternity Services	✓	✓
Day Case Surgery and Procedures	✓	✓
Elective Orthopaedics	✓	
Orthopaedic Trauma	✓	✓
Breast Surgery	✓	

All complex surgery will take place at the Emergency Care site.

In 2019/20, there were c. 652,000 patient contacts at our sites for care and treatment[8]. This included:

- 60,600 emergency admissions (including CDU),
- 118,000 (Type 1) A&E attendances,
- 417,000 outpatient appointments,
- 9,000 paediatric inpatients,
- 55,000-day case and elective inpatient spells, and
- 4,422 births.

To deliver this, we have a workforce of over 6,400 staff that cover the full spectrum of disciplines including medical staff, qualified nursing and midwifery, allied health professionals, healthcare assistants and other support staff, scientific, therapeutic and technical staff and administrative, clerical and management.

1.1.2.1 The local and growing population

The populations across the area have a range of different needs for health and social care services. For example, some people need high levels of care and support, while others use services less regularly. We operate in a complex environment with a growing and ageing population and provide to c. 50,000 residents of North Powys.

Telford & Wrekin has a large, younger urban population with some rural areas and is ranked amongst the most deprived 20% of populations in England. The population is approximately 180,000 and has an unemployment rate of 5.1%, compared to the UK average of 4.5%.

[8] Patient contact data is based on the year 2019-20

Shropshire covers a large rural population with problems of physical isolation and low population density and has a mix of rural and urban ageing populations. Shropshire has a population of approximately 320,000 and an unemployment rate of 3.7%.

In Shropshire, Telford & Wrekin, there are population challenges in meeting the demand for health and social care services. These include:

- Life expectancy rates overall have improved steadily in last decade, however rates in Telford & Wrekin remain significantly worse than average and worse than those in Shropshire.
- Long-term conditions are on the rise due to changing lifestyles; this means we need to move the emphasis away from services that support short-term, episodic illness and infections towards earlier intervention to improve health and deliver sustained continuing support in the community.
- The preventable mortality rate in Telford & Wrekin is approximately 150 per 100,000 people and worse than the average 140 per 100,000. Early death and survival rates for cancer in Telford & Wrekin are also worse than average.
- A higher-than-average proportion of adult's smoke in Telford & Wrekin, 15.7% of adults smoke (circa 21,000 smokers). Maternal smoking is also higher than the national average of 9.5% in Shropshire and Telford & Wrekin, with 12.5% of women being smokers at time of delivery in 2020/21. Whereas in Shropshire levels of smoking are now 13.7%, below the national average of 14.1%.
- Population growth in the Telford & Wrekin population is slightly higher in younger age groups, whereas across Shropshire growth is expected to be concentrated in the over-65 population.

1.1.3 Our challenges and case for change

Through the PCBC, DMBC and wider stakeholder engagement it is recognised that the current acute hospital configuration is not sustainable. We face longstanding challenges that are exacerbated by the inefficient configuration of services, an ageing estate, an unsustainable workforce, a poor financial position, and significant clinical performance issues. The case for change is clear and primarily driven by our urgent need for quality improvements and delivering a clinical model that enables workforce, clinical and financial sustainability.

Our key challenges are:

- the current clinical model is not fit for purpose, with some key services only delivered on one site resulting in complex patient pathways and harm.
- duplicated services are fundamentally fragile including emergency medicine and critical care – challenges that have been exacerbated during the COVID-19 pandemic,
- we are unable to staff multiple key specialties, some for many years, due to the poor clinical model and a fragmented service,
- we need to manage an increasing and ageing population and deliver more care out of hospital,
- our healthcare system is in deficit and faces one of the biggest financial challenges in England, and
- our buildings need urgent modernisation, with emergency departments that are too small, insufficient capacity, structural layouts that impede patient care, and insufficient isolation and single rooms.

These challenges are longstanding and have an increasing detrimental impact on the services that we provide and need to be addressed as soon as possible. Further detail on these challenges is described over the following sections.

1.1.4 Current challenges

Our immediate challenges – which we face every day and that limit the care we can provide now – include an outdated clinical model, critical staffing gaps and buildings that need improvement. These issues create clinical and operational risks and issues daily and are reflected in the care we provide.

1.1.4.1 An outdated clinical model with duplication and fragmentation of services

We have experienced significant difficulties achieving clinical performance targets for many years due to core issues with the current clinical model. For example, our 4-hour performance in A&E has been consistently deteriorating and is currently forecast to continue to be below the national target. Compliance with the 62-day cancer target has only been achieved once since April 2019 and with the present system, we are unlikely to be able to achieve it on a sustainable basis. Referral to treatment (RTT) targets have seen a marked decline since April 2018 with the provision of planned care services regularly impacted by the admission of emergency patients.

The clinical model was not designed to meet the needs of twenty-first century healthcare. It has emerged as a result of many tactical interventions over decades rather than through strategic planning. Unnecessarily complex pathways often result in patients being seen in inappropriate settings with poor facilities. The combination of duplicated and

single site services generates several problems, including creating confusion for patients and staff, variations in care across the two sites, and workforce challenges. The poor integration of duplicated services further impacts patient experience and can lead to patients being unable to see the right person at the right time. Additional operational issues and the lack of available skilled staff to cover these fragmented services results in an unsustainable clinical model.

The current configuration of services prevents us from providing quality care to many patients; it is also increasingly well understood that the sickest patients with multiple co-morbidities have complex physical, mental health and care needs that are not always met. Clinical outcomes for these patients are particularly compromised through the difficulty of delivering consistent consultant-led care seven days a week, particularly in those duplicated services.

CQC ratings have deteriorated over recent years demonstrating the significance of the issues posed by our clinical and operational models (which are linked directly to the layout and quality of our estate). Our 2021 CQC report rated the safety and responsiveness of services as Inadequate. For urgent and emergency services, CQC reported that "patient outcomes were worse than national averages".

Figure 4: Trust CQC reports[9]

CQC domain	2017	2018	2020	2021
Safe	Requires improvement	Inadequate	Inadequate	Inadequate
Effective	Good	Requires improvement	Inadequate	Requires improvement
Caring	Good	Good	Requires improvement	Requires improvement
Responsive	Requires improvement	Requires improvement	Inadequate	Inadequate
Well-led	Requires improvement	Inadequate	Inadequate	Requires improvement
OVERALL	Requires improvement	Inadequate	Inadequate	Inadequate

We recognise that the current configuration of our emergency care services is not fit for purpose and that this greatly inhibits our ability to provide the right level of care to our patients. The variations in care across the two emergency sites create problems in adhering to best practice and national guidelines in a uniform manner. Having separate hospitals for emergency care, means that patients, transported by ambulance or by their own transport, may not go to the most appropriate place for the right care and treatment.

Our A&E model has been further fragmented over the years as many patients, who could be seen in an urgent care setting, attend with minor injuries or ailments that do not require the comprehensive facilities and support of a modern emergency department. The mix of minor and major injuries and ailments presenting to the same A&E department results in the department being overwhelmed adversely impacting clinical outcomes, patient experience and operational performance.

1.1.4.2 Infection control and managing the COVID-19 pandemic

The COVID-19 pandemic has impacted every corner of the NHS, causing disruption to planned care services as well as increasing backlogs. Our ability to provide appropriate capacity when preparing and responding to challenges that arise from the pandemic is critical for managing the current situation and enabling future resilience.

Our response to the pandemic was rapid and included significant efforts to manage the pandemic from an inappropriate, fragmented and outdated estate:

- A number of ward moves took place at considerable pace to accommodate patients with respiratory problems. We were also alert to changes in the number of COVID-19 cases and care required to ensure that we could respond accordingly in terms of staffing, capacity, and personal protective equipment (PPE).
- A COVID-19 Assurance Committee was established and met weekly, attended by the Chief Executive, Trust Chair, Chair of the Quality & Safety Assurance Committee and other executive directors to provide assurance to the board on the approach being taken.

[9] Care Quality Commission

- We worked closely with local system health and care partners to ensure that all aspects of care, both in, and out of hospital, were considered.
- We significantly changed the way we worked, with large numbers of support staff moving to home working, which slowed the spread of the virus and freed up additional space for those who needed to remain at our sites to accommodate 'social distancing'.
- We moved to telephone and virtual outpatient appointments, where this was appropriate.

Early feedback suggests that many of these changes have been positively received by both patients and staff. We are aiming to embrace and embed the positive changes that have been made going forward.

However, despite this, the unsustainability of the clinical model became increasingly clear during the COVID-19 pandemic as it further exacerbated clinical quality and performance difficulties. In March 2020, all routine elective activity was cancelled, and routine diagnostic capacity was reduced, resulting in a significant underperformance against national targets.

Though many parts of the country cancelled elective activity, COVID-19 exacerbated our existing challenges of limited space, overcrowding and the need for separate pathways. We have a lack of flexible clinical spaces, insufficient infection control and separation of patient flows, and limited resilience in our fragmented staffing model. This limited our ability to respond and meant we had to focus only on emergency activity during the pandemic.

Though our proposed model of care was developed before the emergence of COVID-19; it has been further reviewed through the development of this SOC to ensure it remains current. By consolidating care, and providing dedicated and separated facilities, the new model will ensure we can better address future pandemic challenges and better control infection (see Section 1.1.6).

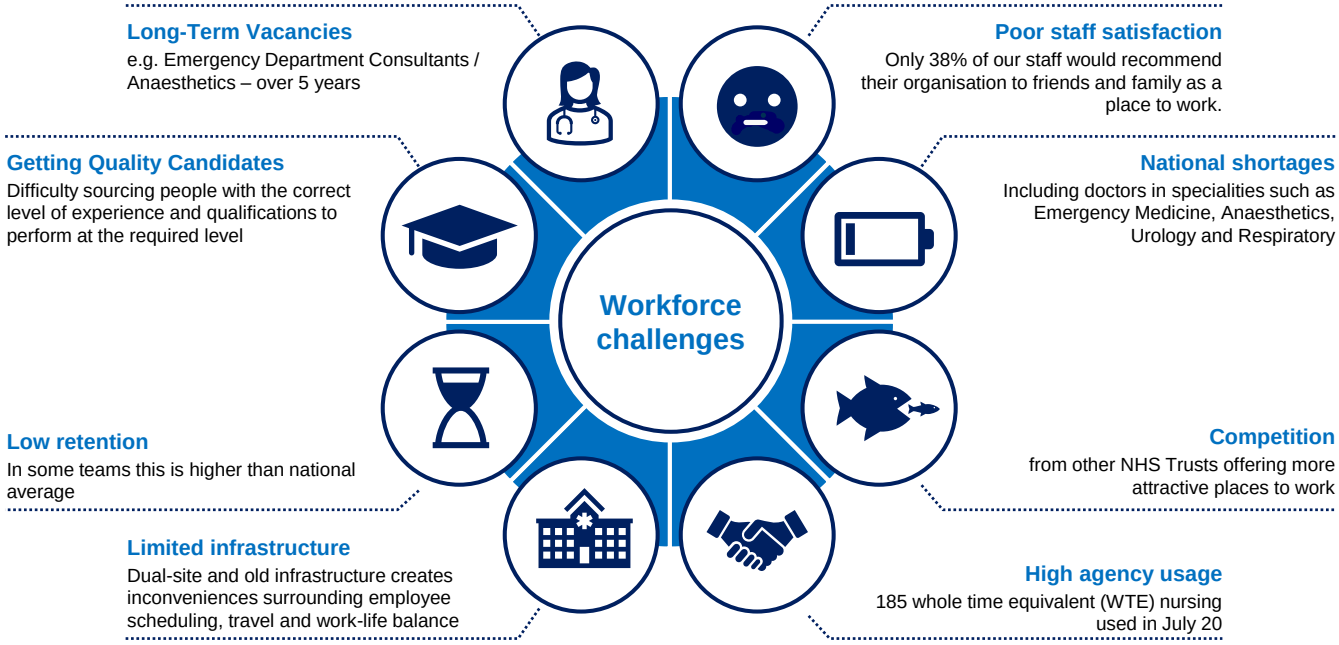
1.1.4.3 Staffing high quality, safe services

Our greatest asset is our staff. We currently employ over 6,400 skilled staff members who strive to deliver high quality patient centred care, all day, every day. However, we do not have all the staff we need in the right places, and we are faced with recruitment difficulties to essential medical, nursing and AHP clinical roles within the emergency departments, critical care services and across the Trust. These challenges are driven by a need to operate services across two-sites and through arrangements that are not conducive to the delivery of excellent care.

As a result of the existing clinical model and fragmentation of services, we find attracting and retaining substantive staff intensely challenging. This results in a heavy reliance on temporary staff and increased pressure on teams, which further impacts the quality of care provided.

To deliver services across the organisation, we have supplemented the substantive workforce with significant levels of agency support over several years. Over the past two years, we have spent more than £30m p.a. on agency staff, almost double the NHSEI agency ceiling rate. We have an ageing workforce profile which will only further exacerbate the current workforce challenges in the coming years.

Figure 5: Our key workforce challenges



The Trust is seeking to address these challenges as part of its wider recruitment and retention strategy. This strategy is a Board approved strategy that looks at a range of initiatives to support recruitment and retention of staff including targeted recruitment campaigns, international recruitment and actions to manage our temporary workforce effectively.

The trust has been successful recently in progressing a number of innovative resourcing solutions, including:

- recruitment drives nationally and overseas,
- sharing posts and rotas with neighbouring Trusts, and
- creating new roles such as fellowships and advanced practice.

However, while these initiatives have had a significant and positive impact, they will not be sufficient to address long term sustainability issues unless we also reconfigure our clinical services. Day-to-day operational plans are in place to ensure the care and safety of patients within our clinical services, but a long-term strategic solution is urgently needed to make us an attractive place to come and work with sustainable staffing arrangements.

Running duplicated services across two sites presents many workforce challenges and results in a poor employee experience for our medical and non-medical teams, compounding the challenging recruitment situation. For the medical workforce, the current service configuration and the requirement for consultants and other specialist staff to cover both hospital sites can, at times, limit the ability to provide senior patient reviews. Currently, we are unable to achieve seven-day services clinical standards. In addition, we are unable to achieve Royal College guidance standards in many areas. For the non–medical workforce the challenges are similar. Senior expertise is split across two sites and the learning environment and provision of workforce development is challenging.

With the current service configuration, it will prove extremely difficult to achieve adequate staffing levels and support seven-day working across both sites. Further, because teams are spread so thinly, services are vulnerable to unexpected absences and the non-availability of staff. The current configuration also continues to create cost pressures for premium rate working, poor economies of scale, and duplication of rotas, as well as exacerbating our ability to recruit to ‘hard to fill’ posts.

Our current buildings are not attractive places to come and work and create operational issues that mean staff are unable to perform their roles efficiently. This creates a poor staff experience in comparison to other, fit-for-purpose, hospitals at a time when competition for talent in the NHS is intense.

The need for a long lasting, sustainable solution is now critical. There is a clear, united voice from staff, management, system partners, and regulatory bodies (including the CQC) that the current situation cannot continue.

1.1.4.4 Buildings in need of modernisation

Our acute hospital buildings are ageing. They are not designed to modern healthcare standards or to meet the needs of Net Zero carbon, and they prevent us from operating effectively and efficiently. For example, the current ambulatory areas are insufficient in size to support effective patient flow and often overflow causing bottlenecks in patient pathways. This is symptomatic of facilities being developed piecemeal over time where the opportunity to develop the estate existed, rather than having the development based on clinical adjacency, functionality and capacity needs. Failure to improve the configuration of the estate and respond to the growing need to address backlog and modern sustainability requirements issues will only increase the risk of future disruption and service closures.

The estate is expected to require investment of c. £96m over the coming five years, including addressing £48m of backlog maintenance. Importantly, the £28m of high and significant backlog cannot be addressed through the current level of allocated capital resources.

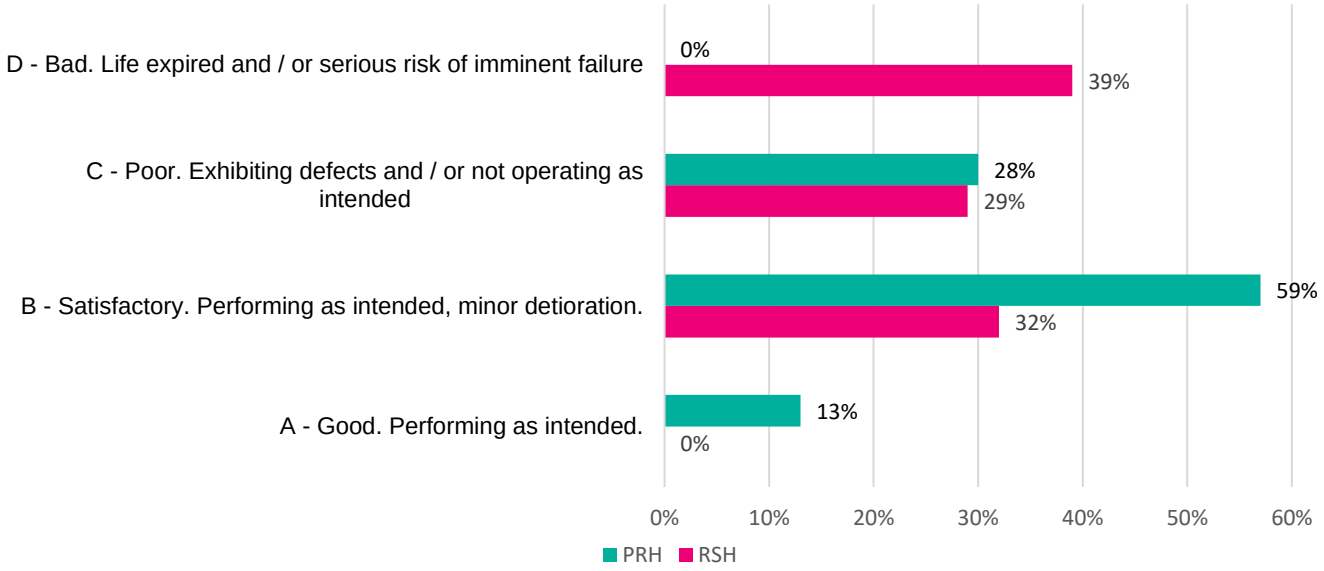
Table 6: Maintenance backlog and investment required (2021–2026) in Trust estate[10]

Estates Criteria	PRH	RSH	Total
Gross internal area (m²)	52,075	67,425	112,775
Net usable area (m²)	38,860	49,120	87,980
Backlog maintenance Year 0 (£m)	16.5	31.4	47.9
Of which high and significant risk (£m)	*11.5*	*15.9*	*27.5*
Further remedial work likely to be required in next five years (£m)	6.9	6.5	13.3
Total investment required (£m, exc. on costs)	23.4	37.8	61.2
Total investment required (£m, inc. on costs)	36.7	59.4	96.1

[10] 2020/21 Six Facet Survey; 2020/21 ERIC return. Usable area derived from six facet survey results. Further remedial work likely to be required in next five years based on site surveys completed May 2021. On costs include fees, VAT, builder preliminaries and optimism bias.

A six-facet survey refresh, commissioned in May 2021, demonstrated that 68% of RSH building stock is 'poor', or 'life expired/unacceptable' status – no areas achieve 'good' status. The 39% of 'life expired/unacceptable' backlog is increasingly concerning as it includes core clinical areas such as inpatient wards, critical care, theatres, pathology, pharmacy, imaging and outpatients. PRH building stock is slightly better, 13% is rated 'good', 58% is 'satisfactory' and 28% is 'poor'. However, the 28% of estate rated 'poor' includes core clinical areas associated with theatres, A&E, imaging, outpatients, mortuary, pathology, and pharmacy.

Figure 6: Condition of estate at PRH and RSH, six facet survey results



Specific issues associated with the current estate include:

- Accident and Emergency: Recent A&E investments in 2019/20 and 2020/21 targeted the urgent and significant CQC issues around enhancing the delivery of patient care. While these investments have sought to address the most pressing estate constraints, the building rating has only marginally increased to 'poor' status. At PRH, the A&E has evolved over time with extensions to the clinical area; poor adjacencies have created an inefficient use of staff time and resource. The size and volume of accommodation is inadequate compared to modern standards and nursing staff must often care for patients in areas that do not allow for easy observation. Whilst every effort is made to ensure that the pathway for an adult and child is separate, the layout and availability of space often makes this difficult to achieve.
- Inpatient wards: There are currently no dedicated isolation rooms at either PRH or RSH. COVID-19 required the introduction of six temporary pods in critical care, however this does not address the longstanding issues that will be further exacerbated by COVID-19, norovirus and influenza in winter. At RSH – a site with over 400 inpatient beds – there are only 23 single rooms with ensuite facilities; this equates to approximately 5%, compared to a national standard of 70%. Due to the age of the wards, there are an inadequate number of toilets, showers and storage. The design of these areas does not support the dignity of patients nearing the end of their life, bariatric patients, or those with dementia.
- Clinical adjacencies and layout: Overall, the clinical adjacencies between departments are extremely poor. There are no dedicated service lifts, resulting in the same lifts being used for patients, goods and services, causing delays. Due to the ad-hoc layout, wayfinding is a challenge resulting in delays, frustration and poor patient experience.
- Patient privacy and dignity: We are currently rated 147th out of 159 providers for patient privacy, dignity and wellbeing. The condition of the estate as described above, is a factor in our ability to provide high quality care in relation to privacy, dignity and wellbeing as maintaining privacy and dignity is a constant challenge in a poor, inadequate estate.

1.1.5 Projecting forward into the future

These issues will worsen if we do not act, and we face growing pressures that make our current service configuration unsustainable. These issues of future demand and sustainability increase the need to progress this proposal.

1.1.5.1 Responding to the needs of a growing population

As outlined above, we are the main provider of district general hospital services from two hospitals, PRH and RSH, serving around half a million people in Shropshire, Telford & Wrekin and Powys.

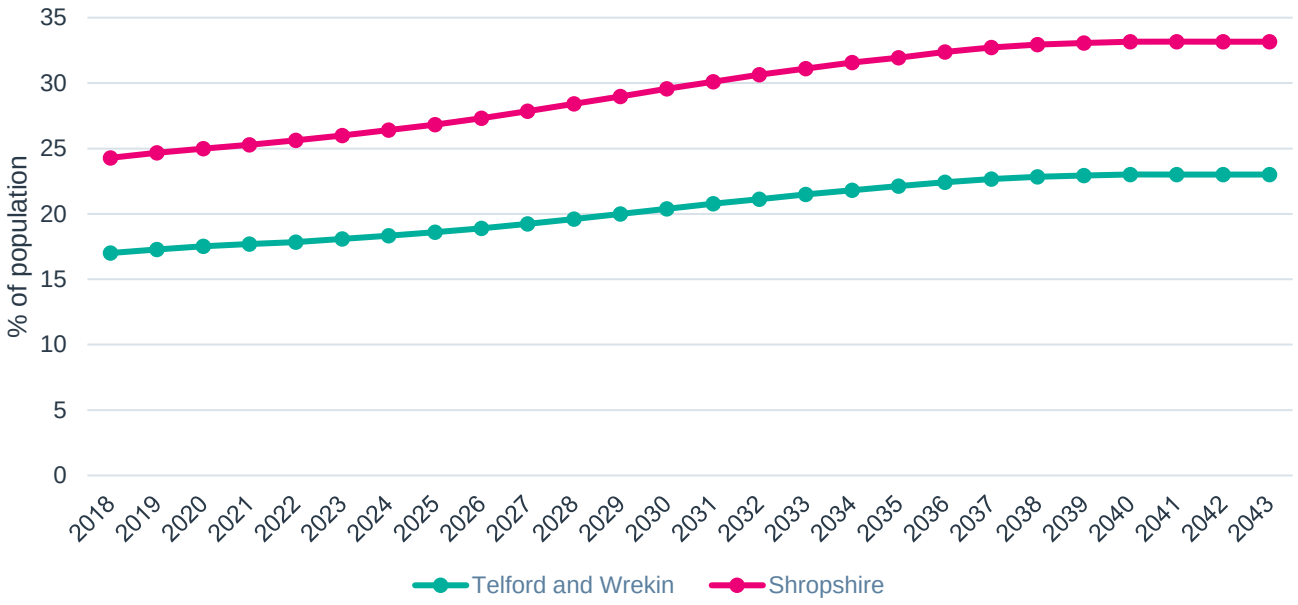
Current demand on our services continues to rise and outstrips the funding available, putting pressure on hospitals, GP practices and social care.

The populations across the Shropshire, Telford & Wrekin and Powys areas have a range of different needs for health and social care services. This need depends on several factors, including population demographics such as age and deprivation (with more younger people in Telford & Wrekin); as well as whether people are living with one or more long term health condition, such as diabetes, asthma, or a mental illness (with more long-term conditions in Shropshire).

The percentage of the population over-65 in Shropshire is expected to grow from c. 25% in 2018 to c. 29% by 2030, and c. 33% by 2043. Similarly, in Telford & Wrekin the percentage of the population over 65 is expected to grow from c. 18% in 2018 to c. 21% by 2030, and to c. 23% by 2043[11]. This is higher than national profile.

As a result, the pattern of demand for services has shifted; there is a greater need for services that can support frailer people – often with multiple long-term conditions – to continue to live with dignity and independence at home and in the community. Our configuration of local care services is not currently equipped to cope with this pattern of demand.

Figure 7: Population growth of people over the age of 65



An additional challenge in the provision of healthcare within Shropshire and Powys is the numbers of patients that live in remote, rural settings; this presents a challenge to developing consistent, sustainable services with equity of access. The area can also be described as a low wage economy; consequently, the wider determinants of health including education, access to employment and housing are significant issues to consider when developing services that support good physical and mental health.

The implications of meeting this demand and new models of care are described in Section 1.1.8.

1.1.5.2 A local healthcare system in deficit

STW is holding a projected deficit of £115m in 2021/22, which is projected to grow by c. £10m p.a. without further intervention.

In this already challenging context, we have a forecast underlying deficit of £62m for 2021/22. Against a total expenditure of £481m, this represents a c.13% deficit. We have reported an underlying recurrent deficit each year since 2008/09.

This unsustainable financial position shows that significant transformation needs to happen to avoid further deterioration.

Key factors driving the deficit include:

- increasing demand for urgent and emergency care services above planned levels,
- greater demand requires more workforce capacity – together with continued high levels of vacancies and less attractive rotas this leads to high use of temporary and agency staff (exceeding the NHSEI ceiling rate, see Section 1.1.4),

[11] ONS Population projections

- increased costs of service delivery due to energy, clinical waste, and higher estates maintenance costs due to backlog deterioration,
- minimal delivery of efficiency improvements, and
- duplication of services across two sites.

Providing emergency, elective, and diagnostic services across two hospital sites creates duplicate structural costs of at least c. £14m that could be removed by consolidating clinical services (estimate from 2019 which will now be higher due to inflation). Delivery of the proposed clinical model will help to address these issues and has the potential to significantly improve the financial position of the Trust and STW. This is considered in detail within the Finance Case.

STW is under intense national scrutiny to resolve the deficit position, with STW directed to develop a pre-submission of their financial recovery plan in 2021 for NHSEI review. HTP is a specific enabler of the STW recovery plan – this scheme is not merely aligned to STW strategic aims, but STW is placing dependency upon successful delivery of this scheme to support its financial sustainability plans (see Section 4).

1.1.6 Implementing a fit for purpose clinical model that is aligned with the consultation outcomes

We now need to address these challenges, for which it will be key to reconfigure services and implement a new clinical model. This needs to be resolved at pace as our challenges cannot wait – and we collectively committed to the public that we will address them.

Our proposals will deliver a step-change in clinical care for patients, delivering the improvements in emergency and planned care we committed to. This includes:

- separation of emergency and planned patient flows, reducing cancellations and improving infection control,
- improving pandemic response, building on the lessons from COVID-19,
- ensuring we can provide safe and high-quality emergency and planned care by consolidating services and improving access to specialists – meaning patients will see the right clinician at the right time when they need specialist care,
- modern, fit-for-purpose facilities, including increased capacity, bigger rooms and departments, better layouts, and more private single rooms,
- becoming an employer of choice, with sustainable staffing models, suitable working environments and an effective clinical model,
- quicker access to care, with reducing waiting times for emergency and planned care, and
- enhanced resilience and infection control, including facilities to isolate infectious patients.

Table 7: Benefits of the future service model

Princess Royal Hospital: Centre for planned care	Royal Shrewsbury Hospital Centre for emergency care
• Surgical centre- optimising care pathways • Leader in day case development • Inpatient medical care • Rehabilitation and wellness • Much improved patient experience – including lowering infection risks, reducing cancellations, reducing patient waits • Improved operational performance – including Referral to Treatment, reduced waiting list • 24/7 urgent care service that maintains local care for most patients (A&E local model – see below) • Improved recruitment and retention of staffing	• Improved quality of care – timely access to appropriate senior clinical decision-maker, supported by clinical adjacencies – delivering better outcomes for patients • Right-sized critical care facilities, consolidated on a single site • Better patient experience – including privacy and dignity, shorter waits, shorter hospital stays • Improved patient flow and operational performance – including eliminating of 12-hour breaches and significantly reducing delayed ambulance handovers • 24/7 urgent care service • Improved recruitment and retention of staffing

A&E Local model at PRH

The integrated urgent care service (A&E Local model) at PRH will include:

- An urgent treatment service that patients can access 24/7 via direct booking using 111, from GPs and primary care practitioners, ambulances for specific patient pathways or as un-booked “walk ins”
- Assessment and treatment of minor illness and injury
- Walk-in patients will be triaged within 15 minutes and directed to the most appropriate service
- Better access to enhanced urgent care services, fully integrated with local (neighbourhood) care pathways
- Medical same day urgent care for the assessment and treatment of all common medical conditions, as laid out in the ambulatory emergency care directory, which can be treated in an ambulatory care setting (e.g., diabetes, heart disease, high blood pressure, cellulitis, DVT, low risk chest pain and pneumonia)
- Frailty service delivered by a multidisciplinary Frailty team receiving referrals from the Urgent Treatment Centre (UTC), primary care (for specific pathway patients) and same day urgent care service
- Flexible outreach to the Mental Health Decisions Unit
- The ability to stabilise any seriously ill “walk-in” patient of any age for transfer to an appropriate facility
- Immediate access to appropriate imaging (including CT and plain film), blood and urine testing and Point of Care testing

Separation of emergency and planned care

The clinical strategy is strongly aligned with the Royal College of Surgeons’ recommendation to separate elective surgical admissions from emergency flows. It creates a planned care centre with planned day case and inpatients attending a hospital dedicated to their care (supported by post-anaesthesia care unit and capacity to stabilise and transfer patients if needed), without the additional disruptive effect of emergency admissions placing pressure on the fixed bed base. In line with recommendations made by the Independent Reconfiguration Panel, plans include the planned care centre having a 24/7 urgent treatment service, which would enable c. 65% of patients who would have attended the traditional accident and emergency medicine department to be seen on that site. The urgent treatment model would enable as much clinically appropriate care to be delivered locally as possible, incorporating an enhanced diagnostics and frailty service.

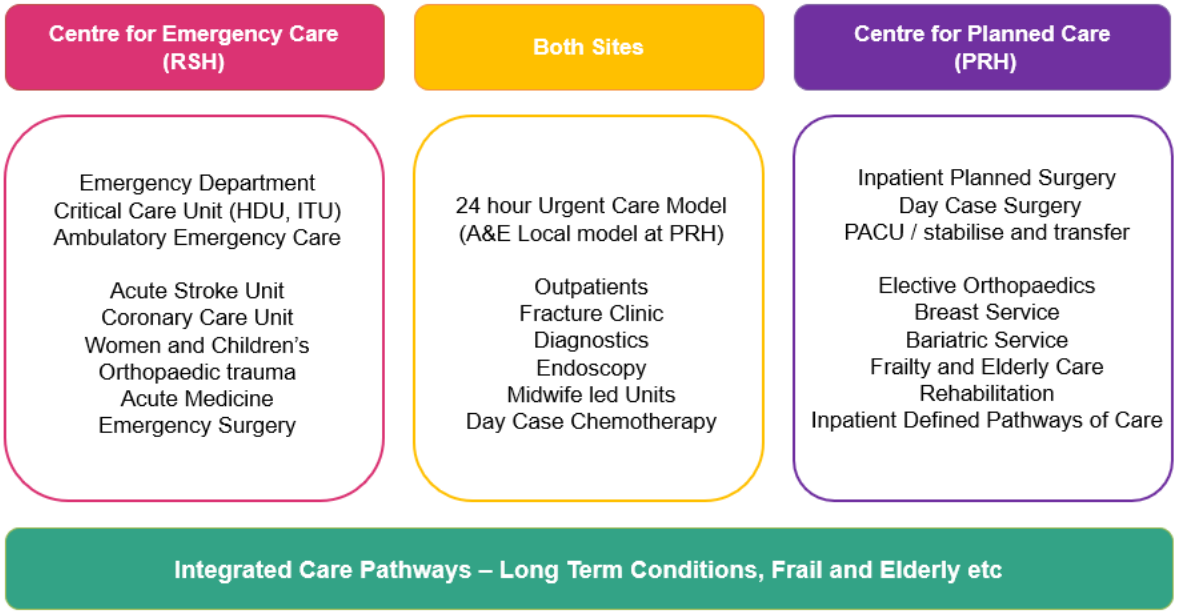
A dedicated emergency care centre with a single dedicated and purpose-built emergency department (including paediatric triage) and critical care department would be supported 24/7 by all the required medical and surgical specialities; these are planned to sit alongside on-site, 24-hour urgent care services, and a large same day emergency care centre with specialist assessment areas. The capacity required has been modelled using the Directory for Ambulatory Emergency Care 6th Edition.

This proposed configuration will result in:

- A single emergency care site with a dedicated and purpose-built emergency department (with paediatric triage), where specialist doctors treat the most serious cases, is safer and provides better outcomes for patients and a reduced length of hospital stay.
- The proposed reconfiguration will contribute substantially towards the sustainable improvements in performance against A&E standards, through more effective workforce deployment
- The consolidation of planned care on a single site will greatly improve the efficiency of the care provided, allowing for the ring fencing of beds for surgical capacity and supporting the delivery of effective planned care services. All of these will contribute positively and significantly to the achievement of waiting times and RTT
- Beds at the planned care site would be allocated for planned operations without a separate competing flow of admitted unplanned patients
- Patients would not have to wait as long for their operation and would have easier access to appropriate rehabilitation, ensuring the earliest possible day of discharge
- A reduction of short notice cancellations and delays, where in previous years c. 500 patients have had their elective procedure cancelled due to the use of beds for emergency admissions. This had been further exacerbated by the impact of Covid-19.
- Planned surgery taking place on one site separate from unplanned patients will reduce the risk of hospital or community acquired infection and help us to better manage any future pandemics.

- There is evidence that cancelled operations result in considerably more complications including depression, urinary tract infection, wound infection, and myocardial infarction. With the new strategy it would be unlikely that an operation would be cancelled because of bed unavailability.
- The model will allow us to attract and recruit a highly skilled and focused workforce, including both clinical and administrative teams, consolidating fragmented teams which will support improvements in the care provided.
- An environment that will support continuous service improvement

Figure 8: High level outline of services on each site



1.1.6.1 Rebuilding from COVID-19: Infection control, recovery and future pandemic response

The future model of care addresses the key issues that arise from COVID-19, including helping us recover from the pandemic, prepare for any future pandemics, and better control infections:

- The clinical model proposes an integrated hospital with clearly distinct sites, one specialising in emergency care and one specialising in planned care. This approach will support the response to any future pandemic, allowing for strict infection control measures and the separation and streaming of patient cohorts.
- The centre for planned care at PRH will be able to continue to deliver planned care to clinically assessed low risk patients and be able to operate efficiently without interruption to planned activities. Dedicated capacity will enable us to improve throughput and reduce cancellations, contributing to system-wide elective and diagnostic recovery.
- The centre for emergency care at RSH will be configured to accept all of our emergency patients. Due to the future design of the emergency department, this facility will have the added ability of streaming patients into segregated cohorts depending on their infective status. The creation of separate red, amber, and green patient flows facilitates strict infection control measures and minimises interruption to acute work.
- The design of the all-new buildings will reflect learning from COVID-19 and post-pandemic infection prevention and control standards. Our design plan further includes a higher ratio of side rooms to open ward beds at RSH, enabling increased levels of segregation and isolation of relevant patient cohorts.

These proposals outlined in this SOC demonstrate that we will be able to deliver the transformation highlighted in the proposed model of care, whilst also ensuring it is sufficiently resilient to for the impact of COVID-19 or future pandemics. As a result of this, we believe that the clinical model is well designed, appropriate and current.

Moreover, the configuration of services between the two sites will ensure that, should a further pandemic take place, the planned care site can function as a non-contagious site; outpatients can consolidate onto this site along with planned diagnostics and the on-going delivery of planned surgery.

1.1.6.2 Improved clinical effectiveness

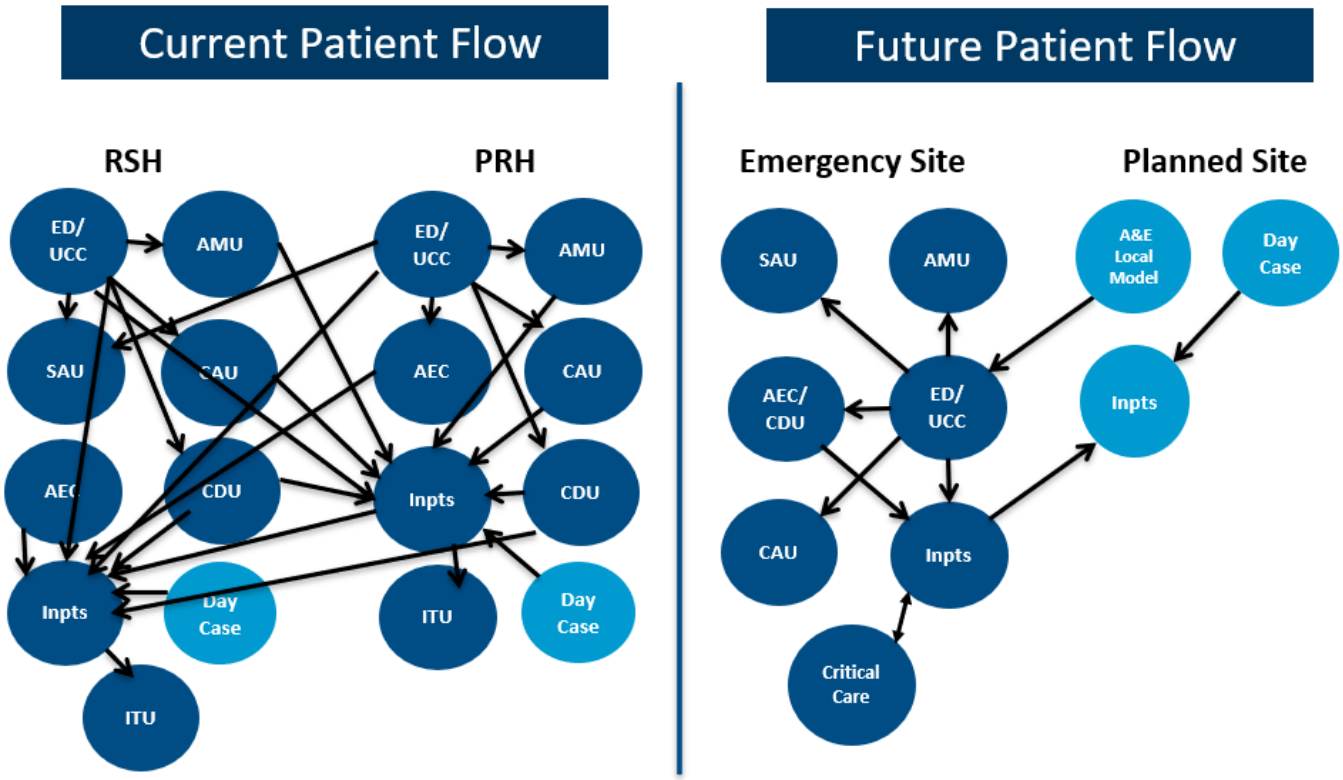
Simplification, clarification and re-mapping of patient care pathways is essential. The proposed clinical model develops planned care and emergency care acute hospital centres, leading to a coordinated and cohorted flow of patients. The core element of the proposed clinical model is that all patients are seen in the right place by the right healthcare professionals, at the right time. This separation of flows will ensure patients with acute illness and injury are treated appropriately and lead to improvements in clinical effectiveness.

Overall, the proposed configuration of services will streamline and simplify patient care pathways. In doing so there will be:

- greater availability of consultant-delivered decision-making and care,
- improved access to multi-disciplinary teams,
- delivery of care in an environment suitable for specialist care, and
- greater collaborative working for specialists who will be able to treat higher volumes of critical cases to maintain and grow skills.

Each of these will contribute to better clinical outcomes, with reduced morbidity and mortality.

Figure 9: Redesigned pathways



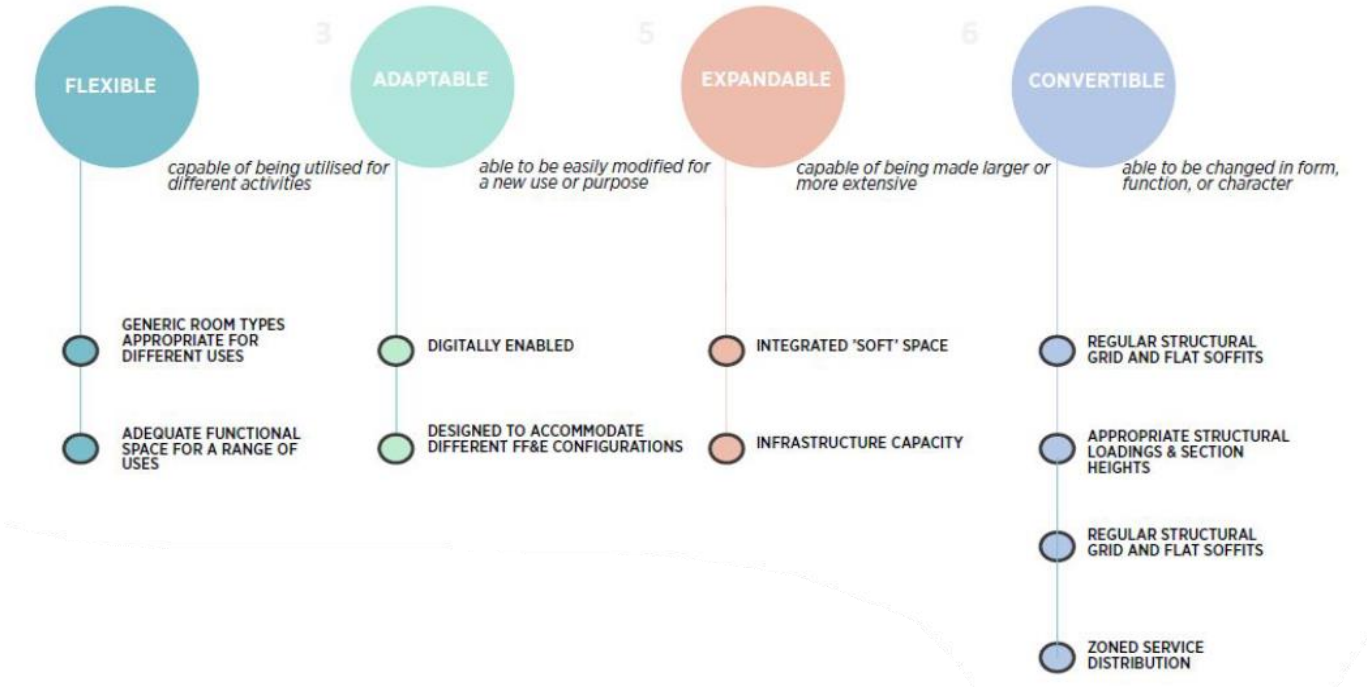
1.1.6.3 Well-designed physical settings with appropriate capacity

Modern design features and appropriate physical settings have been shown to yield a number of different benefits in healthcare settings. For example, evidence shows that access to daylight provides a reduction in the average length of hospital stay, quicker post-operative recovery, reduced requirements for pain relief and quicker recovery from depressive illness. New and refurbished areas of the estate will be designed to modern standards.

The following elements of the reconfiguration will contribute to improvements and clinical sustainability:

- Improved clinical adjacencies and flows through focused redesign: Poor clinical adjacencies and pathways and cramped facilities are not conducive to the levels of efficiency or infection control required, especially during a pandemic. Reconfiguring currently dispersed services is expected to deliver benefits in clinical flow, efficiency and safety (through ensuring that patients have access to the most appropriate services throughout their treatment), reducing their length of stay and encouraging standardised provision of specialised input.
- Greater capacity and space in departments: The proposed design strategy for rooms (Figure 10) is based on utilisation, improvement and expansion of the current library of repeatable rooms and then assembling these into repeatable clusters to allow expansion, adaption and flexibility. The proposed reconfiguration includes improved ward space with appropriately sized facilities.
- Modern buildings: Improvements to the fabric of the building will support improved flow, enhanced safety for both staff and patients and improvements in wellbeing. Newer estates and facilities help to direct clinical benefits by being easier to maintain and clean. In addition, improved working environments will increase staff recruitment and retention and improve staff satisfaction.
- Greater provision of single rooms: The redesigned estate will focus on ensuring a higher proportion of single rooms to support effective infection prevention and control and improve patient privacy and dignity.

Figure 10: HTP room design strategy



1.1.7 More equitable access and support

As a result of changing the clinical model, patients will wait for less time in A&E, wait for less time for operations and have fewer appointments and operations cancelled. We will be able to offer more care in Shropshire and Telford & Wrekin, meaning fewer patients need to travel out of area.

Our clinical model will enable us to provide better support for people with long term conditions and for people living independently, including earlier access to a consultant opinion, less need for hospital admissions, shorter spells in hospital when needed, and less decompensation in frail, elderly people. This will mean better care for all our patients, including the most vulnerable.

1.1.8 Meeting demand through new models of care (expected activity requirements)

Managing the expected growth in demand (see Section 1.1.5) will require us to provide different capacity, aligned to changes in the out of hospital models of care. We have estimated this growth over the coming years to understand the capacity we will require. All options considered provide the overall physical bed capacity required and new pathways of care will also ensure that the utilisation of bed capacity across both sites is optimised.

The growth expected to be seen across each point of delivery (POD) is shown in Table 8. This calculation is based on age banded demographic growth, sensitive to who the consumers of healthcare services are in each POD. The 'Core Scenario' is the activity growth projection used throughout this SOC, which is the net impact of the out of hospital shift, other planned system changes and demographic growth.

Table 8: Expected net activity growth across the Trust to 2026[12]

POD	2018/19 Actuals	24/25 Core scenario	Annual net growth rate
Day Cases	48,655	54,746	2.0%
Elective Inpatient Spells	5,269	5,360	0.3%
Non-Elective Inpatient Spells	58,639	62,010	0.9%
A&E Attendances	44,808	51,432	2.3%
UCC Attendances	109,790	120,736	1.6%
Outpatients Face to Face	484,111	385,691	-3.7%

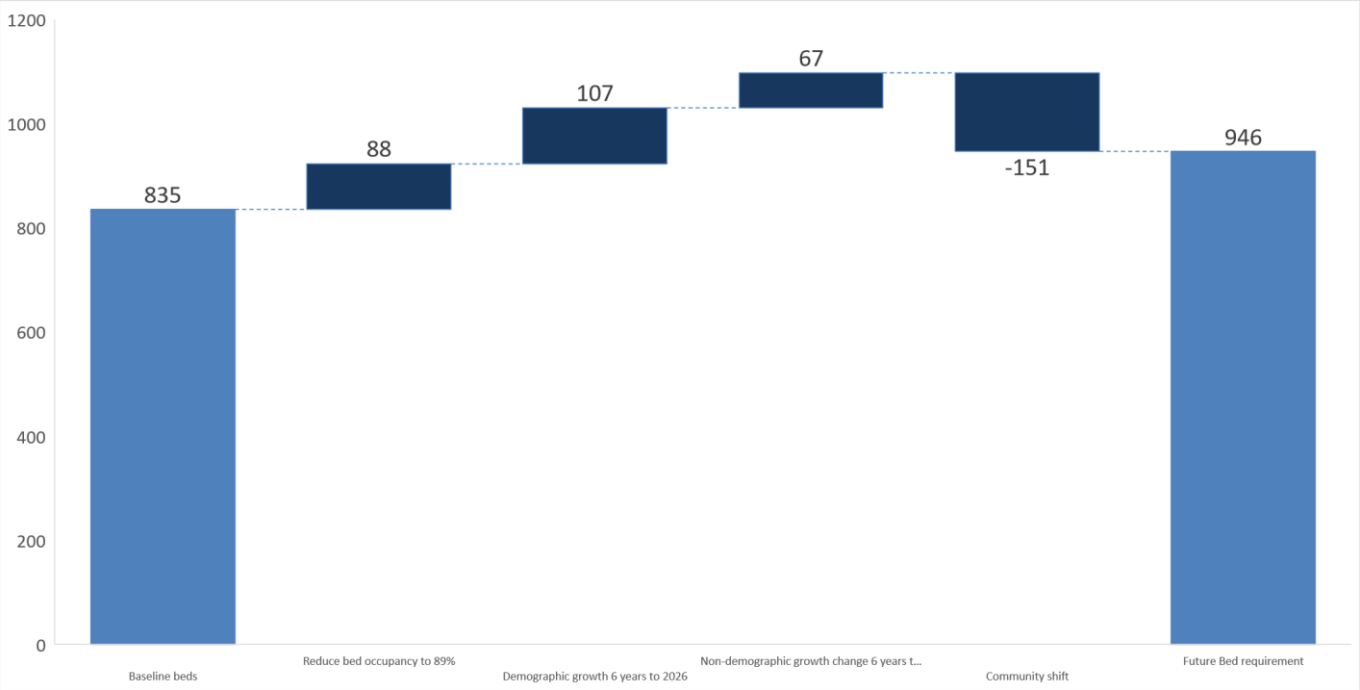
This modelling was developed in late 2020, in collaboration with local system partners. It has been incorporated into the STW system plans, and the financial impact is also reflected in the those plans.

[12] HTP modelling, 2020

The activity levels shown above include a significant level of demand mitigation through internal hospital efficiencies and out of hospital shift, supported by new models of care. These assumptions have been discussed and approved by local stakeholders through the HTP Board and other health and care system boards and are aligned to the system planning assumptions. Further details of the demand and capacity modelling and assumptions are provided in Appendix C.

As a result of these activity outputs, we have developed a schedule of accommodation required to meet future need. These detailed capacity calculations and outputs are also provided in Appendix C. Figure 11 shows the acute bed requirements beginning from a baseline in 2018/19, applying the gross growth assumptions and showing how that growth is moderated by the community shift and system efficiency improvements.

Figure 11: Estimated bed requirements



The bed numbers shown above exclude maternity, neonates, and critical care, and include ambulatory emergency care places, day case places and medical assessment unit. Further detail is provided in Appendix C.

Our demand and capacity requirements were refreshed in late 2020, considering the latest ONS population projections and the latest level of system ambition for out-of-hospital-shift in light of pandemic learnings. Since then, as a system we have committed to additional out of hospital interventions in 2026–2030 that will mitigate growth post-2026. This change is reflected in the demand and capacity estimate used as the basis for this SOC and can be seen in the demand projections included in Figure 11. This is detailed further in Appendix C.

There is a dependency on the system plan for delivering demand management and growth mitigations (community shift of hospital care). The health and care system partners have agreed the plan and signed off the assumptions, however there is a risk that under-delivery creates additional pressure on SaTH sites. The trust will work closely with system partners to support the delivery of this plan and monitor the progress. Potential risks to delivery of this will be maintained through HTP's risk management approach.

These demand and capacity outputs have supported the development of a schedule of accommodation, and capital costing of the options under examination in the economic case.

To support improved patient flow, a reduction in bed occupancy levels is also being targeted (to align with the national standard of 89%), increasing the Trust's overall bed base requirements (see Figure 11).

A revised letter of support received from the CCG and submitted to NHSEI 31 May 2022, confirms the CCG will build on the teamwork that has taken place during the development of the SOC which has ensured that the assumptions are aligned with the wider health system planning assumptions.

1.1.8.1 Out of hospital care

This is a key priority for the local health system that sits outside the scope of HTP and is targeting the expansion of preventative healthcare services along with the development of new models of care that will enable patients to be more effectively managed outside of the acute hospital setting. This programme of work is aiming to moderate the

required increase in acute bed numbers (as can be seen in figure 11 above). During the OBC phase of the Hospitals Transformation Project, further detail will be developed on how these new services will work, improving integration across acute, community, primary, social care and third sector partners.

The system is working jointly to deliver the following objectives, which will support the mitigation of future demand for acute hospital care as shown above:

- single entry point to services,
- early identification of need (inc. risk stratification),
- proactive provision of preventative primary / community-based care,
- partnership working across the system,
- services to demonstrate a reduction in health inequalities through targeted approaches based on population health analysis,
- prevent avoidable hospital admissions and attendances through the provision of timely rapid response and crisis intervention,
- delivery of the required level of admission avoidance and acute bed reduction,
- a multi-disciplinary decision-making approach across health and social care,
- deliver timely, cost effective, efficient services that meet an individual's needs and improve clinical outcomes, and
- optimise wellbeing, prevention, and independence as per the Long-Term Plan.

As part of the OBC development, acute and community services will work together to develop the specific interventions, which will deliver the objectives.

The demand and capacity requirements of PRH and RSH have additionally been modelled to 2030. If unmitigated this would represent an additional increase in required hospital capacity. The system is committed to mitigating any further growth in acute hospital capacity from 2026 to 2030 through delivery of a range of targeted out of hospital services. These plans will be developed further in parallel with our further work as part of the ongoing business case process, including linked interventions to support the expected changes in patterns of activity across the system.

1.1.9 Urgent action is needed to maintain long term continuity and sustainability of clinical services

To overcome the challenges we describe above, we urgently need to change how services are configured across our sites and invest in appropriate facilities to support this – and we have an agreed solution. The Future Fit consultation looked at the issues, consulting the public on a new configuration of services in 2018.[13] In 2019, our commissioners confirmed the decision to reconfigure services and develop RSH as an emergency site and develop a planned care centre at PRH.

Given the pressing urgency of our challenges, we need to move quickly – implementing these changes cannot wait.

Rapid implementation of these proposals was supported by the Independent Reconfiguration Panel and the Secretary of State for Health and Social Care. Since then, the need for change has only increased with COVID-19. Our latest CQC report rated the Trust as Inadequate, with continuing deterioration of performance. If the reconfiguration does not progress, there is an increasing risk to both the quality and continuity of core clinical services at both sites.

We now need to move rapidly to implement these changes and secure investment in our hospitals. This is a significant milestone in the development of plans to investment significantly in healthcare facilities for the people of Shropshire, Telford & Wrekin and Powys.

We have an agreed way forward to resolve these challenges involving significant changes in configuration and need to move quickly to implement them. We have consulted the public on a clinical model that will address these challenges by reconfiguring services at Royal Shrewsbury Hospital and Princess Royal Hospital. We have agreed that Royal Shrewsbury Hospital will become an emergency care centre and that a planned care centre will be located at the Princess Royal Hospital. Both hospital sites will continue to provide 24/7 urgent care, and routine services such as outpatients and diagnostics, meaning most people will continue to receive care at their local site.

This will be supported by a significant investment in our hospitals to provide modern, fit-for-purpose facilities and an improved patient and staff experience. Our proposals comprise one of the biggest planned investment in the public sector across Shropshire, Telford and Wrekin and Powys, making a big contribution towards the national levelling up agenda.

[13] https://www.nhsfuturefit.org/

1.2 Responding to the wider strategic context

1.2.1 National context

Our proposals align to national priorities, delivering the NHS Long Term Plan, supporting COVID-19 response and recovery, and reducing critical risks to the delivery of healthcare. Investing in our sites represents a big contribution to levelling up Shropshire, Telford & Wrekin and will result in the creation of two vibrant hospitals sites in Shrewsbury and Telford.

Our plans have been developed in this context and in response to national priorities, described below.

1.2.1.1 The Long Term Plan

The Long-Term Plan (LTP), published by the Department of Health (2019)[14] focuses on the need to accelerate the redesign of patient care to be able to future-proof the NHS for the coming decade.

The plan sets out a series of planned improvements focused around:

- population health and local partnerships through integrated care systems,
- strengthened out of hospital care,
- reduced pressure on hospital emergency services,
- delivery of person-centred care, and
- mainstreaming of digitally enabled care.

Delivery of the plan is supported by a planned increase in funding of c. 3.4% p.a., an increase compared with the c. 2% p.a. received over the five prior years. Hospital funding levels will be set with the assumption that activity trends over the past three years continue. However, it is expected that increased investment and service change in community and primary care will moderate the growth in our hospitals.

The LTP has influenced our clinical strategy along with the development of STW strategies and plans, and we are actively working with our partners to manage more patients closer to home and increase preventative health services.

1.2.1.2 New Hospitals Programme

In 2020, DHSC and NHSEI jointly established the New Hospitals Programme (NHP) to build 48 new hospitals. This project is not one of the schemes included in the NHP, however we are in regular dialogue with the NHP team and the front runner Trusts, so that we can build the learnings from these schemes into our plans. As the NHP schemes progress through detailed design convergence, procurement and into delivery, we will seek to make use of these design and commercial opportunities where they have potential to contribute to our investment objectives.

1.2.1.3 Levelling up

Levelling up the country and reducing regional inequalities is “the defining mission of this Government”.[15] This includes dedicating the new Department for Levelling Up, Housing and Communities to this aim.[16] Commitments have included *Build Back Better: Our plan for growth* (published alongside the March 2021 budget), £4.8bn for levelling up infrastructure investments, £3.6bn regeneration fund for town centres, £2.5bn skills fund, a £12bn UK Infrastructure Bank and the relocation of 22,000 civil service jobs from London and the south-east.[17]

This is an ambitious agenda to address regional inequalities and direct significant investment outside London and the south-east. This project is aligned with the Government’s priorities in this area.

1.2.1.4 Sustainability and Net Zero carbon

The Government has committed to “Build Back Greener” by decarbonising the UK economy by 2050 and the NHS aims to reach Net Zero (for direct emissions) by 2040, with an 80% reduction by 2032.[18]

We are committed to net zero and have a robust Net Zero Carbon Strategy (Appendix N) that has guided the development of our options. All the options have net zero as part of their design and will meet our net zero obligations. We will, through the design and construction phases, work to meet the forthcoming net zero carbon hospital standard for new developments. These will be outlined in more detail in later stages of the business case process.

During the next phases of development, we will further explore ways to ensure our new sites are as sustainable as possible and meet our obligations.

[14] https://www.longtermplan.nhs.uk/
[15] www.gov.uk/government/news/ambitious-plans-to-drive-levelling-up-agenda
[16] https://www.gov.uk/government/news/ambitious-plans-to-drive-levelling-up-agenda
[17] https://www.instituteforgovernment.org.uk/sites/default/files/publications/levelling-up.pdf; **Error! Hyperlink reference not valid.**
[18] https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/ ; https://www.gov.uk/government/publications/net-zero-strategy

1.2.1.5 Digital

We recognise the importance of investment in digital transformation as a key driver of sustainability. We are committed to delivering the significant digital enhancements in advance of, and as preparation for, new ways of working outlined by the reconfiguration. During 2019–20, we successfully secured funding of £6m to implement a new electronic patient records system and to further develop our digital transformation agenda. Further progress has been undertaken to enhance our capability to undertake digital transformation and to move forward in areas such as remote working and virtual outpatient consultations.

The impact of COVID-19 was exacerbated by our long-standing structural issues, especially the ageing estate and the challenges of staffing two major acute sites. Following COVID-19 there are several implications to be considered for the design of new hospital buildings to make them better able to cope with diseases like this in the future, including the embedding of digital technologies. The use of these technologies is likely to have a material impact on the delivery of care, improving population health outcomes and reducing costs in the future.

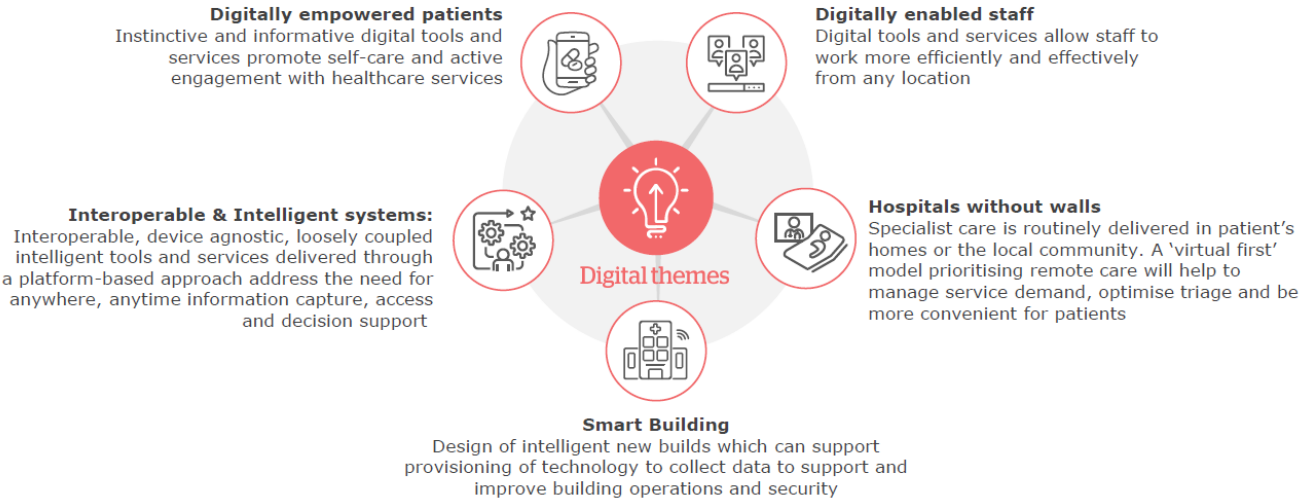
We have a 12-month rolling digital roadmap incorporating the key priorities that underpin our core commitments to delivering improved digital services for both patients and staff, including re-provision of the life expired PAS, and mobilising the delivery of Electronic Patient Records.

On 31 August 2021 NHSX published the 'What good looks like framework' and 'Who Pays for What'. Guided by these, our long-term digital plans are under development, focused on developing technology solutions and working across STW to share infrastructure, resources and knowledge to deliver joined-up, digitally enabled patient pathways.

Initially we are focussing on consolidating infrastructure and harmonising digital standards across the ICS which will allow it to leverage initial efficiencies. With joined-up infrastructure, we will then be able to develop pathway specific solutions to meet the clinical need across STW.

Current and future digital plans are aligned to current and emerging guidance on the best use of digital within the NHS. HTP offers the system the opportunity to invest in and implement the latest technologies, including those outlined in the HIP digital blueprint set out by NHSX and its partners, and demonstrates the strategic drive and mandate for the delivery of them. Through the delivery of this reconfiguration, we will seek to progress delivery of the vision for digital hospitals set out within the NHSX digital blueprint, shown below.

Figure 12: NHP digital blueprint vision[19]



The HTP includes a digital workstream, which will ensure that the delivery of the Future Fit consultation outcome is aligned to the delivery of the digital programme. HTP will support the infrastructure which facilitates an enhanced digital experience for clinicians.

As the digital transformation project is funded through alternative NHS funding streams, HTP has not included any capital funding requirements or cost savings associated with the digital programme.

Digital transformation plans will continue to be developed and refined as these proposals progress, including at the next stage of planning as an interdependent programme of work, aligned to relevant guidance.

[19] NHSX

1.2.2 Regional context

1.2.2.1 Shropshire, Telford & Wrekin Integrated Care System

It is becoming increasingly difficult to ensure local people have access to consistent, high-quality care that is affordable and sustainable and addressing this challenge is a key regional priority.

To meet the growing needs of the population and address regional sustainability issues (see Section 1.1.5 and 1.1.8), Shropshire and Telford & Wrekin needs to operate as a single health economy, working together for the benefits of the population.

STW became a shadow ICS on 1 April 2021 and will become an ICB on 1st July 2022 which will provide a united approach for planning and providing healthcare services across Shropshire, Telford & Wrekin. ICSs bring together hospitals, community and mental health Trusts, GPs and other primary care services with local authorities and other care providers across the whole area. This approach enables better use of resources, leading to higher quality, more efficient and effective services.

Key elements of the STW ICS strategy include:

- a greater emphasis on prevention and self-care
- helping people to stay at home with the right support with fewer people needing to go into hospital
- giving people better health information and making sure everyone gets the same high-quality care
- utilising new technologies to drive innovation, supporting people to stay independent and manage their conditions
- attracting, developing, and retaining world class staff
- involving and engaging staff, local partners, carers, the voluntary sector and residents in the planning and shaping of future services
- developing an environmentally friendly health and care system

1.2.2.2 Sustainability programme and new models of care

STW has developed a sustainability programme with six initial key steps to achieving a sustainable position. The six items that have been identified as the immediate focus for improving system sustainability are:

- musculoskeletal (MSK),
- Hospitals Transformation Programme,
- local care services,
- workforce,
- outpatients, and
- integrated place-based commissioning.

Local care neighbourhood working is an approach to developing community centred models. This programme includes initiatives that range from development of peer-led roles right through to the design and implementation of NHS services in community settings. This approach evolved naturally in response to several issues, one of the most significant of which was to challenge the current deficit-based model of care which promotes dependency.

STW and partners are committed to seizing the opportunities associated with more innovative and creative solutions, co-produced by those to whom the changes affect the most. These solutions will address people's individual goals and support the growth of vibrant and healthy communities which empower people through the promotion of independence. Where possible, acute services will be replaced with community-based services and delivered in people's homes.

1.2.2.3 Recovery support programme

Partners in the STW recognise that the health economy needs to address a significant financial challenge. Doing nothing is not an option and there is agreement that the healthcare economy will only succeed if action is taken collectively.

The new NHS System Oversight Framework (SOF) for 2021/22 came into effect from the 1 July 2021. The Trust and STW are currently in Segment 4 of the SOF and part of the Recovery Support Programme (RSP) for both quality and finances which replaces the separate quality and finance special measures programmes that were previously in place. In terms of finances, the ambition is to build credibility and deliver the system sustainability plan over the next three to five years, which in turn will support the trust in being able to exit RSP. The trust is working towards exiting RSP in March 2023, subject to achieving the six exit criteria.

1.2.2.4 Elective recovery

STW has historically had insufficient capacity as a system to deliver sustainable day case or elective inpatient activity and meet the expectations of the National Elective Recovery Plans.

We have elective capacity constraints that persist annually, coupled with ever-increasing winter emergency surges and COVID-19, which has resulted in a significant elective backlog. Elective activity across the system has been compromised by the use of ward and day surgery unit space for inpatient non-elective medicine demand and reduced bed capacity as a result of COVID-19 related infection control restrictions. This included inpatient and day case provision, across both hospital sites. Emergency pressures within the system continue to impact on our ability to maintain pre-pandemic elective activity levels and facilitate the required growth to deliver elective recovery.

Over the last two years while operating in COVID-19 conditions, STW has lost a total of over 18,000 theatre cases. Consequently, the combined waiting list for STW (including Welsh patients) has increased from 33,244 in March 2020 to 49,456 in December 2021. SaTH has seen a rise in all urgent cancer referrals and the number of two week wait (2WW) referrals received in September 2021 was the highest in two years as demand recovers.

Therefore, solutions are required to:

- ring-fence capacity that will enable us to reinstate previous levels of activity, and
- address the expectations of the National Elective Recovery Plans for delivery of 130% of pre-pandemic elective activity levels.

To help address this, STW ICS has proposed the expansion of day case provision at PRH to service elective demand. This would offer a protected green zone, providing COVID-19 and future pandemic resilience as well as protecting elective activity from future emergency surge impact. This will be safer for patients (only standard testing required) and safer for staff (standard infection control requirements) whilst providing necessary capacity to address the elective backlog and improve future productivity and efficiency.

This will be delivered via the Targeted Investment Fund (TIF2) which significantly increases day case capacity at PRH and delivers an important element of the wider Future Fit ambition.

1.2.2.5 Alignment of the Hospitals Transformation Programme

The clinical model and reconfiguration of services across RSH and PRH are well aligned to the vision of STW, including:

- ability to recruit, develop and retain staff due to effectively consolidating services across the two sites with safer patient care, greater educational opportunities, care provided in appropriate settings and an enhanced environment,
- a greater degree of timely consultant delivered decision-making and care,
- new build elements of the reconfiguration will provide an environmentally friendly single-site care system in line with Net Zero,
- allowing for regeneration and greater employment for the wider community, therefore contributing to levelling up the deprived towns that we serve,
- contributing to the sustainability of the local health economy and overall system deficit,
- provision of improved discharge to community settings,
- increased integration with community care will help people stay at home, and
- enablement of better digital technology that helps patient flow and minimises administrative tasks.

This alignment is reflected in the investment objectives and proposals included within this SOC.

The detail of the STW system development plan is provided in Appendix B1.

1.2.3 Local context

The Hospitals Transformation Programme is a local priority and has brought together local system partners to ensure its success. It is a key part of the trust's organisational and clinical strategy, which is currently being updated, and part of the system's broader plans. This includes enhanced collaboration with local organisations to support rapid implementation – which we all recognise is critical to our collective success.

1.2.3.1 Collaboration with other organisations

There are several areas where this investment will serve as a vehicle to deepen our relationships with partners in Shropshire and Telford & Wrekin where they are aligned and complementary to the clinical model and DMBC recommendations. Ultimately, these will focus on improving the quality of care and efficiency of services provided by the Shropshire and Telford & Wrekin healthcare economy.

This scheme has enabled stronger collaboration and partnerships between the Trust and multiple system partners, including:

- Healthwatch Shropshire
- Healthwatch Telford & Wrekin
- Powys Community Health Council
- Shropshire Local Authority
- Telford & Wrekin Local Authority
- Powys Teaching Health Board
- West Midlands Ambulance Service NHS Foundation Trust
- Welsh Ambulance Services NHS Trust
- Robert Jones and Agnes Hunt NHS Foundation Trust
- Midlands Partnership
- Shropshire Community Health NHS Trust
- STW CCG
- Shropshire Doctors Cooperative Ltd

To ensure continual collaboration, the Hospitals Transformation Programme team engage with these organisations regularly, both directly and through more formal arrangements including the HTP Board and Implementation Oversight Group (IOG) that meet regularly and are made up of representatives from these organisations. This will continue to facilitate appropriate clinical, operational and strategic input to HTP, ensuring it remains aligned with wider priorities and developments as appropriate.

In addition to these partnerships, we have several other ongoing or recent partnerships that also support the reconfiguration of services of the Hospitals Transformation Programme (HTP).

- In 2020, we entered an improvement alliance with University Hospitals Birmingham NHS Foundation Trust (UHB) to provide support to improve the safety and sustainability of patient services. The targeted resource and expertise from UHB, along with an associated package of support will help us to deliver the changes necessary to improve the quality of care provided to patients.
- In 2019–20, we started working in partnership with Macmillan Cancer Support, the Lingen Davies Cancer Fund and RSH League of Friends to build a new Macmillan Cancer Support Service and extend existing services within the Hamar Centre at RSH.
- We were successful in our bid for medical leadership development funding and partnered with the Faculty of Medical Leadership and Management to deliver training and development programmes in the latter part of 2020.
- We have entered a maternity improvement partnership with Sherwood Forest Hospitals NHS Foundation Trust. We are focusing on maternity leadership development, quality of evidence and reporting, clinical governance approaches, working practices, culture and patient experience.

1.2.3.2 Strategic estates plan

As part of the Trust's strategic estates plan, we will be seeking investment from the Public Sector Decarbonisation Fund (PSDC) for a new energy centre. In addition, our renal dialysis service changes will deliver community dialysis provision in a purpose designed facility in Telford following public engagement post Future Fit.

1.2.4 Future Fit consultation outcome

The Future Fit public consultation, led by the CCGs, ran for 15 weeks from 30 May to 11 September 2018. It asked people from Shropshire, Telford & Wrekin and Powys for their views on the future of hospital services provided by RSH and PRH.

Following an extensive options appraisal – including multiple options for the future of services in Shropshire, Telford & Wrekin across one and two sites – the CCG consulted the public on options for the future.

The consultation focused on our commissioners proposed new model of hospital care, which would involve centralisation of emergency care services (including women and children's inpatient services) and planned care services. The consultation asked for people's views on this proposed model of hospital care and the two short-listed options by which it could be delivered:

- Option 1: RSH becomes an emergency care site and PRH becomes a planned care site.
- Option 2: PRH becomes an emergency care site and RSH becomes a planned care site.

Reconfiguration proposals were agreed in 2019 and defined a new configuration of acute services in Shropshire, Telford & Wrekin and Powys. Option 1 was confirmed as the future configuration of services, resulting in agreement to change how services are organised at RSH and PRH:

- Both hospitals to continue to provide urgent treatment (24/7), outpatient clinics, renal dialysis, diagnostics, midwifery-led deliveries and ante- and post-natal clinics.
- A planned care centre located at PRH, including planned inpatient surgery, day case surgery, inpatient breast services and medical wards.
- An emergency care centre located at RSH, including an emergency department (24/7), critical care, ambulatory emergency care, emergency surgery, emergency medicine, consultant-led inpatient women and children's services, and complex planned surgery.

Table 9: Agreed configuration of services across RSH (emergency care) and PRH (planned care)[20]

Princess Royal Hospital: Centre for planned care	Royal Shrewsbury Hospital: Centre for Emergency care
• 24/7 Urgent Care Centre (A&E Local model) • Theatres • Surgical wards • Day surgery unit (inc. planned surgery for urology, gynaecology, colorectal, head and neck, orthopaedics, gastroenterology, upper GI, vascular, and breast) • Medical wards (inc. care of the older person, rehabilitation and end of life care) • Midwife-led unit • Diagnostics (inc. endoscopy, MRI, CT, X-ray, cardiorespiratory, ultrasound scanning (inc. maternity), mammography) • Renal dialysis • Day case chemotherapy • Specialist breast services • Outpatients (specialties within obstetrics, children's, medicine, surgery, orthopaedics and therapies) • Pharmacy	• Emergency department, including paediatric triage • Urgent care centre • Critical care unit • Ambulatory Assessment • Surgical assessment (all surgical specialties inc. gynaecology assessment and treatment unit) • Theatres • Medical wards (inc. respiratory, renal, cardiology, stroke, care of the older person, dermatology, diabetes, oncology and haematology) • Surgical wards (inc. emergency and complex surgery for urology, gynaecology, colorectal, head and neck, trauma and orthopaedics, gastroenterology, upper GI, vascular) • Children's inpatient ward (inc. day case, oncology and haematology, medical and surgical) • Children's assessment unit • Maternity wards (inc. early pregnancy assessment services, antenatal, postnatal, delivery suite, midwife-led unit) • Neonatal Intensive Care Unit • Diagnostics (inc. endoscopy, MRI, CT, X-ray, interventional radiology, cardiorespiratory, ultrasound scanning (inc. maternity), mammography) • Renal dialysis • Day case chemotherapy • Radiotherapy • Outpatients (specialties within obstetrics, children's, medicine, surgery, orthopaedics and therapies) • Pharmacy

There is strong support for these proposals across the system, which settled the long-running debate about the configuration of services. The most appropriate configuration was decided by commissioners in 2019 following extensive consultation and was subsequently supported by the Clinical Senate, STW and Trust Board.

In 2019, the IRP recommended to the Secretary of State for Health and Social Care that the reconfiguration of acute services should be go ahead as planned. The IRP visited the county to speak not only to clinicians, but also to those who had objected to the plans. Following this, it was the unanimous verdict of all members of the Panel that the proposals that have been put forward should go ahead "without further delay". It was noted that the current model of emergency services provided through the two hospitals compromises safety and quality and so their advice came with several recommendations, including specific recommendations that the urgent care model should enable as

[20] These definitions were included in the DMBC in January 2019. Since the DMBC, urgent care centres have been adjusted to urgent treatment centres, in line with national guidance; ambulatory assessment will be delivered via same day emergency care. Neurology is no longer provided by the Trust.

much clinically appropriate care to be delivered at PRH as possible and that options for, diagnostics, ambulatory emergency care and frailty assessment must be considered. We support these recommendations and will continue to explore them through the development of the outline business case and full business case.

"The Panel's view is that the proposal to establish a single emergency centre at Royal Shrewsbury Hospital with a full range of complementary services at Princess Royal Hospital, Telford, is in the interests of health services in Shropshire, Telford and Wrekin and should proceed without further delay…

"The urgent care model should enable as much clinically appropriate care to be delivered at PRH as possible. Options for diagnostics, ambulatory emergency care and frailty assessment must be considered."

Independent Reconfiguration Panel, Referral to Secretary of State (2019)

In 2019-20, at the conclusion of the consultation, the Hospitals Transformation Programme was established to lead the implementation of the agreed new models of care.

As outlined above, within the strategic context, the plans for the elective recovery are being taken forward by the trust through a separate business case and proposal. This is therefore excluded from the scope of this SOC.

1.2.5 Reconfiguration of local services - Overview

We have an urgent need to reconfigure services across Shrewsbury, Telford and Wrekin following a full public consultation and nearly a decade of discussion about the proposals.

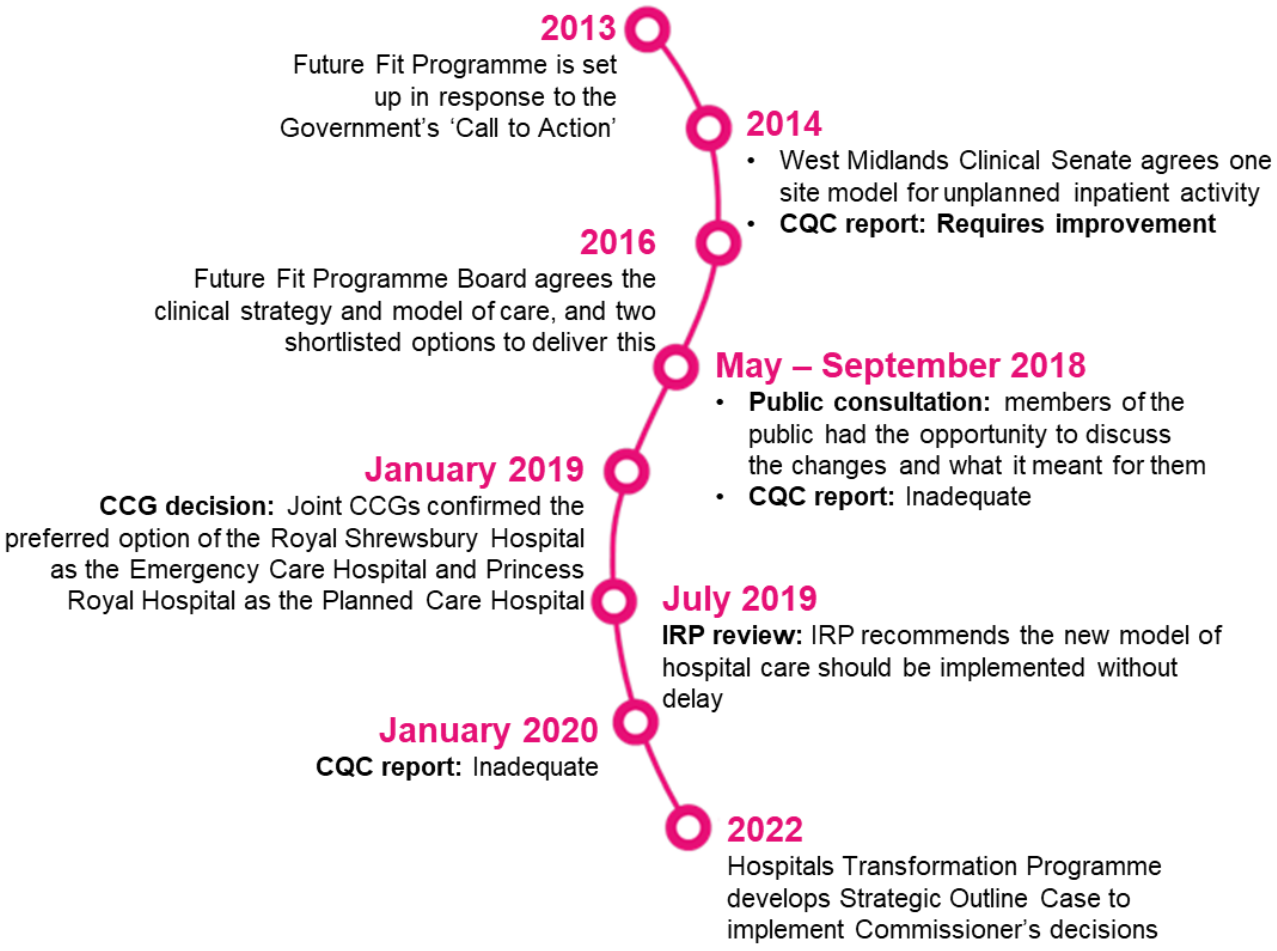
The proposal for the reconfiguration of services for Shrewsbury and Telford was developed as part of the Future Fit consultation and is now being implemented through the Hospitals Transformation Programme. While the proposals have continued to be debated over recent years, the issues we face have become much more urgent.

The Future Fit Programme was set up in 2013 in response to the Government's 'Call to Action'. This asked NHS staff, patients, the public and politicians to come together and agree what changes were needed to make local NHS services fit for the future. There was agreement that significant changes were required. Over four years, following more than 200 events, the opinions of thousands of local people, including NHS staff, patients and community groups, were sought and collated.

In November 2016, the Future Fit Programme Board agreed the clinical strategy and model of care including reconfiguring services to deliver an emergency care centre at one site and a planned care centre at the other. This led to a public consultation from May to September 2018. In January 2019, the Shropshire and Telford & Wrekin Clinical Commissioning Groups (CCGs) confirmed the preferred option of RSH becoming the centre for emergency care and a planned care centre being located at PRH.[21]

[21] https://nhsfuturefit.org/key-documents/joint-committee-meeting/688-decision-making-business-case/file

Figure 13: Background to this SOC



The scheme has not progressed through the approval process and at the same time the issues being faced by the Trust have become more challenging. Issues with workforce sustainability, clinical performance and quality, and financial sustainability have worsened and will continue to escalate if the scheme does not progress. This document further explains why the proposal needs to progress as soon as possible to address the case for change and ensure that we reach a sustainable position and mitigate the risk of further deterioration.

1.2.6 Scope of this SOC

This SOC builds on the work completed previously and the agreed configuration of services and intends to deliver the core outputs of the DMBC and move towards the wider Future Fit ambitions. This previous work identified that a planned care centre would be located at PRH and RSH would become the emergency care centre. It considered alternative configurations (including single-site options) and discounted them as not offering the best solution for our patients. It also considered the impacts of these changes, including on quality, access and equality.

Rapid implementation was recommended in 2019. COVID-19 and recent challenges have only underlined the need to move quickly to the agreed solution.

Feedback from NHSEI has confirmed that we must consider an option that only uses the allocated funding. As this does not deliver the entirety of the Future Fit ambitions, this SOC focuses on delivering the core DMBC requirements and how much of these wider ambitions can be delivered for the allocated funding and the additional incremental value of larger investments.

The scope of this SOC complements the Trust's wider strategic plan which includes:

- planned TIF2 funding for regional day case hub at PRH – this will deliver the day case components of the Future Fit consultation,
- PSDS funding for the energy centre at RSH – this will deliver critical components of the strategic estates plan,

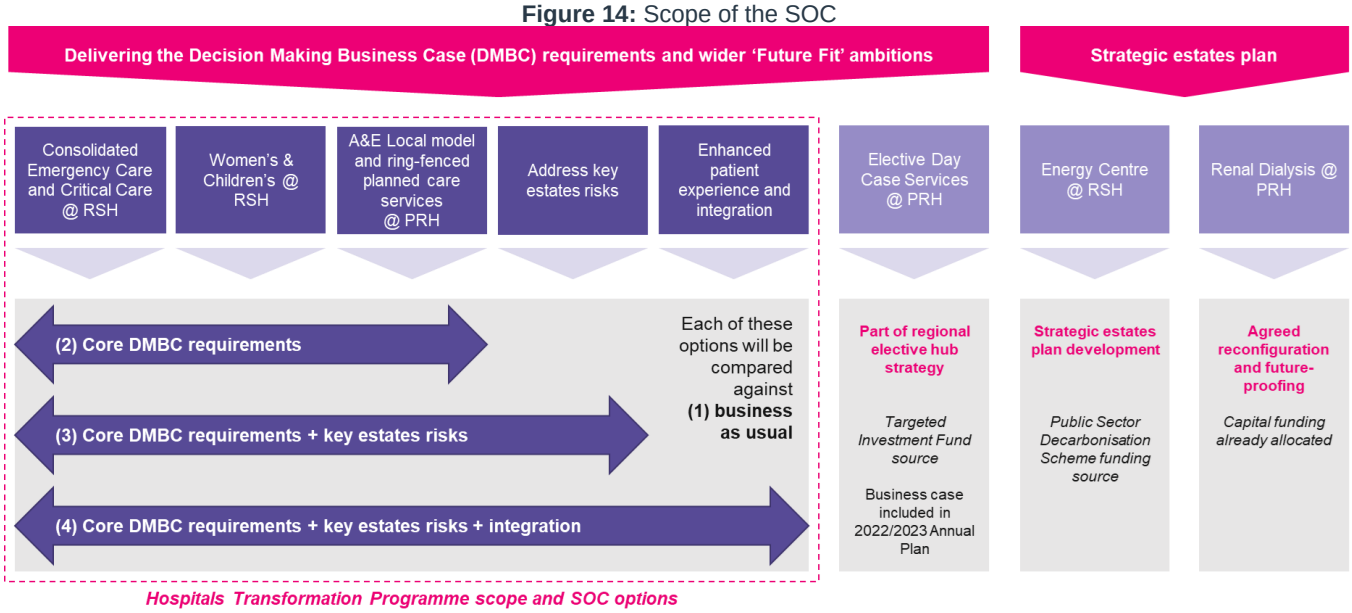
- planned capital funding for renal dialysis – this will deliver critical components of the strategic estates plan based on the more recent public engagement[22], and
- the digital transformation programme is being implemented in conjunction with HTP and is funded through alternative NHS sources.

These areas of scope will not be included in the options considered in this SOC as they are separately funded developments.

Delivering the core DMBC requirements and moving towards the wider Future Fit ambitions is the priority investment objective of this SOC. This underpins the development of the options, and as such all SOC options (except business-as-usual) must support the trust to move towards the delivery of this objective (see Economic Case).

The diagram below outlines the scope of the SOC, and the initiatives and investments outside of the scope of this SOC:

Figure 14: Scope of the SOC



These options are discussed and assessed in more detail in the Economic Case.

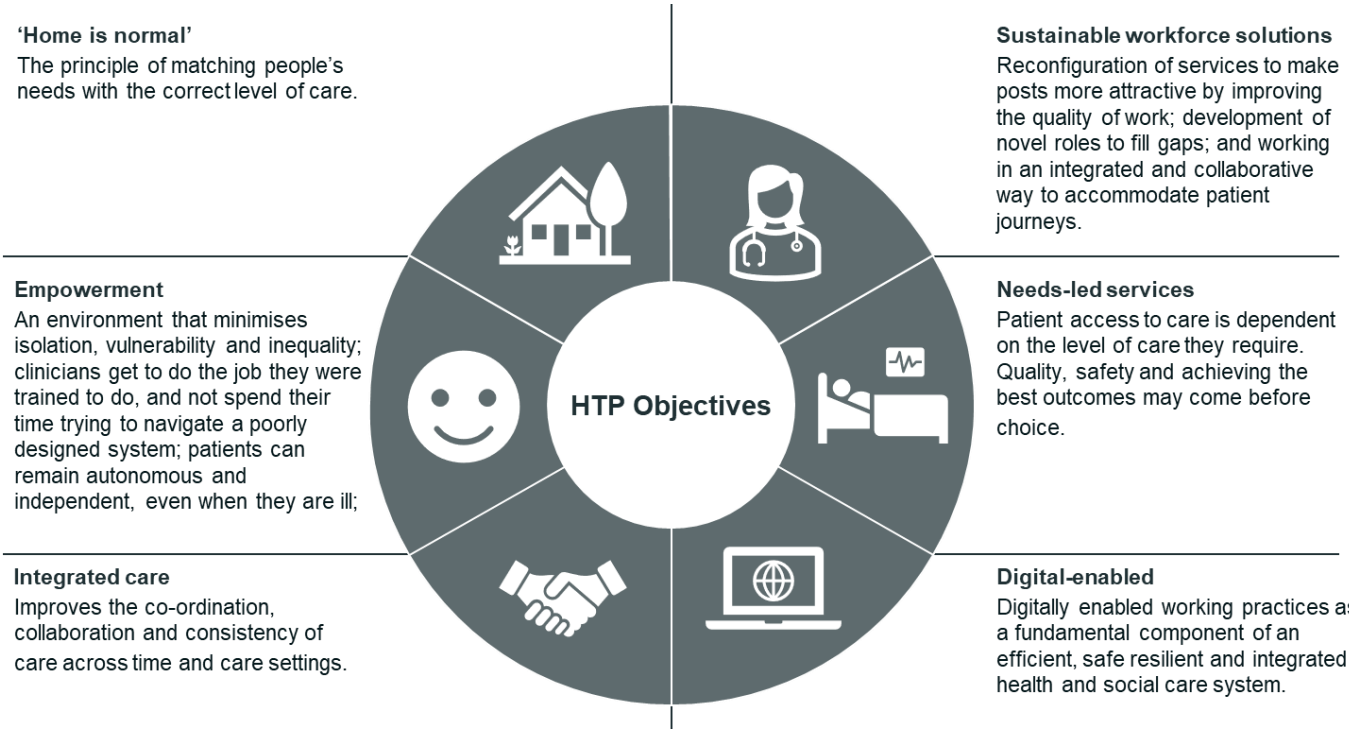
1.3 Implementing the Hospitals Transformation Programme

1.3.1 Overview of the programme and its aims

The overall priority of HTP is to deliver the clinical model and reconfiguration as described in the Future Fit consultation and agreed by national, regional and local stakeholders – and thereby realise the opportunity offered by reconfiguring services. Our principles are described below; reconfiguration is critical to achieving these.

[22] Renal dialysis services at PRH - SaTH

Figure 15: Principles of HTP



HTP's aims also align to key national and regional objectives:

- **To support the delivery of the NHS Long Term Plan.** The HTP and reconfiguration aligns with the NHS Long Term Plan. The publication of the NHS Long Term Plan (January 2019) and the national drive towards more preventative, integrated care supports the clinical model in respect of the out of hospital shift, the split between elective and emergency pathways, increased access to same day emergency care (SDEC), and the development of a more extensive urgent care model that will treat a greater proportion of our current A&E patients. The model is also underpinned by greater utilisation of technology, new ways of working, and delivery of patient-centred care. Further, the financial assumptions allow the development of the Economic and Financial analysis required to demonstrate the economic impact and financial affordability of the reconfiguration.
- **To support the national levelling-up agenda.** The scheme supports this critical government priority and will transform local health services. The scheme supports major investment in two hospital sites in an area of regional inequality and historical underinvestment. It will support two high-quality sites and help us become an employer of choice, providing regeneration and employment for the local community.
- **To address estates risks and deliver a new model of care.** The scheme will support modern fit-for-purpose and efficient use of estates and increase service resilience. It is envisaged that the new build requirements associated with the HTP scheme will target and alleviate the high and significant backlog issues identified across prime clinical areas at both RSH and PRH, assisting the delivery of the clinical model of care for the region. Investment into the reconfiguration of services and estate will ensure that the healthcare environments are safe and fit for use by all occupants.

The programme approach enables us to have an overarching strategy and vision which underpins all the required changes and objectives, ensuring business cases are aligned and developed effectively and efficiently across the programme.

Our proposals have the support of the system (including STW and CCG, whose letters of support are included in the appendices), and we will continue to work closely together as these proposals further develop.

1.3.2 Investment objectives

Investment objectives focus on the rationale and drivers for further intervention and the key outcomes and benefits we are seeking to achieve in support of our business strategy. Investment objectives will typically address one or more of the five generic drivers for intervention and spend, which are provided below:

- Effectiveness: improve the quality of public services in terms of the delivery of agreed outcomes.
- Efficiency: delivery of public services in terms of outputs.

- Replacement: re-procure services to avert service failure.
- Economy: reduce the cost of public services.
- Compliance: meet statutory, regulatory or organisational requirements and accepted best practice.

The objectives of this investment and the HMT category they address are defined in Table 10.

Table 10: Investment objectives

#	Objective	Definition / measures	HMT category / categories
1	PRIORITY OBJECTIVE Consultation: Deliver the core DMBC requirements and move towards the wider Future Fit ambitions by 2029	• Delivering the configuration and clinical model defined in the DMBC (i.e., defined in DMBC S9.3, and associated capacity), and moving towards the wider Future Fit ambitions by 2029 • Maintained access to services, as defined in DMBC	*Effectiveness* *Compliance*
2	Clinical Quality and Safety: Deliver safe, effective, and quality healthcare services for patients by 2029	• Improved clinical outcomes – delivering improvements in clinical outcomes identified in clinical strategy and DMBC from current 2022 levels by 2029. (These include cancer 62-day wait from urgent GP referral, currently c. 44%, NHS cancer screening service referral, currently c. 39% and RTT – max 18 weeks incomplete wait, currently c. 58%) • Increase in patients treated in lower acuity settings – reflected in increased proportion of patients treated in UTC, via SDEC, as outpatients or as day cases (vs. A&E, NELIP, day cases and ELIP respectively), including 50% increase in ZLOS pathways and 10% increase in day case rates (currently 80%) from current levels by 2029 • Improved infection control – reflected in reductions in HCAIs from current levels (c. 17 2019/20) towards target of c. 14 (20% reduction), reflecting impact of facilities by 2029	*Effectiveness*
3	Patient Experience: Improve patient satisfaction and wellbeing in purpose-built accommodation by 2029	• Improve patient satisfaction and experience – reflected in improved National Patient Survey results from current levels (8.3 in 2020) by 2029 • Solution provides enhanced privacy and dignity – providing 72% single rooms in new build areas, eliminating mixed sex breaches (35 in Jan 2022, breach rate of 2.5), and increasing ratings for patient privacy, dignity and wellbeing from current levels by 2029 • Improving RTT from 76% (2019/20) towards target of 90% by 2029 • 4-hour waits from 68% (2019/20) towards target of 85% by 2029	*Effectiveness*
4	Workforce: Enable sustainable staffing and be an attractive place to work by 2029	• Improved workforce sustainability – reflected in a reduction in critical rota gaps through consolidation of rotas, meeting staffing standards in all specialties, and reduced staff sickness absence (from c.4.3% (2019/20) towards upper quartile of comparator Trusts (c.4.2%) by 2029 • Improved workforce availability – reflected in improved recruitment and retention, reduced staff turnover and reduced agency spend (target £2.6m reduction p.a.) by 2029 • Improved staff satisfaction – reflected in staff morale, feedback and wellbeing, including an increase in staff recommending the Trust as a place to work (from c.38% (2019/20) towards national average (66%) by 2029	*Effectiveness*

#	Objective	Definition / measures	HMT category / categories
5	Effectiveness: Deliver improved adjacencies and enhanced patient flow, supporting the efficient operation of the hospital and reduce elective cancellations by 2029	• Improved flow – reflected in reduced lengths of stay (average 0.5-day reduction from current levels which are NEL 6.5 days and EL 3.5 days) by 2029 • Improved efficiency – reflected in increased theatre utilisation from c. 75% (2019/20) to 85% by 2029 • Improved elective capacity – reflected in reduced elective cancellations from c. 630 (2019/20) towards target of c. 315 (50% reduction) by 2029 • Improved bed occupancy – from c. 92% (2019/20) towards target of 89% by 2029	*Efficiency*
6	Estate: Deliver a safer, modern, financially sustainable estate by 2029	• A more efficient estate, reflected in reduced maintenance costs per sqm (from c. £97–109/sqm (2019/20) to upper quartile of comparator Trusts (c. £75/sqm)) and reduced energy and utilities spend (from c. £28–45/sqm (2019/20) to upper quartile of comparator Trusts (c. £25/sqm)) by 2029 • Elimination of high/significant risk backlog maintenance (£39m 2020/21) by 2029 • Elimination of issues identified by CQC (2021) associated with the facilities from which healthcare is being delivered by 2029, including poor urgent & emergency care environments at RSH and PRH, maternity care, wards and end of life care. • Net zero carbon construction and operation by 2029 • Delivery of a commercially viable solution by 2029 • Deliverable by 2029 – accelerating where possible by 2028 • Solution has the support of the local system – reflected in confirmed CCG/ICS support by 2029 • Solution makes best use of available NHS estate, eliminating condition C/D Trust estate by 2029	*Replacement* *Compliance*
7	Finance: Contribute to overall financial sustainability by 2029 (revenue affordability)	• Affordable solution – annual revenue benefits from the investment measured against the annual revenue costs (PDC and depreciation) – determining the net contribution by 2029 • Value for money – solution offers a positive NPSV/BCR and maximises the social value and benefit of the investment by 2029	*Economy*
8	Finance: Meeting capital availability requirements (capital affordability)	• Affordable solution – capital required is expected to be available to HTP (c. £312m currently allocated) by 2029	*Economy*

The current services provided need to be transformed to appropriately meet the needs of the population, patients, staff, and our finances. Investment in a new clinical model and modern purpose-built accommodation will substantially enable this and is reflected in the investment objectives.

These investment objectives have been widely tested and iterated with stakeholders to develop a broad consensus on what the scheme is planning to achieve.

Key stakeholders involved included Trust Board, STW ICS CE Group / Board, HTP Assurance Committee, and HTP Board (see HTP governance, Section 5.1.1).

Each of these groups agreed the investment objectives as an appropriate reflection of our aims. Satisfying the potential scope for this investment will deliver the high-level strategic benefits shown below. As these plans progress, these will move towards realisation (see Section 5.3).

Table 11: Strategic benefits

	Benefit	Description
B1	Workforce savings	• A reduction in duplication and the ability to combine rotas will enable rota efficiencies • Reduced agency dependency, resulting in a reduction in agency premium costs • Improved recruitment and retention through reduced staff turnover and greater ability to attract staff • Staff satisfaction and absence improvements through a modern, purpose-built working environment
B2	Enhanced building efficiencies	Improved quality of facilities will enable: • Maintenance costs to be reduced • Backlog to be reduced • Energy and utilities costs to be reduced
B3	Reduced length of stay	A modernised estate has potential to deliver a reduced length of stay through measures including[23]: • Increased provision of single rooms • Improved natural light • Noise reducing measures • More efficient layout • Increased integration with community care and improved discharge to community settings • Improved patient flow
B4	Treating patients in a lower acuity setting	Enablement of: • Avoidance of UTC referrals to A&E • Same day emergency care • Integrated care
B5	Theatre utilisation	• Fewer cancelled operations • Improved theatre productivity
B6	Improved performance and outcomes	Clinical outcome improvements through compliance with key targets, including: • ED waiting time • Referral to treatment times • Delivery of cancer targets • Improved access to multi-disciplinary teams • Delivery of care in an environment suitable for specialist care

[23] Fable Hospital 2.0
https://www.thehastingscenter.org/uploadedFiles/Landing_Page/SadleretalFableHospitalBusinessCase_HastingsJan11%281%29.pdf

	Benefit	Description
B7	Patient experience	Patient experience will improve through: • Modern environment and facilities • Reduced waiting times • Fewer cancelled operations • Increased single rooms, improving privacy and dignity • Effective wayfinding and accessibility
B8	Patient safety	• Reduction in HCAI through improved pathways and where design supports improved infection prevention and control • Reduction in adverse drug events through improved pathways and where design improves physical working environment improving oversight and reducing distractions • CQC compliance
B9	Environmental	• Reconfiguration and new build will contribute to the trust's NZC ambitions
B10	The main disbenefit is the disruption caused during construction	• This will be mitigated through careful planning and phasing as described in the management case.

1.3.3 Risks, constraints, and dependencies

The main business and service risks associated with the potential scope for this project are summarised in Table 12: , together with their countermeasures. Our approach to risk management is described in the Management Case (Section 5.4) and the Risk Register is within Appendix I.

Table 12: Strategic risks and counter measures

Risk area	Risk		Countermeasure(s)
Design	R1	Existing design assumptions and/or demand and capacity / hospital sizing outputs necessitate material changes, increasing the capital cost of the scheme	Assumptions have been agreed with Trust and ICS working groups Informal engagement with national and regional regulators ahead of formal SOC submission Sensitivity analysis on size of build Ongoing review and refinement through OBC process, including further development of out of hospital plans
	R2	The capital cost of the scheme exceeds the allocated capital driven by inflation or other cost pressures and regulators do not approve the SOC	The scheme has been developed and costed using best practice benchmarks Informal engagement with national and regional regulators ahead of formal SOC submission
	R3	The system financial plan is not signed off and/or assumptions change	Regular engagement with the system financial plan development, and accountability of those delivering it through the Programme Board and STW Board
Development	R4	Funding earmarked for scheme is no longer available from the government	Continuous engagement with NHSEI to show continued commitment to the scheme. Revised scope against original PCBC criteria developed
	R5	Failure to deliver programme due to workforce planning	The workforce plan has been revalidated and informs the current Strategic Outline Case
Implementation	R6	Time and cost overruns lead to inability to complete scheme	Financial affordability and timelines have been revised since the previous SOC approval in 2016 Governance arrangements have been reviewed and strengthened

Risk area	Risk		Countermeasure(s)
Operational	R7	Delays in programme delivery and further operational challenges post public consultation	Public consultation process completed, with timescales to approval developed as part of wider Future Fit consultation
	R8	Inability to adopt clinical model and realise benefits	Extensive clinical engagement within the developed model. Programme shows model is achievable and will be resolved through workforce plan Ongoing clinical engagement in clinical model led by HTP Medical Director
Termination	R9	Appointed contractor is unable to complete the works	Selection of contractors will ensure that a capable contractor is appointed. This may be supported by using an applicable framework where contractors have been pre-selected, or through selection criteria in a traditional procurement
Political	R10	Delays to the scheme as a result of ongoing political uncertainty lead to an increase in the capital required for the scheme	Ongoing engagement with key stakeholders (including political representatives), to secure their buy-in to the overall priority of the scheme and to get their support for the urgent progression of plans for the investment

Constraints are the external conditions and agreed parameters within which the programme must be delivered, over which the project has little or no control. The project is subject to the constraints in Table 13.

Table 13: Main constraints

Constraint		Description
C1	Capital availability	Capital within the NHS is significantly constrained. While the scheme has had previous allocations, these have excluded the impact of external factors/changes such as inflation, single room requirements, Net Zero carbon and addressing the impact of COVID-19. Recent feedback from NHSEI has confirmed the HTP SOC must include an option that describes how it would use the allocated funding (£312m). Given this situation, the scheme has sought to demonstrate what can be delivered within capital availability, and the incremental impact and value realised by further investment, to demonstrate an optimum return on capital
C2	Workforce	We must design, build and operate the development within the capacity of the staff available at each point. This constraint is derived from the national and local shortage of clinical staff
C3	Service configuration	The SOC must move towards the delivery of the configuration of services set out by commissioners and agreed to within the DMBC. As this has been consulted on, any changes to this will require further review by commissioners

The project is subject to dependencies in Table 14 that will be carefully monitored and managed throughout the lifespan of the scheme. These can be interdependencies between other programmes and projects or external dependencies outside of the project environment. It is expected that the delivery of the dependencies will be managed by the relevant project, programme or operational management structures and resources. HTP will work closely with each to confirm they are delivering to plan and will highlight potential risks as they emerge. These will be reviewed and updated at the next stage of the business case process.

Table 14: Main dependencies

Dependency	
D1	System financial position and possible regulatory requirements relating to system control totals
D2	Strategic alignment with the system and STW
D3	National clinical policy changes
D4	Prompt approval of business cases by regulators and Government
D5	Continued availability of capital throughout the programme
D6	Capacity of suppliers to develop the reconfiguration within the required timeline
D7	Delivery of day case capacity via TIF 2 funded programme

Dependency	
D8	Delivery of energy centre at RSH
D9	Trust digital delivery programme
D10	Delivery of local care services transformation

1.4 Conclusion

In Shropshire Telford & Wrekin, we face some of the biggest acute care challenges in the NHS and fundamental changes are required to the configuration of services across both hospital sites.

This strategic outline case considers the ways we can invest in our hospitals to move towards the delivery of the agreed clinical model and improve quality and safety, enhance patient experience, become an employer of choice, improve patient flow and efficiency, deliver a sustainable estate, and contribute to the financial sustainability of our healthcare system. The options for delivering this are discussed in detail within the Economic Case and recognise the balance between these competing priorities.

We now need to implement the agreed models of care as our services are not sustainable in the longer term. Our proposals will lead to benefits for patients by improving the quality and safety of care they receive, enhancing the environment in which they are treated, and providing rapid access to the right clinical staff with the right skills – while delivering the commitments we made through the public consultation. This case is a key part of the trust and systems strategic plans for addressing the challenges we face and delivering improvements to patient's experience and outcomes.

Our approach factors in the inter-dependencies with other key strategic transformation programmes across the local health system. This document considers the specific elements to be funded via capital allocated to this scheme and seeks to maximise the benefits of this in delivering the core DMBC requirements. It seeks an appropriate balance between cost and benefit to move us towards the Future Fit ambition and realise benefit for our patients.

Our proposals are part of an integrated system-wide plan and have full partner support. They are a key component of the system's plan for achieving sustainability and delivering high quality healthcare in a more effective and efficient way.

This SOC appraises a number of strategic options that will deliver the service reconfiguration agreed through the Future Fit consultation, thereby addressing a number of the health system's most pressing acute challenges. These challenges arise principally from two inadequately sized emergency departments, split site delivery of key clinical services (including critical care), insufficient physical capacity (particularly impacting elective services), mixing of planned and unplanned care pathways and poor clinical adjacencies.

In assessing the available strategic options, this SOC seeks to explore the most appropriate way to balance a number of competing priorities and objectives:

- delivering the full ambition behind the extensive public consultation (Future Fit)
- implementing new national standards (for example around COVID-19 requirements, increased proportion of single rooms and Net Zero)
- establishing a sustainable infrastructure to support the delivery of excellent healthcare
- the funding available to achieve those changes - the current allocation of funding for this scheme is based on costings, inflation assumptions and national standards from 2016

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Integrated Care System
Shropshire, Telford and Wrekin

2 Economic Case

2 Economic case

Building on the outputs of the extensive consultation completed in 2018–2019, we have considered the appropriate way to implement the agreed clinical model and address the case for change set out in the strategic case. We have appraised the costs and benefits of these options to assess the option that will deliver the highest net value for our local population and the UK public.

In assessing the available strategic options, this SOC seeks to explore the most appropriate way to balance a number of competing priorities and objectives:

- delivering the full ambition behind the extensive public consultation (Future Fit)
- implementing new national standards (for example around COVID-19 requirements, increased proportion of single rooms and Net Zero)
- establishing a sustainable infrastructure to support the delivery of excellent healthcare
- the funding available to achieve those changes - the current allocation of funding for this scheme is based on costings, inflation assumptions and national standards from 2016

This includes consideration of:

- **1. Business-as-usual (c. £72m):** Continuation of current arrangements, including the Trust's baseline annual capital programme over the appraisal period.
- **2. Core DMBC ('Do minimum') (c. £312m):** The minimum capital investment required to deliver the priority Investment Objective" (DHSC/HMT guidance) – i.e., deliver the core DMBC requirements and move towards wider 'Future Fit' ambitions.
- **3. Core DMBC + key estates risks (c. £481m):** This allows us to deliver the core DMBC requirements and some of the wider Future Fit ambitions. It seeks to expand the opportunity for redevelopment whilst improving overall sustainability. This is a fuller development – including additional new wards, theatre refurbishment, improving the physical environment and substantially reducing the estates risk.
- **4. Core DMBC + key estates risks + integration (c. £534m):** Seeks to maximise the opportunity for redevelopment and improvements to overall sustainability. Delivers the core DMBC requirements and most of the wider Future Fit ambitions – including additional new wards, theatre refurbishment, improving the physical environment, substantially reducing the estates risk, optimising estate layout across both sites and facilitating more integrated health and wellbeing services.

Based on reaching an appropriate balance between competing priorities and informed by the detailed assessment against the CSFs, Option 2 has been selected as the Preferred Way Forward at this stage

- Options 2 and 4 offer significant clinical, workforce and operational benefits vs. business-as-usual and help address the issues we are facing
- Option 4 (Delivering the core DMBC, addressing key infrastructure issues and improving health service integration) offers greatest clinical, workforce and operational benefit
- For this reason, it is preferred across multiple qualitative CSFs (inc. clinical model, quality, workforce and effectiveness) and offers greatest NPSV
- Options 2 and 4 are all broadly affordable from revenue perspective – as they offer financial benefits greater than the cost of capital
- However, Option 3 and Option 4 require more capital than is currently available and fail the capital affordability CSF. Given their relative benefits, these will be explored more, if further capital became available
- Option 2 (Delivering the core DMBC requirements) delivers a similar ROI to option 3 and 4, delivering the core DMBC requirement and moving us towards the wider Future Fit ambition by delivering the first phase of redevelopment – resulting in delivery of the majority of expected Future Fit benefits. This can be enhanced through additional phases in future if capital is available
- As Option 2 passes all CSFs (including capital availability), and offers a positive NPSV and BCR, it has been selected as the Preferred Way Forward at this stage – balancing the potential benefits and capital available
- This will be considered further within the Outline Business Case – including further optionality around implementation

Our preferred way forward involves investing £312m in Royal Shrewsbury Hospital and Princess Royal Hospital to provide improved facilities that will better meet the needs of our patients. It will put in place the core elements of the service reconfiguration described in the Future Fit consultation, help us to address our most pressing clinical challenges, and establish solid and sustainable foundations upon which to make further improvements. A number of significant challenges will remain, particularly in relation to the standard of patient accommodation at the RSH site, and whilst these can be managed over the medium term, they will need to be addressed in the long term.

The preferred way forward is also fully aligned with local health system objectives and is one of a number of strategic initiatives that will transform the health and wellbeing of the population of Shropshire, Telford & Wrekin and Powys. One of the core local health system assumptions underpinning the design of the HTP relies on the transformation of out of hospital services, which will be delivered through the ICS's Local Care programme and is expected to lead to a much lower increase in acute bed requirements over the medium to long term.

This economic case documents the wide range of options that have been considered in response to the strategic case and assesses these to identify the options that should be taken forward to the OBC process.

In this section:

- The investment objectives (Section 1.3.2) are developed into critical success factors (CSFs) (Section 2.1) that must be met for an option to be considered further in the OBC process.
- The possible options to achieve the investment objectives are developed within an options framework (Section 2.2). This includes scope, solution, delivery (procurement), implementation (phasing) and funding.
- The options within each dimension of the options framework are appraised against the qualitative CSFs. These include:
    - Scope options (Section 2.3.2) arising from the Future Fit decision-making business case (DMBC) – two scope options are short-listed: Core DMBC requirements and the wider Future Fit ambition.
    - Solution options (Section 2.3.3) to deliver the preferred scope. Three options, in addition to the business-as-usual comparator pass the CSFs and are carried forward to the short-list.
    - Procurement (delivery) options (Section 2.3.4) are appraised, and multiple options remain for consideration in the OBC stage.
    - One Phasing (implementation) option (Section 2.3.5) is considered - phased delivery which is carried forward. More options will be considered at the OBC stage.
    - Funding options (Section 2.3.6) are appraised and PDC is identified as the preferred mechanism for funding the scheme.
- The short-listed options identified above are carried forward for the detailed economic appraisal of the costs, benefits, value for money and affordability (Section 2.5). These options are assessed against the quantitative CSFs.
- A high-level risk appraisal is conducted on the short list options (Section 2.6) and a review against the Public Consultation outcomes (Section 2.7).
- Finally, the economic case provides the conclusion of the options appraisal process and identifies the preferred way forward (Section 2.8).

This appraisal is based on the available evidence when this SOC was developed. If additional options become apparent as the scheme progresses, we will remain open to considering them.

The process of developing and appraising options is based on the standard HMT Green Book approach. It has been informed by a series of workshops and best available evidence. Where appropriate, outputs and conclusions have been tested more widely, including with the CCG and regulators. The outputs at each stage have been agreed by, as relevant, the Programme Board and the Trust Board.

Figure 16: Economic case development and appraisal process

This process, including key workshop and sign-off points, is detailed further in relevant sections for critical success factors (Section 2.1), long-list development (2.2), long-list appraisal (2.3.1) and the resulting short-list (2.4).

2.1 Critical success factors

CSFs are the attributes essential for successful delivery of the project, against which the initial appraisal of the options was carried out. They are pass/fail criteria and align with one of the following HM Treasury categories:

- strategic fit and business needs,
- potential value for money,
- supplier capacity and capability,
- potential affordability, and
- potential achievability.

Based on our investment objectives, we defined a range of CSFs for assessing the options. These are all the factors an option must pass for us to give them further consideration. We have also identified where an option is preferred (most favourable) against each of the critical success factors.

2.1.1 Agreed critical success factors

Some CSFs are only relevant to certain elements of the options framework. The alignment of CSFs to relevant dimensions is shown in the table below.

Table 15: Critical success factors, mapped to investment objectives (Section 1.3.2)

Investment Objective	Critical success factor	Description	HMT Category
1. PRIORITY OBJECTIVE Consultation	Clinical model	• Delivering the core DMBC requirements (defined in DMBC S9.3, and associated capacity) and moving towards the wider 'Future Fit' ambitions	Strategic fit and business needs
2. Clinical Quality and Safety	Clinical quality and patient experience	• Supports required improvement in service and clinical quality and safety Supports required improvement in patient experience	
3. Patient Experience			
4. Workforce	Workforce	• Supports required improvement in workforce availability and sustainability	
5. Effectiveness	Effectiveness / Access	• Services must be located to maintain or improve access for local population (patients and staff) and to improve adjacencies and enhance patient flow	
6. Estate	Commercial viability	• Procurement route facilitates access to suppliers with capacity and appropriate capability	Supplier capacity and capability
	Build deliverability	• Makes an appropriate use of existing NHS estate • Deliverable by target year of opening • Site locations must be able to deliver the required footprint and capacity • Supported by commissioners and the system	Potential achievability
7. Finance	Value for money	• Net present social value and benefit-cost ratio[24]	Potential value for money
8. Finance	Revenue affordability	• Net contribution to the system's income and expenditure position	Potential affordability
	Capital affordability	• Relative capital affordability of the option versus the original allocated capital of c. £312m	

2.2 Long-list and options framework

Building on the extensive options appraisal completed in 2018–2019, we have considered how best to implement the agreed clinical model. We have appraised the costs and benefits of these options to understand an appropriate value option for our local population and the UK public.

[24] Net present social value (NPSV) is defined by the Green Book as the present value of benefits less the present value of costs: it provides a measure of the overall impact of an option. Benefit-cost ratio is defined by the Green Book as the ratio of the present value of benefits to the present value of costs: it provides a measure of the benefits relative to costs. (HM Treasury Green Book, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/938046/The_Green_Book_2020.pdf)

The options framework is provided by HM Treasury to help schemes systematically work through the options available to them, covering the choices for what, how, who, when and the associated funding arrangements. These five dimensions of the Options Framework are shown in Table 16:

This SOC considers each of the five dimensions of the options framework. This SOC builds on the Future Fit DMBC, which defines the scope and configuration of hospital services in Shropshire, Telford & Wrekin.

The scope dimension has been defined through the Future Fit options appraisal, including the number and location of sites. The clinical model delivered by the options we considered is consistent with the acute components of the agreed Future Fit model of care which we consulted on, and which was supported by the Secretary of State:

- an emergency care centre at RSH comprising an emergency department, a critical care unit and women and children's inpatients (with all the required acute medical and surgical specialities co-located)
- a planned care centre at PRH
- urgent care services at both sites
- routine planned care services on both hospital sites – outpatients and diagnostics on both hospital sites

Most patients will continue to receive their care at their local site and all our communities will benefit from improvements to the quality of care they receive.

As the scope has been determined by Future Fit, and we need to move quickly to address immediate clinical and operational issues, this SOC focuses primarily on how to deliver the scope (solution options) and how best to phase the project and accelerate the benefits. Procurement and funding options have been considered and will continue to be explored through the business case process.

Table 16: Summary of Green Book options framework[25]

Dimension	Description
Scoping options – choices in terms of coverage (the what)	The choices for potential scope are driven by business needs and the strategic objectives at both national and local levels. In practice, these may range from business functionality to geographical, customer and organisational coverage. Key considerations at this stage are 'what's in?', 'what's out?' and service needs.
Service solution options – choices in terms of solution (the how)	The choices for potential solution are driven by new technologies, new services and new approaches and new ways of working, including business process re-engineering. In practice, these will range from services to how the estate of an organisation might be configured. Key considerations range from 'what ways are there to do it?' to 'what processes could we use?'.
Service delivery options – choices in terms of delivery (the who)	The choices for service delivery are driven by the availability of service providers. In practice, these will range from within the organisation (in-house), to outsourcing, to use of the public sector as opposed to the private sector, or some combination of each category. The use of some form of public private sector partnership (PPP) is also relevant here.
Implementation options – choices in terms of the delivery timescale	The choices for implementation are driven by the ability of the supply side to produce the required products and services, VFM, affordability and service need. In practice, these will range from the phasing of the solution over time, to the modular, incremental introduction of services.
Funding options – choices in terms of financing and funding	The choices for financing the scheme (public versus private) and funding (central versus local) will be driven by the availability of capital and revenue, potential VFM, and the effectiveness or relevance/appropriateness of funding sources.

Each dimension of the options framework was considered in turn by the HTP team, clinicians, other staff groupings and system partners, and a recommended long-list in each dimension was agreed by the Programme Board in April 2022.

The long list takes into account the potential variations in scope, while still delivering the core DMBC decision, the service solution options, and the arrangements to deliver the scope and service solutions outlined, aligned to the HMT Green Book options framework, which includes additional consideration of implementation routes (to be considered further at OBC).

These options have been developed within an overall Development Control Plan (DCP) for RSH and PRH available at Appendix D5.

[25] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/938046/The_Green_Book_2020.pdf; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/749086/Project_Business_Case_2018.pdf

We have appraised the following long list:

Table 17: Dimensions of options framework and long-list

#	Domains and options
Scope	
	Business-as-usual (comparator)
a.	Delivering the core DMBC requirements
b.	Delivering the wider Future Fit ambitions
Service solution	
1	Business-as-usual (comparator)
2	Core DMBC ('Do minimum')
3	Core DMBC + key estates risks
4	Core DMBC + key estates risks + integration
Service delivery	
i.	Single-stage tender
ii.	Two-stage tender
iii.	Procurement framework
Implementation	
-	Phased delivery
Funding	
-	Public dividend capital

Note:

(1) Options deliver the outcome of consultation and associated clinical model, scope and solution – comparators do not, but are included to meet regulatory requirements

(2) Business-as-usual does not deliver the agreed clinical model, scope of solution, but is required by HMT Green Book and is included as a comparator.

This creates 16 potential permutations including the business-as-usual comparator at the long-list stage:

#	Scope	Service solution	Service delivery	Implementation	Funding
1	*Delivering business-as-usual*				
2	Delivering the core DMBC requirements	Core DMBC ('Do minimum')	Single-stage tender	Phased delivery	Public dividend capital
3	Delivering the core DMBC requirements	Core DMBC ('Do minimum')	Two-stage tender	Phased delivery	Public dividend capital
4	Delivering the core DMBC requirements	Core DMBC ('Do minimum')	Procurement framework	Phased delivery	Public dividend capital
5	Delivering the core DMBC requirements	Core DMBC + key estates risks	Single-stage tender	Phased delivery	Public dividend capital
6	Delivering the core DMBC requirements	Core DMBC + key estates risks	Two-stage tender	Phased delivery	Public dividend capital
7	Delivering the core DMBC requirements	Core DMBC + key estates risks	Procurement framework	Phased delivery	Public dividend capital

#	Scope	Service solution	Service delivery	Implementation	Funding
8	Delivering the core DMBC requirements	Core DMBC + key estates risks + integration	Single-stage tender	Phased delivery	Public dividend capital
9	Delivering the core DMBC requirements	Core DMBC + key estates risks + integration	Two-stage tender	Phased delivery	Public dividend capital
10	Delivering the core DMBC requirements	Core DMBC + key estates risks + integration	Procurement framework	Phased delivery	Public dividend capital
11	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Single-stage tender	Phased delivery	Public dividend capital
12	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Two-stage tender	Phased delivery	Public dividend capital
13	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Procurement framework	Phased delivery	Public dividend capital
14	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Single-stage tender	Phased delivery	Public dividend capital
15	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Two-stage tender	Phased delivery	Public dividend capital
16	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Procurement framework	Phased delivery	Public dividend capital

The following sections provides the appraisal of the options within each dimension of the options framework. The appraisal has focused on the qualitative CSFs at the long-list stage, with the focus on the service solution dimension as that is where the most meaningful variation in options exists.

The scope options are largely defined by the Future Fit public consultation, and the procurement, implementation and funding options are considered at a high-level, with further appraisal expected at the next stage of the business case process (Outline Business Case).

This is based on significant engagement and appraisal with clinical, operational and financial leads.

We reviewed all options for opportunities to improve net value by minimising the capital investment requirement. This included reviewing inflation, the impact of modern methods of construction, standardised/repeatable design, and full comparison of our capital costs against key benchmarks (including New Hospital Programme developments).

2.3 Appraisal of long list against qualitative critical success factors

The long-listed options and their appraisal against the CSFs are considered in the next sections. In line with guidance at this stage, options may fail, pass or be preferred against the CSFs.

Table 18: Appraisal definitions

Appraisal	Definition
Fail	• Fail a Critical Success Factor – not expected to meet a Critical Success Factor • Not taken forward
Pass	• Pass a Critical Success Factor – are expected to meet a Critical Success Factor • Taken forward
Preferred	• Preferred against a Critical Success Factor – is expected to be most favourable against a Critical Success Factor • Taken forward and offer material advantages vs. other options that have passed

This appraisal has been undertaken against each element of the options framework in turn.

Once completed for each domain, this provides us with a short-list of options to undertake a further economic (quantitative) appraisal. The conclusions of the long list appraisal are summarised in Sections below, with the further quantitative appraisal undertaken in Section 2.5.

2.3.1 Appraisal process

This appraisal has been based on broad engagement and consideration of the evidence, including:

- Extensive engagement throughout the summer of 2021 in the development of the first draft of this SOC
- Further engagement and appraisal of options in early 2022 including a qualitative appraisal workshop attended by representatives of the Transformation Programme, Trust clinicians and the wider system (multiple workshops from 10 March concluding w/c 21 March 2022).
- The economic appraisal was undertaken by the programme finance workstream, based on standard methodologies (concluded 21 March 2022).
- This overall appraisal, short-list and preferred way forward was supported by the CCG governing body (13 April 2022) and supported by the Trust Board (14 April 2022).

The supporting evidence for these appraisals is included in the Appendix E.

2.3.2 Long-list appraisal: Scope

This section considers the scope of the scheme.

Scope was extensively considered as part of the Future Fit consultation, including as part of the pre-consultation business case, public consultation and decision-making business case. During the Future Fit process, a long list of scope options, including different sites, and configurations of services across sites was considered. Through this process, we agreed the shape of the reconfiguration of acute services across Shropshire, Telford & Wrekin.

The agreed configuration of services was for the RSH to become an emergency care centre and for a planned care centre to be located at PRH, with the scope of the services to be provided on each site defined in the Future Fit decision-making business case.[26]

This SOC considers how to implement the configuration outcome. Therefore, all the scope options must deliver the configuration of the services defined and agreed through the Future Fit consultation.

We are not seeking to review or amend the scope decisions through this SOC. This approach is consistent to similar SOCs seeking to implement agreed reconfiguration decisions.

2.3.2.1 Delivering the consultation outcomes and configuration of services has informed the scope options

This SOC focuses on options that deliver the agreed configuration and clinical model for Shrewsbury, Telford & Wrekin, and Powys, assessing affordability and value for money, without imposing a specific capital limit.

But in line with guidance from NHSEI, we have considered what could be delivered by utilising only the £312m of originally allocated funding. As a result, the scope options considered are:

- Business as usual – continuation of current arrangements. This does not deliver any of the requirements of the DMBC and is included for comparative purposes.
- Delivering the core DMBC requirements

[26] Future Fit Option 1, as defined in DMBC S9.3, and associated capacity; see: https://nhsfuturefit.org/key-documents/joint-committee-meeting/688-decision-making-business-case/file

- Delivering the wider Future Fit ambition

As outlined in the strategic case (Section 1.2.6), there are areas of the trust's wider strategic plan, such as the development of a day case hub at PRH that are out of scope as they are being delivered as separate projects to this investment. As a result of the clear direction provided by the consultation, and the wider strategic plans, the scope of this investment is therefore targeted towards delivering the core DMBC requirements and delivering the wider Future Fit ambitions.

Both delivering the core DMBC requirements, and the wider Future Fit ambition were assessed against the Critical Success Factors and **both shortlisted to carry forward for appraisal.**

Table 19: Summary appraisal of the scope options

Critical Success Factor	Delivering the core DMBC requirements	Delivering the wider Future Fit ambition
Clinical Quality and Patient Experience	Pass	Pass
Workforce	Pass	Pass
Effectiveness	Pass	Pass
Clinical Model	Pass	Pass
Commercial Viability	Pass	Pass
Build Deliverability	Pass	Pass
Value for Money	Pass	Pass
Affordability	Pass	Pass
Summary	**Short-listed**	**Short-listed**

2.3.3 Long-list appraisal: Solution

This section considers the solution options for the new hospitals and the estates solutions that have potential to deliver the proposed scope.

2.3.3.1 Summary of the long-listed options

This section summarises the options which are considered as the long list of solution options. Given the defined scope there is a limited range of solution options. These are:

- Business-as-usual – continuation of current arrangements
- Core DMBC ('Do minimum')
- Core DMBC + key estates risks
- Core DMBC + key estates risks + integration

If further solution options that have not been considered at this stage become known, they will be considered as part of the next stage of the business case process.

Option 1: Business-as-usual

Table 20: Business-as-usual

Description	Continuation of current arrangements, including our baseline annual capital programme over the appraisal period. Includes: • annual essential backlog items across both sites which is risk adjusted, creating an ongoing challenge annually to meet the demands of a flexing clinical service, particularly during the winter months. • This option also includes funding for additional modular ward capacity to address operational bed pressures due to bed capacity shortfalls and clinical pathway issues across both hospital sites. Whilst providing a short term solution, over time this tactical approach will not enable the trust to address the issues around the quality of its clinical built environment or

	patient pathways, instead further adding to the trusts estates challenges and increasing clinical and operational risk.
Advantages	• Less capital investment required
Disadvantages	• No changes in overall clinical model – risk to the sustainability of clinical services will continue to increase • Does not deliver agreed clinical configuration or Future Fit outcome, which would result in stakeholder challenge • No improvement in single rooms and post-COVID-19 separation – due to the age profile of the RSH & PRH sites, there is a minimal amount of single room provision • Does not help to address workforce challenges (e.g. fragmentation and duplication of clinical teams remains)
Conclusion	Continuing with business-as-usual is not a viable option, as the investment objective is to deliver the core DMBC requirements and move towards the wider Future Fit ambitions, which would not be met by this option. The business-as-usual option fails on several critical success factors, as it does not deliver the changes to services that are critical for clinical and financial sustainability. This option is required as the economic comparator, so will be included in the appraisal process.

In the business-as-usual option, the configurations of RSH and PRH remain broadly as-is.

Option 2*:* Core DMBC ('Do minimum')

Table 21: Core DMBC ('Do minimum')

Description	This scenario considers what can be achieved with a capital budget of £312m, which was the estimated cost of implementing the core DMBC requirements and wider Future Fit ambitions in 2016. Due to inflation in build costs and additional mandatory build requirements (including Net Zero and single room requirements), £312m would now only enable the clinical model to be delivered (core DMBC requirements) and would not allow other key elements of the previous scope to be included (including increased single room provision). This option would: • Consolidate planned care at PRH (particularly, when considered alongside day case hub investments) • Provide ongoing medical care wards and rehabilitation wards at PRH • Deliver new consolidated emergency department facilities, consolidated critical care, core women and children's developments and some additional ward capacity at RSH • Provide required expansion of pathology and pharmacy (sufficient to support increased activity levels) • Provide 24/7 urgent care at both PRH and RSH Any additional scope has been excluded from this option as a result of the capital constraint, including: • Redevelopment of RSH outpatients and theatres • Addressing long terms estates issues/risks • Full redevelopment to improve flow and adjacencies in all areas • Redevelopment of the three upper floors of the existing ward block at RSH to repatriate off site support services, administration and expanded education areas • Replacement of ward block accommodation, increasing proportion of single rooms • Further consolidation of Women and Children's services, this option will result in continued utilisation of current facilities at RSH which are not purpose designed • Redesign of pathology and pharmacy areas to improve workflow • Development of estate to better support integrated system working

Advantages	• Delivers the consulted clinical model (core DMBC requirements), improving some pathways and some facilities for staff and patients • Delivers some of the planned pathway benefits • Provides physical capacity needed for future demand (will require full utilisation of existing wards) • Increases single room provision at RSH (to c. 23%)
Disadvantage	• Requires the continued use of existing sub-optimal wards from a space utilisation & Functional suitability perspective, the existing Ward Block does not meet the requirement for modern clinical standards of care and will remain a clinical delivery risk. • Levels 3,4 and 5 of the ward block is considered to be in condition 'D' – this accounts for 210 beds • Limits clinical adjacencies, reducing efficiency improvement opportunity • Does not support further consolidation of all Women and Children's services with some elements remaining in existing accommodation at RSH which is not purpose designed • Provides limited increase in single room provision across the entirety of the ward estate (most of the site development activity associated with this option takes place at the RSH site and the works are focused primarily on implementing the clinical reconfiguration. As a result, the majority of the existing ward accommodation will continue to be utilised). • This solution would result in a significant contrast between buildings, with some new build elements compliant with modern standards and HBNs, and some buildings unaltered and remaining in poor condition
Benefits	• Better patient outcomes (including improved morbidity and mortality) – urgent and emergency care • Reduced waiting times (including ambulance handovers) • Improved emergency department throughput, better emergency access target performance • Improvements to clinical adjacencies and flow • Improvements to patient and staff experience (improving recruitment and retention) • Delivers the consulted clinical model (core DMBC requirements), improving some pathways and some facilities for staff and patients • Provides significant improvements to the urgent and emergency care pathways • Provides improved facilities, but only in the new build areas of the development
Risks	• This option leads to continued use of the existing ward accommodation in the upper three floors of the ward block deemed as condition 'D' (poor), which is poorly located, impacting on clinical adjacencies and efficiencies; poor environment for both patients and staff influencing patient experience of quality and impacting on staff recruitment and retention • Key estates risks are not addressed leaving significant ongoing maintenance and estate issues including, but not limited to, heating, ventilation, drainage, and internal building fabric issues • Interdependent on the progression of both the day case hub and energy centre developments
Consequences	• Does not address backlog maintenance, including significant /high risk backlog • Does not facilitate upgrades and refurbishments of declining estate at the PRH site • Less efficient solution, which will not fully address the wider clinical risks (including CQC feedback) • Remaining estate will fail to meet stakeholder expectations and will not be optimised to deliver efficiency improvements • Involves repurposing a number of existing areas to provide additional bed capacity - will not deliver increased single room provision and may not achieve latest standards • Will not deliver improved workflow through Pathology and Pharmacy, impacting on timely availability of results and pharmaceuticals • Will not improve patient quality and experience across the entirety of the estate • Staff will continue to work in an aging estate in need of high levels of maintenance

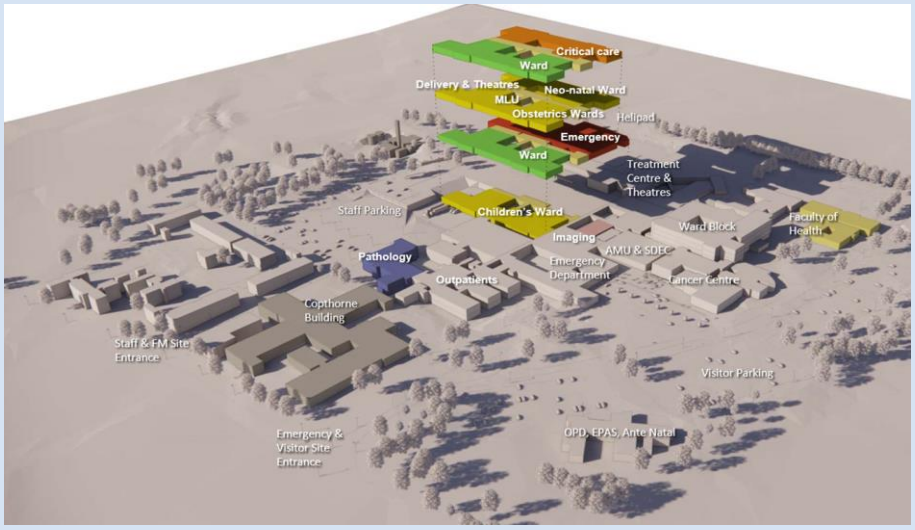
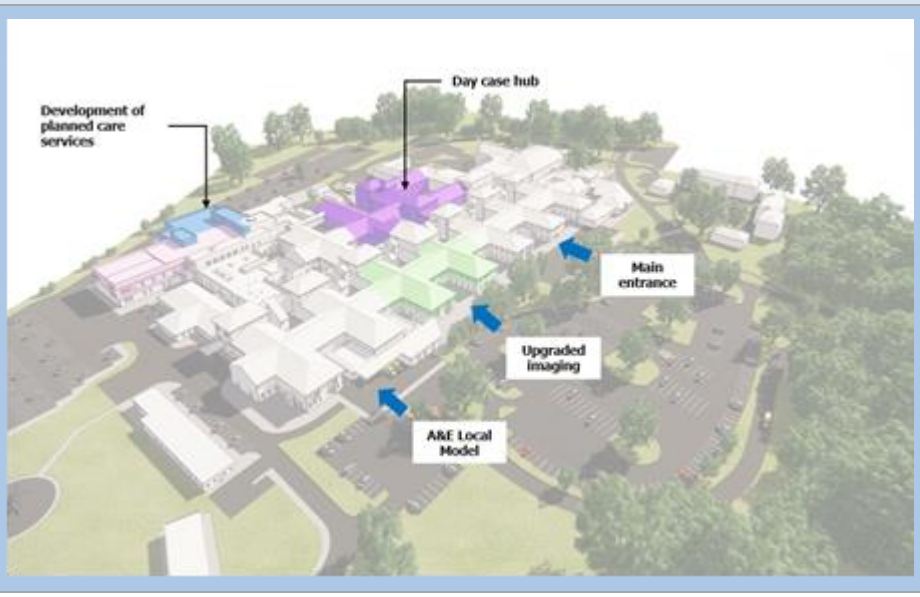
To note, the Hospital Transformation Programme (HTP) has considered the estate driven recommendations derived from the Lord Carter Efficiency Review within its current design proposals. As identified within the Estates strategy the latest Model Hospital space utilisation data identifies the non-clinical space across the Trust as being below the national targets (30.9%) and below the peer meridian (32.5%), currently non-clinical space is identified at 25.7%. The

preferred way forward consists of much needed new build clinical space that will not take the trust over the national target and will see existing non-clinical space reutilised as part of the new build proposals.

Empty space at the trust whilst identified at the time of the survey was slightly over the benchmark target of 1.1% and the peer meridian of 0.9%, currently at 1.8%, this was due to the Copthorne building refurbishment works at RSH, this large building displaced a number of clinical services for Asbestos, Fire and Essential Backlog works to be completed. This has now been completed and Copthorne has been re-occupied with clinical services, it is envisaged at the next survey the empty space and under-utilisation figure will come back down to below the national target.

The other Carter metric does not specifically apply to the Trust as we have no dedicated private patient space.

Figure 17**:** Summary representation Core DMBC ('Do minimum')

RSH site option 2 (phase 1)		Option 2 is based on a reduced scope of new build development at RSH, with most of our ward capacity remaining in the existing tower block -Enabling & estates works -4 Wards - A&E, C/C, W&C -Expansion of Pathology & Imaging capacity (Trust Funded)
PRH Site option 2 (phase 1)		Option 2 builds on the work completed to implement the consolidated day case hub (separate programme development) and delivers: -A&E Local Model -Upgrade of Imaging -Development of planned care services

Option 3: Core DMBC + key estates risks

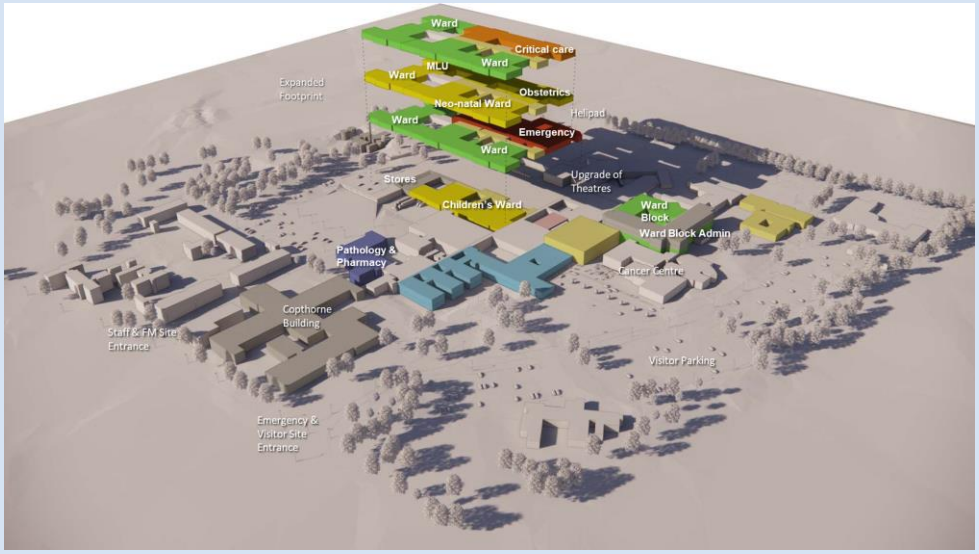
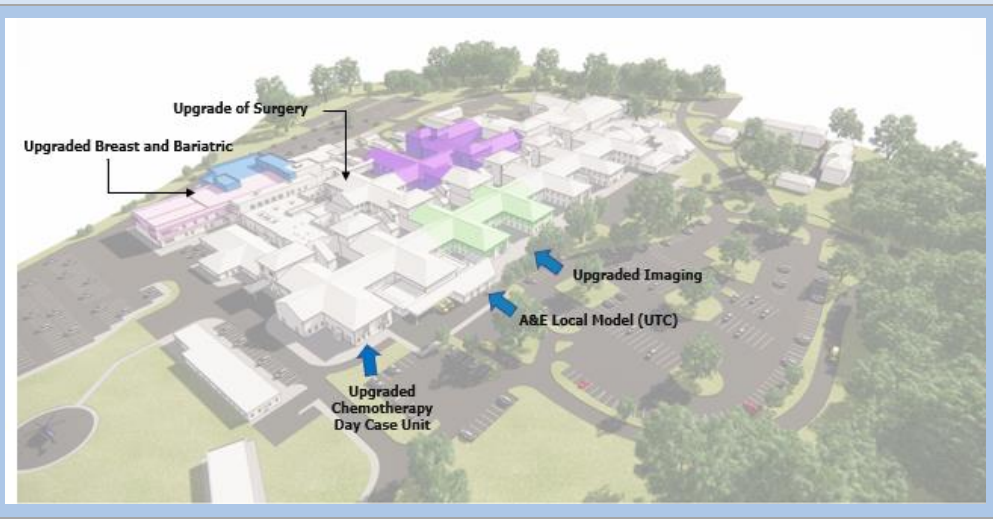
Table 22: Core DMBC + key estates risks

Description	This option allows us to progress beyond the core DMBC requirements towards some of the wider Future Fit ambitions; this includes enactment of the clinical model along with addressing the highest risk estates issues. It seeks to maximise the opportunity for redevelopment and improvements to overall sustainability. This is a fuller development – including additional new wards, theatre refurbishment and reduction in estates risk. This option would:

	• Consolidate planned care at PRH (particularly, when considered alongside day case hub investments) • Deliver new consolidated emergency department facilities, consolidated critical care, consolidate all women and children's services, and delivers new ward accommodation at RSH that meets latest standards • Provide limited expansion and updating of pathology and pharmacy (sufficient to support increased activity levels) • Addresses key estates risks • Includes redevelopment of the ward block to repatriate off-site support services, administration, and education • Refurbishment of theatres
Advantages	• Delivers the core DMBC requirements and some of the wider Future Fit ambition, improves most of the facilities for staff and patients • Delivers the benefits associated with the pathways • Provides increased single room provision (c. 47% RSH, 16% PRH) • Addresses areas of highest-estate risk • The capacity we need for the future would be met within new ward accommodation at RSH that meets latest standards • Facilitates the colocation of all Women and Children's services • Provides an increased footprint to repatriate off-site staff and deliver educational requirements
Disadvantages	• Lack of redevelopment of Outpatient Department impacts on improvements to flows and efficiencies • Restricts ability to integrate acute and community services • When implemented through a phased approach, delivery timelines are extended (and overall costs increased)
Benefits	• Delivers the core DMBC requirements and some of the wider Future Fit ambition • Provides the bed capacity to vacate and repurpose the upper three floors of the ward block, an area with significant estates risks • Better patient outcomes (including improved morbidity and mortality) – urgent and emergency care • Reduced waiting times (including ambulance handovers) • Improved emergency department throughput, better emergency access target performance • Further improvements to patient and staff experience (over and above option 2) • Further improvements to clinical adjacencies and flow, better bed utilisation (over and above option 2) • Provides increased pandemic / infection control resilience on the RSH site (reduced risk of HCAIs) • Expanded range of elective services (increased efficiency and access / better outcomes) • Results in improved facilities and environment
Risks	• Interdependent on the progression of both the day case hub and energy centre developments
Consequences	• Will not improve patient quality and experience across the entirety of the estate • Will not support wider optimisation of activities on each site

The use of RSH and PRH are summarised below. Further information is included in the Appendix D.

Figure 18 : Summary representation option 3 (RSH) (PRH)

RSH site option 3		Option 2 plus -4 New Wards -Rationalise & Repatriate Ward Block to Admin -Upgrade of Theatres -W&C expanded footprint to repatriate Antenatal Clinic, OPD, EPAS -Upgrade of Pharmacy - Upgrade of Pathology
PRH Site option 3		Option 2 plus - Upgrade of Breast & Bariatrics - Upgrade of Surgery - Upgrade to Chemo Day case

Option 4: Core DMBC + key estates risks + integration

Table 23: Core DMBC + key estates risks + integration

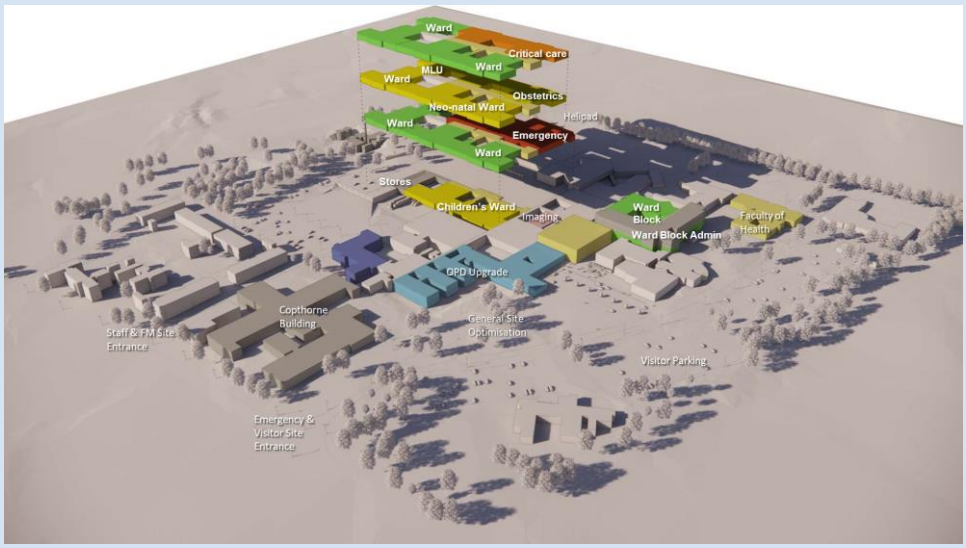
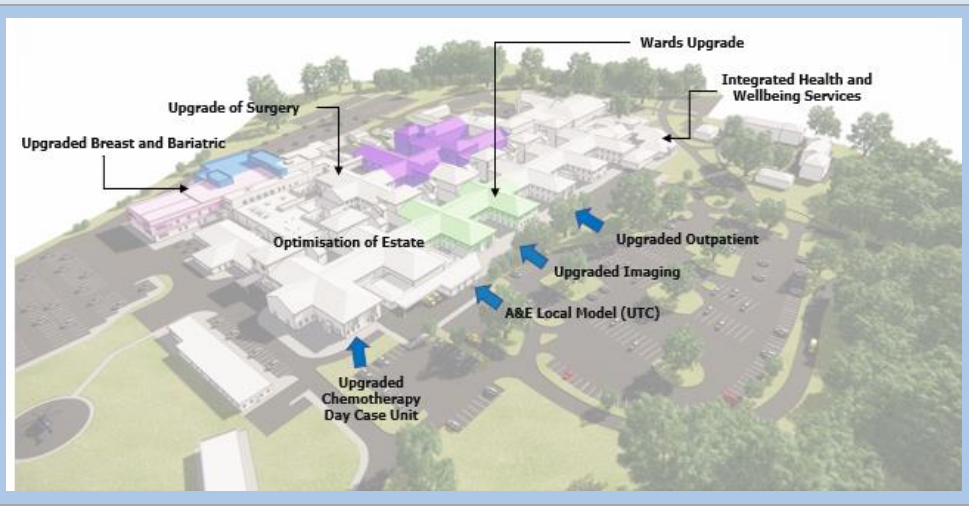
Description	Seeks to maximise the opportunity for redevelopment and improvements to overall sustainability. Delivers the core DMBC requirements and most of the wider Future Fit ambitions – including ward accommodation that meets latest standards, outpatient and theatre refurbishment and reduction in significant/high estates risk. This includes: • Development and expansion of elective centre services • Delivery of new emergency department facilities, critical care, women and children's and new ward capacity at RSH

	• Address key estates risks • Redevelopment of the ward block to accommodate off site support services and education • Refurbishment of Theatres • Redevelopment and upgrade of pathology and pharmacy (including improved workflow) • Redevelopment and upgrade of outpatient departments (increasing effectiveness and improving patient and staff experience) • Development of estate to support wider system integration plans • Site optimisation to improve flow, adjacencies and utilisation • Integrated health and wellbeing services
Advantages	• Delivers the core DMBC requirements and most of the wider Future Fit ambition, improves all facilities for staff and patients • Delivers the benefits associated with the pathways • Provides increased single room provision (c. 47% RSH, 16% PRH) • Addresses key estates risks • The capacity we need for the future would be realised • Facilitates the colocation of all Women and Children's services • Provides an increased, consolidated footprint to deliver educational requirements • Fit for purpose and sustainable estate and infrastructure to deliver clinical services
Disadvantages	• When implemented through a phased approach, delivery timelines are extended (and overall costs increased)
Benefits	• Delivers the agreed clinical model, reconfiguration and associated clinical benefits (quality, safety, and workforce) • Optimises site layouts and facilities, with additional improvements in adjacencies and patient flow leading to enhanced quality, performance, and experience (more efficiency and improved utilisation) • Better patient outcomes (including improved morbidity and mortality) urgent and emergency care • Reduced waiting times (including ambulance handovers) • Improved emergency department throughput, better emergency access target performance • Further improvements to patient and staff experience • Further improvements to clinical adjacencies and flow, better bed utilisation • Provides increased pandemic / infection control resilience on the RSH site (reduced risk of HCAIs) • Further expansion of range of elective services (above option 3, increased efficiency and access / better outcomes) • Enhanced access to rehabilitation services • Enhanced support for LTCs through enhance integrated models of care • Improved and seamless integration of services with system partners – Health and Wellbeing services • Enables the repurposing of significant areas of the ward block • Provide workforce sustainability
Risks	• Interdependent on the progression of both the day case hub and energy centre developments
Consequences	• Limited adverse consequences as this option delivers the core DMBC requirements and most of the wider Future Fit ambition

The use of RSH and PRH are summarised below.

Further information is included in the Appendix D.

Figure 19: Summary representation of option 4 (RSH) (PRH)

RSH site option 4		Option 3 plus -Optimisation of Estate -Upgrade OPD
PRH Site option 4		Option 3 plus -Optimisation of Estate - Upgrade of OPD - Upgrade of Wards - Development of integrated health and wellbeing services unit

2.3.3.2 Qualitative appraisal

The summary qualitative appraisal against the critical success factors for each long-listed solution option is shown below. The evidence underpinning this appraisal is provided in the Appendix E.

CSF1: Clinical model

Options 2 to 4 deliver the core configuration of our services and achieve the priority investment objective (delivery of core DMBC requirements and move towards the wider Future Fit ambitions before 2029). Options 3 and 4 deliver more of the wider Future Fit ambition and provide further improvement in adjacencies and service experience

Table 24: Clinical Model appraisal

		Delivery of core DMBC requirements and move towards the wider Future Fit ambitions before 2029	
1	Business-as-usual	Will not deliver the DMBC decision, as it is a continuation of current activities	Fail
2	Core DMBC ('Do minimum')	Delivers the core DMBC requirements and moves towards the DMBC ambition.	Pass
3	Core DMBC + key estates risks	Delivers the core DMBC requirements and moves towards the wider Future Fit ambition. Improved adjacencies	Pass

		Delivery of core DMBC requirements and move towards the wider Future Fit ambitions before 2029	
4	Core DMBC + key estates risks + integration	Delivers the core DMBC decision and wider Future Fit ambition Further improvement in adjacencies, wider improvements in the experience of the service	Preferred

CSF2: Clinical quality and patient experience

Options 2 to 4 offer improvements in quality and safety, with option 3 and 4 offering more single rooms, better clinical adjacencies, expansion of clinical support service capacity, improved outpatient facilities and enhanced patient experience.

Table 25: Overall single room provision (new build areas at 72%)

		RSH	PRH
1	Business-as-usual	<5%	16%
2	Core DMBC ('Do minimum')	23%	16%
3	Core DMBC + key estates risks	47%	16%
4	Core DMBC + key estates risks + integration	47%	16%

In the Core DMBC ('Do Minimum') option, the limited allocated investment funds have been focussed almost entirely on delivering the pathway changes described in the consultation documents. As a result, very little funding has been allocated to wider estate improvements (including increasing the ratio of single rooms and addressing other areas of estate backlog).

The Trust's longer-term ambition is to address these wider challenges, some of which would be resolved if Options 3 or 4 were progressed, although these options would cost more than the allocated funding.

As part of the service reconfiguration on the RSH site, four new wards are being added (with 75% single room provision), which means that the proportion of single rooms (adult beds) at the RSH site will increase from 14% to 27%.

No additional ward capacity is being added at the PRH site and so the proportion of single rooms will remain at 16%.

Table 26: Quality appraisal

		Supports improvement in service and clinical quality and safety from current levels	Supports improvement in patient experience from current levels	
1	Business-as-usual	Substantial issues with quality and safety not addressed Risk of further deterioration and threat to patient safety	No improvement in experience	Fail
2	Core DMBC ('Do minimum')	Improvements in quality and safety driven by consulted clinical model which better integrates care, enabling coordinated and seamless patient experience across the pathway (clinical outcomes, waiting times, safety) Provides improvements to some pathways Lack of redevelopment of OPD impacts on improvements to capacity and patient experience Continued use of the existing ward accommodation in the tower block	Improvements in experience driven by consulted clinical model (waiting times, coordination of care) Provides improved facilities, but only in the new build areas of the development Continued use of the existing ward accommodation in the tower block (poor environment)	Pass
3	Core DMBC + key estates risks	As Option 2, plus: Improvements in quality and safety driven by enhanced build environment (pandemic / infection control, resilience) Provides improvements to most pathways Allows mitigation of all significant clinical risks Upgrades of Breast, Bariatrics & Surgical services Lack of redevelopment of OPD impacts on improvements to capacity and patient experience Provides enough new bed capacity to vacate the ward block (mitigates IPC risk)	As Option 2, plus: Improvements in experience driven by enhanced build environment (design, privacy, dignity) Increased single room provision (privacy, dignity) Provides enough new bed capacity to vacate the ward block (mitigating poor experience)	Pass
4	Core DMBC + key estates risks + integration	As Option 3, plus: Further improvements driven by estate optimisation, additional upgrades (OPD, wards) and Health & Wellbeing services	As option 3, plus: The Integrated Health & Wellbeing offer will be enhanced to support more seamless services for patients who will be cared for by multidisciplinary and multi-partner teams working together. Provides further improvements to site utilisation and operational effectiveness	Preferred

CSF3: Workforce

Options 2 to 4 offer improvements for the workforce driven by the clinical model, however option 4 also offers additional benefits associated with further optimisation and upgrades across the sites support staff morale, recruitment and retention and increased staff engagement. Role attractiveness also improved through better integration with partners and enhanced Health and Wellbeing services.

Table 27: Workforce appraisal

		Supports improvement in workforce availability and sustainability from current levels	
1	Business-as-usual	No improvement in workforce availability and sustainability	Fail
2	Core DMBC ('Do minimum')	Improvements in workforce availability and sustainability driven by clinical model (rotas, recruitment, retention) Improvements in workforce availability and sustainability driven by enhanced physical environment (morale, wellbeing), limited to redeveloped areas only	Pass
3	Core DMBC + key estates risks	As option 2, with: Further improvements in workforce availability and sustainability driven by enhanced physical environment (morale, wellbeing), limited to key estates risks	Pass
4	Core DMBC + key estates risks + integration	As option 3, with: Further improvements in workforce availability and sustainability driven by enhanced physical environment and optimisation across both sites Increased staff engagement and role attractiveness through better integration with partners to deliver enhanced Health and Wellbeing services	Preferred

CSF4: Access/Effectiveness

Options 2 to 4 result in the reconfiguration of services

Table 28: Access/effectiveness appraisal

		Services must be located to maintain or improve access for local population (patients and staff)	
1	Business-as-usual	No change in travel time No improvement in waiting times	Fail
2	Core DMBC ('Do minimum')	Increases in travel time mitigated through DMBC actions Reductions in waiting times for hospital services delivered through clinical model Improved access to appropriate specialists	Pass
3	Core DMBC + key estates risks	Increases in travel time mitigated through DMBC actions Reductions in waiting times for hospital services delivered through clinical model Improved access to appropriate specialists Improved staff access to patients	Pass
4	Core DMBC + key estates risks + integration	Increases in travel time mitigated through DMBC actions Reductions in waiting times for hospital services delivered through clinical model Improved access to appropriate specialists Improved staff access to patients	Preferred

CSF5: Commercial viability

Options 2 to 4 have viable procurement routes – to be explored further during OBC.

Table 29: Commercial viability appraisal

		Procurement route facilitates access to suppliers with capacity and appropriate capability	
1	Business-as-usual	BAU Trust procurement can apply	Pass
2	Core DMBC ('Do minimum')	Several procurement routes are available all of which have potential to find a contractor who can deliver the required services	Pass
3	Core DMBC + key estates risks	Several procurement routes are available all of which have potential to find a contractor who can deliver the required services	Pass
4	Core DMBC + key estates risks + integration	Several procurement routes are available all of which have potential to find a contractor who can deliver the required services	Pass

CSF6: Build deliverability capacity & support

Options 2 to 4 pass all the components of this CSF including making good use of the existing NHS estate, being deliverable by 2029, delivering the footprint and capacity required and are supported by commissioners and the system. As outlined in the table below, there are some variations in the extent to which each of these options meet these components, however, in the appraisal workshop, neither option was considered as clearly preferred.

Table 30: Build deliverability appraisal

		Makes best use of existing NHS estate	Deliverable by target year of opening (2029)	Site locations must be able to deliver the required footprint and capacity	Supported by commissioners and the system	
1	Business-as-usual	Does not address backlog and estates issues	Ongoing programme	Deliverable on site footprint	Unlikely to be supported – does not deliver system aims	Fail
2	Core DMBC ('Do minimum')	Makes good use – but not full refurbishment / reduction in backlog Does not address estates risks	Deliverable by 2026	Deliverable on site footprint Future capacity needs met (via ward block)	Supported – delivers core DMBC requirements	Pass
3	Core DMBC + key estates risks	Enhanced / fuller refurbishment Significant estates risk addressed Low risk backlog risks remain	Deliverable by 2028 (Phase 1 2026)	Deliverable on site footprint Future capacity needs met (new wards)	Supported – delivers core DMBC requirements and moves towards wider future fit ambitions	Pass
4	Core DMBC + key estates risks + integration	Enhanced / fuller refurbishment Significant estates risk addressed	Deliverable by 2029 (Phase 1 2026, Phase 2 2028)	Deliverable on site footprint Future capacity needs met (new wards)	Supported – delivers core DMBC requirements and moves towards wider future fit ambitions	Pass

2.3.3.3 Solution options appraisal summary

Based on the qualitative evidence provided in Section 2.3.3.2, and the quantitative evidence presented in Section 2.3.3.2, the Programme Board endorsed the appraisal of the Solution options shown below on 14 September 2021.

Table 31: Appraisal of Solution Options against CSFs

Appraisal Section	CSF	1 Business-as-usual	2 Core DMBC ('Do minimum')	3 Core DMBC + key estates risks	4 Core DMBC + key estates risks + integration
Qualitative	Clinical Quality and Patient Experience	Fail	Pass	Pass	Preferred
	Workforce	Fail	Pass	Pass	Preferred
	Effectiveness	Fail	Pass	Pass	Preferred
	Clinical Model	Fail	Pass	Pass	Preferred
	Commercial Viability	Pass	Pass	Pass	Pass
	Build Deliverability	Fail	Pass	Pass	Pass
Summary		Carry forward as BAU	Short-listed	Short-listed	Short-listed (preferred)

Key: ■ fails criterion; ■ passes criterion; ■ best option or is the equal best option for this criterion

Based on the appraisal against the qualitative CSFs for the service solution options, **options 2 to 4 are carried forward to the short-list appraisal**. Based on the qualitative appraisal option 4 is preferred over options 2 and 3.

The business-as-usual is carried forward into the short-list appraisal as an economic comparator, however it should be noted this is not a viable option as it fails several CSFs.

Table 32: non-cash releasing benefits

Investment Objective	Description	Option (2)	Option (3)	Option (4)
Clinical Quality and Safety	Improve **cancer waiting times** as a result of ringfenced elective capacity/facilities and more effective pathways (improve cancer waiting times against peer trusts from lowest quartile 1 to highest quartile 4)	●	●	●
	Support **elective restoration and recovery** in medium-term with additional, pandemic resilient, ringfenced elective capacity (helping to deliver 130% of pre-pandemic elective activity by 2024/25)	●	●	●
	Reduce average **elective LoS** by 0.5 days as a result of improved adjacencies and separation of emergency flows	◑	◕	●
	Eliminate **delayed transfers (longer than 2 hours) from critical care**	◑	●	●
	Increase **weekend discharges** from 35% of the average weekday discharges to 75%	◑	◕	●
	Increase adoption of **zero length of stay pathways** (meeting Directory of Ambulatory Emergency Care upper recommended levels for patients deemed suitable for AEC treatment)	●	●	●
	Eliminate **mixed-sex breaches**	◑	◕	●
Patient Experience	Eliminate **'day before' and 'on day' elective cancellations** resulting from emergency escalation	●	●	●
	Improve patient experience (increase Friends and Family uptake from 13% to 20% and maintain 99% positive outcomes)	◑	◕	●
Effectiveness	Improve **referral-to-treatment performance** (exceeding national target of 90%)	◕	●	●
	Eliminate **12-hour breaches**	●	●	●
	Reduce **4-hour emergency access breaches** (exceeding NHSE/I A&E target of 85%, upper quartile performance vs peer NHS Trusts)	◕	●	●
	Improve **general and acute bed occupancy** (from an average of 92%, peaking at 98% during winter escalation, to a target of 89% across the year)	●	●	●
	Ensure 95% of patients are **admitted to ward** within 45 minutes of decision to admit time (including resus)	◕	●	●
	Reduce **ambulance handover times** (95% of handovers within 30 mins)	●	●	●
Workforce	Positive impact on **staff experience** leading to improvements in recruitment and retention (increase staff recommending SaTH as a place to work into the upper quartile of peer NHS Trusts, reduce staff turnover by 5%)	◑	◕	●
Estate	Improve the standard of the hospital estate, **reducing overall estate risk and improving experience** (for patients, familiies and staff)	◑	●	●

Key

- ○ No improvement
- ◔ Minor improvement
- ◑ Moderate improvement
- ◕ Major improvement
- ● Significant improvement
- ● Achieved through elective restoration initiative

The table above demonstrates how option 4 will deliver further qualitative benefits beyond options 2 and 3, supporting the option appraisal conclusions against the qualitative CSFs.

However, the pathway changes and service consolidation proposed within the Core DMBC ('Do Minimum') option deliver a range of benefits for our population:

- Addressing one of the biggest strategic challenges for the local health system by separating the emergency and planned care flows and consolidating fragmented teams and pathways (including critical care)
- Considerably improving the clinical adjacencies for emergency care, leading to better outcomes and experience for patients
- Providing more physical capacity to support the new clinical model, increased single room provision and improved IPC
- Supporting the delivery of planned care throughout the year across a primarily green hospital site, significantly improving access to services, reducing cancellations/waiting times/backlogs and improving patient experience
- Improving recruitment and retention by offering a better staff experience – reducing vacancy rates and the need for agency staff

In the Core DMBC ('Do Minimum') option, the limited allocated investment funds have been focussed almost entirely on delivering the pathway changes described in the consultation documents. The Core DMBC ('Do Minimum') option will result in some improvements to length of stay, delayed transfers of care, weekend discharges and mixed sex breaches associated with these pathway changes, however the allocated funding is insufficient to address our wider estate ambitions. It is also expected that the Core DMBC ('Do Minimum') option will help to support an improvement in CQC ratings.

The Trust's longer-term strategy is to progress the wider estate ambitions, some of which would be resolved if options 3 or 4 were selected, increasing the qualitative benefits (as described above) but exceeding the allocated funding.

Because of the modular design of this development, if option 2 is selected the further scope outlined in options 3 and 4 could be added at a later stage if further funding was made available. These additional areas of scope would realise further benefits and hence lead to an additional incremental positive impact on CQC ratings.

2.3.4 Long-list appraisal: Procurement

This range of options considers the procurement route we will take to appoint contractor(s) to deliver the provision of design and construction services for chosen solution option. As it is part of the options framework, we have considered the potential procurement options, including:

- Single-stage tender
- Two-stage tender
- Framework procurement (CCS/NHSE&I ProCure23)

This is considered further for the preferred way forward in Section 3.3.3 and will be considered further within the OBC process.

Table 33: Option i: Traditional procurement – Single Stage Tender

Description	This option would see us develop designs for the new hospital and run a traditional procurement to have it constructed via a Single Stage Tender
Advantages	• Competitive tender process • Provides maximum flexibility • Opportunities to include modern methods of construction, and repeatable design element from the outset. • Design team is under direct Trust control • Potential continuity of design team from SOC stage

Disadvantages	• More complex to manage; integration and delivery risks remain with the Trust • Separating the design development and construction process exposes both the contractor and the customer to high levels of risk. • Contract terms and conditions require significant consideration to best manage risks and likely additional costs from legal advisors. • The price will not be known until the design is complete – there is no opportunity to improve the buildability or increase the savings during the design phase • Significant expense and effort expended by the bidding contractor (with only a small chance of a contract award)
Conclusion	This option would be a high-risk option, but would afford us maximum flexibility and control

Table 34: Option ii: Design and build contract – Two Stage with Potential Novation

Description	This option describes the appointment of an integrated design and build contractor potentially via a two-stage tender, with potential for design to be novated after the first stage.
Advantages	• Value for money demonstrated through competitive tender • Single Point Responsibility for Design & Construction can be achieved • Greater options to manage risk • Pricing Approach can allow Target Price option • Retention of two competing designs can maintain competitive pressure into the agreement of the build contract, maximising value for money
Disadvantages	• Statutory definition of required timescale • Trust will need to manage a complex procurement process and qualify potential bidders • Contract terms and conditions require significant consideration to best manage risks and likely additional costs from legal advisors. • Potential additional cost if commercial strategy is to develop two competing designs
Conclusion	This option would allow us to transfer some risk to the contractor and has the potential to maximise value for money through open tender but leaves us with significantly more risk than a framework route.

Table 35: Option iii: Framework Procurement (CCS / NHSE&I ProCure23)

Description	Whilst other frameworks within the design and construction fields exist, it is specifically the ProCure23 (or P23) framework under consideration due to the scale of the HTP requirement and because it is the fourth generation of the ProCure23 route to market for the provision of design and construction services explicitly for NHS capital projects.
Advantages	• It is the primary procurement route in line with NHSEI business case guidance (unless an alternative route to market can be justified), to appoint Principal Supply Chain Partners (PSCPs) • All potential suppliers are proficient with complex, health-specific design and construction projects • Potential to shorten length of procurement with the ability to introduce early engagement activities with potential PSCPs in a way that is compliant with Public Contracting Regulations. • Likely reduction in the legal and management burden to the Trust • Effective Contract Management and administration is supported by the set of pro-formas for use alongside the provisions within the NEC4 model contract used for all ProCure23 awards • An established price mechanism (guaranteed maximum price) • Variations to contract activities are managed (e.g., increase/decrease in costs via the Compensation Events process) during the works • Training for all project team members to enhance project proficiency and Implementation advisor support, offered in a neutral capacity (free of charge)
Disadvantages	Potential suppliers may be locked out of the process if not awarded onto ProCure23 from the outset.
Conclusion	ProCure23 is likely to present the most favourable route.

	It is acknowledged that it is critical to have clear understanding and agreement when setting the quality/price ratio in relation to this project's needs, and also as well as understanding the balance of risk between Trust and PSCP will need consideration throughout the procurement process.

2.3.4.1 Procurement options appraisal summary

Table 36 summarises the appraisal of each option against the CSFs that are appropriate to this dimension.

Table 36: Summary appraisal of service delivery options

Critical Success Factor	Option i Single Stage Tender	Option ii Two Stage Tender	Option iii Framework Procurement
Clinical model	Not applicable	Not applicable	Not applicable
Quality and experience	Not applicable	Not applicable	Not applicable
Workforce	Not applicable	Not applicable	Not applicable
Effectiveness	Not applicable	Not applicable	Not applicable
Commercial Viability	Fail: The pool of contractors able to commit to single stage contract is unlikely to be large enough to run a viable competition	There is strong track record of successful delivery of major public sector capital projects through this mechanism	This is the recommended approach in line with current business case guidance
Build Deliverability	Integration and design risks will be for the Trust to manage	Trust will need to qualify bidders and manage a significant procurement process	Contractors are pre-qualified to support a simpler procurement process
Value for Money	Demonstrated through competitive tender	Demonstrated through competitive tender	Negotiated rates have already been agreed
Summary	Discounted	Short-listed – Not Preferred	Preferred Way Forward

Key: ■ fails criterion; ■ passes criterion; ■ best option or is the equal best option for this criterion

Based on the qualitative appraisal of the available procurement options, **our preferred way forward is (Option iii) the ProCure23 framework** route to market for the provision of design and construction services. This will be reviewed during the OBC phase.

2.3.5 Long-list appraisal: Implementation (phasing)

This section considers the different approaches to phasing the options which can be carried forward from the scope, solution and procurement dimensions of the options framework. Typically, phasing a solution can have the effect of bringing benefits and capital spend forward – enhancing the NPSV – or phasing can be a mechanism to reduce risk of a single large implementation.

As described in Section 2.3.3 the proposed service solution options are designed to build incrementally on the core scope of works. This will enable the programme to optimise and prioritise the delivery of the clinical model and minimise operational disruption to maintain clinical activity. The solution would be delivered as follows:

- Core DMBC ('Do minimum'): Delivered through a single, core, phase of works
- Delivering the core DMBC requirements and addressing key estates risks: Delivered through two phases, the first delivering the works outlined in the do minimum option, and the second phase delivering the additional works of this option
- Delivering the core DMBC requirements, addressing key estates risks and improving health service integration: Delivered through three phases, the first two phases are consistent with the option above, and the third phase will deliver the additional works of this option

A phased implementation is therefore carried forward to the short-list appraisal.

2.3.6 Long-list appraisal: Funding

Following the Future Fit consultation in 2018, funding of £312m was confirmed as part of the 2018 Wave 3 Sustainability and Transformation Partnership capital budget. This was based on the costings included in the pre-consultation business case which was completed in 2016.

Due to inflation, costs have significantly and unavoidably increased since the capital was estimated in 2016 (by £183m, a c. 59% increase). In addition, several additional requirements have been mandated (including Net Zero and single room requirements), and the costs of the proposal have been impacted by several on-balance sheet adjustments, comprising a further £102m.

As a result, the allocated capital funds of £312m will not support the delivery of all the wider Future Fit ambitions.

Alternative sources such as the New Hospitals Programme (NHP) have been considered, but this scheme is not part of the NHP. The NHP have confirmed that funding for this scheme is not available through that programme.

Based on current business case guidance, public private partnerships or similar funding mechanisms have not been considered in detail. At OBC stage, we will consider whether there are opportunities for developer funding of any elements of the build.

The preferred way forward will deliver the core DMBC requirements within the allocated funds of £312m and is planned to be funded through PDC.

2.3.7 Long-list appraisal: Conclusion

The long list appraised a wide range of possible options against defined criteria. This appraisal is summarised below in Table 37.

Table 37: Summary of appraisal

#	Domains and options	Summary of appraisal
Scope		
	Business-as-usual	Carried Forward – Economic Comparator
a	Delivering the core DMBC requirements	Short-listed
b	Delivering Future Fit DMBC ambition	Short-listed
Service solution		
1	Business-as-usual (comparator)	Carried Forward – Economic Comparator
2	Core DMBC (‘Do minimum’)	Short-listed
3	Core DMBC + key estates risks	Short-listed
4	Core DMBC + key estates risks + integration	Short-listed (preferred)
Service delivery		
i	Single-stage tender	Not carried forward
ii	Two-stage tender	Short-listed
iii	Framework procurement	Short-listed
Implementation		
-	Phased delivery	Short-listed
Funding		
-	Public dividend capital	Short-listed

Key: ■ fails one of more CSFs; ■ passes all CSFs

The implications for the options framework are outlined below.

2.4 Short-list

The preferred and possible options identified in the long-list appraisal will be carried forward into the short-list for further appraisal and evaluation at OBC stage. Discounted options are excluded at this stage.

Optionality exists within the short-list in the scope, solution and procurement dimensions. For the purposes of the short-list appraisal, the procurement options are excluded and considered in more detail within the Commercial Case. This creates 4 potential permutations for further consideration in the short-list.

This short-list was supported by the CCG governing body (13 April 2022) and the Trust Board (14 April 2022).

The short-list is summarised in the table below and includes:

- **Business-as-usual (c. £72m)**: Continuation of current arrangements, including the Trust's baseline annual capital programme over the appraisal period.
- **Core DMBC: ('Do minimum') (c. £312m)**: The minimum capital investment required to deliver only the priority Investment Objective" (DHSC/HMT guidance) – i.e., deliver the core DMBC requirements and move towards wider 'Future Fit' ambitions.
- **Core DMBC + key estates risks (c. £481m)**: This allows us to progress beyond the core DMBC requirements towards some of the wider Future Fit ambitions. It seeks to maximise the opportunity for redevelopment whilst improving overall sustainability. This is a fuller development – including additional new wards, theatre refurbishment and addresses all key issues with physical environment and reduces estate risk.
- **Core DMBC + key estates risks + integration (c. £534m):** Seeks to maximise the opportunity for redevelopment and improvements to overall sustainability. Delivers the core DMBC requirements and most of the wider Future Fit ambition – including additional ward, outpatient and theatre refurbishment and addresses all key issues with physical environment and reduces estate risk.
- These will be further appraised at OBC stage to identify the preferred option based upon detailed design information.

Table 38: High-level description of the short-listed options

Dimension	1. Business-as-usual	2. Core DMBC ('Do minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Scope	Maintain current services	Core DMBC decision	Core DMBC decision, and wider Future Fit ambition	Core DMBC decision, and wider Future Fit ambition
Service solution	n/a	Delivery of clinical model	Delivery of clinical model and addressing key estates issues	Delivery of clinical model and addressing key estates issues and improving health service integration
Procurement*	n/a	Framework procurement, or Two stage tender	Framework procurement, or Two stage tender	Framework procurement, or Two stage tender
Implementation	n/a	Phased implementation	Phased implementation	Phased implementation
Funding	n/a	Public Dividend Capital	Public Dividend Capital	Public Dividend Capital

*The variation in the procurement options is considered in the Commercial Case and will be considered in more detail in the Outline Business Case. It is not expected that any option will result in notable differences in capital cost or quantitative benefit, and as such they are not considered in the short-list appraisal.

Note that business-as-usual (Option 1) failed Critical Success Factors in the long-list appraisal, but these are carried onto the short-listed for comparison purposes.

2.5 Appraisal of short-list options against quantitative critical success factors

2.5.1 Benefits

2.5.1.1 Estimating benefits

The benefits identified fell into the main categories set out below. In each case, the sources and assumptions underlying their use are explained in the detailed schedule of benefits provided in Appendix F and G.

Table 39: Main benefit categories

Type	Description	Direct to organisation(s)	Indirect to organisation(s)
Cash releasing	These are financial benefits – for example, avoided spend, reduced cost etc.	Accounted for in economic and financial case appraisals	Accounted for in economic case appraisals only
Non-cash releasing	These are economic benefits – for example, opportunity cost of staff time etc.	Accounted for in economic case appraisals only	Accounted for in economic case appraisals only
Quantitative	Measurable, but not in financial terms	Subject to weighting and scoring – see below	Subject to weighting and scoring – see below
Qualitative (or non-quantifiable)	Not measurable, even through proxies	Subject to weighting and scoring – see below	Subject to weighting and scoring – see below

The benefits identified differentiate the options and these are summarised below.

Table 40: Summary of per annum benefits in 21/22 prices

	1. Business-as-usual	2. Core DMBC ('Do minimum')	3. Core DMBC + key estates risks	4.Core DMBC + key estates risks + integration
Cash releasing benefits (annual, £k, 21/22 prices)	n/a	15,827	26,591	33,633
Cash releasing benefits (discounted whole life, £k)	n/a	341,387	557,109	691,697
Non-cash releasing (productivity) benefits (NHS productivity) (annual, £k, 21/22 prices)	n/a	7,004	7,772	8,058
Non-cash releasing benefits (discounted whole life, £k)	n/a	150,971	166,307	171,779
Societal benefits (annual, £k, 21/22 prices)	n/a	3,668	5,372	6,323
Societal benefits (discounted whole life, £k)	n/a	88,191	122,369	140,819
Total economic benefits (annual, £k, 21/22 prices)	n/a	26,500	39,737	48,014
Total economic benefits (discounted whole life, £k)	n/a	579,945	845,785	1,004,295

Business-as-usual is used as the economic comparator and therefore delivers no additional incremental benefit.

The full solution (Option 4) will deliver the most financial benefits, with a total of £48m of annual economic benefits – of which £34m are cashable benefits available after implementation of the solution. Over the life of the investment, option 4 has the most economic benefits at c.£1bn discounted benefits.

We expect there would be further quality, operational and societal benefits associated with options 3 and 4 driven by the broader impacts of the larger investments, and these will be explored in more detail at the OBC stage. These may include

- patient outcome and QALY benefits driven by pathway improvements
- patient outcome and QALY benefits driven by improved prevention of disease and reduced mortality
- health benefits associated with shorter waiting times and waiting lists
- improvements to health and wellbeing,
- improved productivity associated with earlier returns to the workplace
- investment in local companies and increased employment (often not quantifiable within the economic appraisal as per DHSC/HMT guidance)
- and other wider societal benefits.

2.5.2 Costs

2.5.2.1 Estimating costs and affordability

Costs of each solution option were estimated by our external cost consultants.

We reviewed all options for value engineering opportunities to minimise the capital requirement. The outline designs, and associated costs, include:

- inflation to midpoint of construction (varies by option), based on latest PUBSEC indices,
- impact of modern methods of construction,
- opportunities for standardised and repeatable design, and
- standard uplifts for optimism bias and planning contingency (see Section 2.6.1).

We have reviewed these costs against key benchmarks, including NHP developments and our estimates compare favourably.

The capital costs of the options are summarised below. Further information is included in Appendix D with cost advisors commentary provided in within the OB forms within Appendix items D1–4 .

Table 41: Capital costs of solution options

£m, nominal capital cost	OB form reference	1. Business-as-usual	2. Core DMBC ('Do minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Works, Fees and Equipment	Line 10A	43	181	275	300
Optimism Bias and Contingency	Line 10C	12	48	76	83
Economic case total (included in CIA model)		**55**	**229**	**351**	**383**
Inflation	Line 11	12	51	90	102
Net Value Added Tax	Line 12 less VAT in 10C and 11	5	31	41	49
Total Capital Cost		**72**	**312**	**481**	**534**

The higher capital cost of the full solution is primarily driven by the additional capacity and changes in layout offered by this option. These in turn drive higher benefits (see Section 2.5.1).

As a result of the capital costs of each option, the capital charges resulting from each investment is estimated in the table below, based on a typical (60 year) useful life, a 15% asset impairment (in line with other national schemes, and agreed with NSHEI regional team in summer 2021) and a PDC rate of 3.5%. Capital charges and I&E impacts are estimated in more granularity and on a year-by-year basis in the financial case to produce I&E impacts of the scheme.

These capital charges are set against the cashable benefits from to estimate the impact of each investment on our deficit in Table 42.

We reviewed all options for opportunities to improve net value by minimising the capital investment requirement. This included reviewing inflation, the impact of modern methods of construction, standardised/repeatable design, and full comparison of our capital costs against key benchmarks (including New Hospital Programme developments).

Table 42: Revenue affordability (2031/32)

£m, nominal capital cost	1. Business-as-usual	2. Core DMBC ('Do minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Estimated Capital Charges	(3.3)	(15.8)	(26.3)	(29.9)
Cashable Benefits[27]	-	15.8	29.4	37.2
Impact on I&E	(3.3)	-	3.1	7.3

2.5.3 Economic appraisal (BCR / NPSV)

Net present social value (NPSV) is defined by the Green Book as the present value of benefits less the present value of costs. It compares all the financial and economic costs and benefits over a 60-year horizon and expresses these as a single metric to support a comparison of options. It provides a measure of the overall impact of an option.

The benefit-cost ratio is defined by the Green Book as the ratio of the present value of benefits to the present value of costs. It provides a measure of the benefits relative to costs.[28]

The differential costs and benefits of the options, along with their detailed phasing, VAT treatment, inflation etc. are used to support the calculation of NPSVs. This analysis is presented in the CIA model, provided in Appendix H.

Table 43: Key results of economic appraisals

Metric	1.Business-as-usual	2. Core DMBC ('Do minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Net present social value (NPSV) (60 years) excl. PDC vs. BAU (£m)	n/a	424	593	727
Benefit Cost Ratio	n/a	3.7	3.3	3.6

All options offer positive NPSVs and pass the value for money CSF. Option 4 has a more favourable NPSV meaning it is much better value for the UK public.

A BCR greater than 3 benchmarks favourably against other Government projects, reflecting the fact that this scheme represents an opportunity to reconfigure services and deliver significant cash releasing, productivity and wider societal benefits.

2.5.4 Sensitivities

2.5.4.1 Economic appraisal sensitivity analysis

Sensitivity analysis has been carried out on the solution options to consider if reasonable changes in input assumptions affect the ranking of the economic analysis. Variables adjusted were:

- Capital costs: each option being adjusted +/- 10%.
- Change in benefits: +/- 20%.

The results of the NPSV sensitivity analysis are shown below. Note, the reference to basecase in Table 44 and Table 45 below is the level of capital and benefits associated with the option before any sensitivities are applied. Each option has a different level of capital and benefits.

[28] HM Treasury Green Book, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/938046/The_Green_Book_2020.pdf

Table 44: Effect of sensitivities on NPSV

Net Present Social Value (£m)	1. Business-as-usual	2. Core DMBC ('Do minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Capital Basecase, Benefits Basecase	n/a	424	593	727
Capital +10%, Benefits Basecase	n/a	408	568	699
Capital -10%, Benefits Basecase	n/a	439	619	754
Capital Basecase, Benefits +20%	n/a	540	763	928
Capital +10%, Benefits +20%	n/a	524	738	900
Capital -10%, Benefits +20%	n/a	555	788	955
Capital Basecase, Benefits -20%	n/a	308	424	526
Capital +10%, Benefits -20%	n/a	292	399	498
Capital -10%, Benefits -20%	n/a	323	449	553

In all sensitivities, the rank ordering of NPSVs remains consistent.

Table 45: Effect of sensitivities on BCR

Net Present Social Value (£m)	1. Business-as-usual	2. Core DMBC ('Do minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Capital Basecase, Benefits Basecase	n/a	3.71	3.33	3.61
Capital +10%, Benefits Basecase	n/a	3.38	3.03	3.28
Capital -10%, Benefits Basecase	n/a	4.13	3.71	4.01
Capital Basecase, Benefits +20%	n/a	4.46	4.01	4.33
Capital +10%, Benefits +20%	n/a	4.05	3.65	3.94
Capital -10%, Benefits +20%	n/a	4.95	4.46	4.82
Capital Basecase, Benefits -20%	n/a	2.97	2.67	2.89
Capital +10%, Benefits -20%	n/a	2.70	2.42	2.63
Capital -10%, Benefits -20%	n/a	3.30	2.97	3.21

In all sensitivities, the rank ordering of BCRs remains consistent and the Core DMBC ('do minimum') option delivers the optimal BCR across all sensitives.

2.5.5 Appraisal against quantitative CSFs

Based on the quantitative appraisal, the four short listed options have been appraised against the quantitative CSFs. This demonstrates that only the Core DMBC ('do minimum') option meets all the CSFs. The BAU fails to deliver value for money, and revenue affordability, and options 3 and 4 fail the capital affordability CSF as they require more capital funding than the available envelope.

Table 46: Appraisal of short list options against quantitative CSFs

Appraisal Section	CSF	1. Business-as-usual	2. Core DMBC ('Do minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Quantitative	Value for money	Fail	Pass	Pass	Pass
	Revenue affordability	Fail	Pass	Pass	Pass
	Capital affordability	Pass	Pass	Fail	Fail

Key: ■ fails criterion; ■ passes criterion; ■ best option or is the equal best option for this criterion

2.6 Risk appraisal of short-listed options

The development of the capital costing of the scheme identified and quantified various risks. These are included in the overall capital costing of the scheme and detailed here.

2.6.1 Risk and planning allowances across all short-listed options

These risk and planning allowances have been calculated for all options considered in detail in the short list appraisal and are provided for the Preferred Way Forward in Table 47. These allowances will also apply across all short-listed options.

The options include a 6% planning allowance based on industry standard rates at this stage of the process. Additionally, each option has an optimism bias allowance, based on the optimism bias mitigation calculations set out in Appendix D7. For option 2 ('do minimum') this equates to 22.25%.

At this SOC stage the allowances (planning allowance and optimism bias) will be higher as there is less detail behind the current plans; these values may come down as we move through the process and gain more cost certainty with more detailed designs. At this stage these values are benchmarked costs based on similar schemes - these will be refined at OBC based on a greater understanding of design risks, enabling optimism bias and contingency to become separate allocations.

These allowances are detailed in the OB forms (within the departmental costs for planning allowance and under the optimism bias line for optimism bias) and included in the capital costs within the CIA Model (see Appendix D1-4 and Appendix H).

Table 47: Summary of risk and planning allowances included in capital costing

Risk	1. Business-as-usual	2. Core DMBC ('Do minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration	Description
Planning allowance	£1.9m	£8.3m	£12.6m	£13.8m	6% mark up on works costs across all options The Planning allowance is an allocation of cost for unknown local authority requirements resulting from the local planning engagement process.
Optimism Bias	22.29% £11m	22.25% £48m	21.03% £76m	23.12% £83m	% mark up on works costs adjusted for the scope of work (e.g., new build vs refurbishment), Based on appraisal of the current project status and design maturity

Detailed cost build up is available in Appendix D including OB forms for each option.

2.6.2 Risks of specific short-listed options

The different short-listed options will introduce different risks into the scheme.

Table 48: Risks to each do something option

Option	Risks
Option 2: Core DMBC requirements ('Do minimum')	• This option leads to continued use of the existing ward accommodation in the upper three floors of the ward block deemed as condition 'D' (poor), which is poorly located, impacting on clinical adjacencies and efficiencies; poor environment for both patients and staff influencing patient experience of quality and impacting on staff recruitment and retention. • Key estates risks are not addressed leaving significant ongoing maintenance and estate issues including, but not limited to, heating, ventilation, drainage, and internal building fabric issues. • Interdependent on the progression of both the day case hub and energy centre developments
Option 3: Core DMBC + key estates risks	• Interdependent on the progression of both the day case hub and energy centre developments
Option 4: Core DMBC + key estates risks + integration	• Interdependent on the progression of both the day case hub and energy centre developments

Risks of the Preferred Way Forward and risk management processes are further defined in Section 5.4.

2.7 Public consultation

This scheme has been subject to public consultation through Future Fit and the process has been passed back to us for delivery of the agreed outcome. This outcome was endorsed by the Independent Reconfiguration Panel and the Secretary of State for Health and Social Care.

This SOC ensures that the Preferred Way Forward delivers on the consultation outcome and a core investment objective is to deliver the agreed clinical model.

All options that are being carried forward deliver the agreed configuration of services. As such, further public consultation is not required for the scheme to proceed to OBC.

The comparator (i.e., the £72m business-as-usual) does not deliver the outcome of consultation. There is a risk if these were pursued that further public consultation would be needed, and we would not be fulfilling the previous commitments made to our population.

The scheme includes a process of public engagement and communication as the detailed design progresses, which is further explored in the Management Case.

2.8 Conclusion and Preferred Way Forward

We have undertaken a comprehensive and robust appraisal of all the options that could deliver the consultation outcomes, consistent to NHS and Government guidance for SOCs. Our appraisal against the CSFs identifies the option that achieves the most appropriate balance between delivering the commitment we made as a system during consultation, addressing our urgent clinical and operational risks, protecting the continuity of our services and providing value for money for taxpayers. Table 49 summarises the appraisal results against all 9 CSFs:

Table 49: Summary of appraisal against CSFs

Appraisal Section	CSF	1. Business-as-usual (comparator)	2. Core DMBC ('Do minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Qualitative	Clinical Quality and Patient Experience	Fail	Pass	Pass	Preferred
	Workforce	Fail	Pass	Pass	Preferred
	Effectiveness	Fail	Pass	Pass	Preferred
	Clinical Model	Fail	Pass	Pass	Preferred
	Commercial Viability	Pass	Pass	Pass	Pass

Appraisal Section	CSF	1. Business-as-usual (comparator)	2. Core DMBC ('Do minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
	Build Deliverability	Fail	Pass	Pass	Pass
Quantitative	Value for money	Fail	Pass	Pass	Pass
	Revenue affordability	Fail	Pass	Pass	Pass
	Capital affordability	Pass	Pass	Fail	Fail
CONCLUSION			Preferred way forward	Explore if further capital became available	Explore if further capital became available

To achieve an appropriate balance between overall net benefits and affordability, Option 2 has been selected as the Preferred Way Forward at this stage

Options 2 to 4 offer significant clinical, workforce and operational benefits vs. business-as-usual and help address the issues we are facing. Option 4 (Core DMBC + key estates risks + integration) offers greatest clinical, workforce and operational benefit. For this reason, it is preferred across multiple qualitative CSFs (inc. clinical model, quality, workforce and effectiveness) and offers the greatest NPSV.

Options 2 to 4 are all broadly affordable from a revenue perspective – as they offer financial benefits greater than the cost of capital. However, Option 3 and Option 4 require more capital than is currently available and fail the capital affordability CSF. Given their relative benefits, these will be explored more if further capital becomes available.

Option 2 (Core DMBC ('Do minimum')) delivers a similar BCR to option 3 and 4, delivering the core DMBC requirement and moving us towards the wider Future Fit ambition by delivering the first phase of redevelopment – resulting in delivery of the majority of expected Future Fit benefits. Because of the modular design of this development, if option 2 is selected the further scope outlined in options 3 and 4 could be added at a later stage if further funding was made available.

This option will:

- be delivered in full by December 2026 as per the programme plan set out in the management case
- deliver improvements in quality, safety & experience driven by consulted clinical model as well as workforce availability and sustainability
- improve workforce availability and sustainability driven by enhanced build environment
- reduce waiting times and travel times for hospital services delivered through clinical model and improved access to appropriate specialists
- meet future capacity needs (new wards) - avoids potentially significant and additional unnecessary costs associated with temporary measures required to address service capacity issues
- better supports the integration of emergency and planned care pathways, enabling coordinated and seamless patient experience across the pathways
- offer excellent value for money, with a strong benefit-cost ratio of 3.7 and a positive net present social value of £424m
- be affordable, with costs of capital of £15.8m offset by financial benefits of c. £15.8m p.a.

This option is the first step in the journey towards transforming clinical care provision for patients across Shropshire, Telford & Wrekin and Powys, by delivering the improvements in emergency and planned care we committed to in 2019. It will help ensure we can provide our patients with safe and high-quality emergency and planned care in a timely and accessible fashion, from modern fit-for-purpose buildings.

This appraisal is based on the available evidence when this SOC was developed. If additional options become apparent as the scheme progresses, we will remain open to considering them.

Our preferred way forward involves investing £312m in Royal Shrewsbury Hospital and Princess Royal Hospital to provide improved facilities that will better meet the needs of our patients. It will put in place the core elements of the service reconfiguration described in the Future Fit consultation, help us to address our most pressing clinical challenges, and establish solid and sustainable foundations upon which to make further improvements. A number of significant challenges will remain, particularly in relation to the standard of patient accommodation at the RSH site, and whilst these can be managed over the medium term, these risks will need to be addressed in the long term.

The preferred way forward is also fully aligned with local health system objectives and is one of a number of strategic initiatives that will transform the health and wellbeing of the population of Shropshire, Telford & Wrekin and Powys. One of the core local health system assumptions underpinning the design of the HTP relies on the transformation of out of hospital services, which will be delivered through the ICS's Local Care programme and is expected to lead to a much lower increase in acute bed requirements over the medium to long term.

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NHS Trust

Integrated Care System
Shropshire, Telford and Wrekin

3 Commercial Case

2.9 Commercial case

Procurement options available to the Trust for appointment of the Principal Supply Chain Partner include undertaking a local tender process or a framework procurement.

At this stage, the ProCure23 framework for design and construction of NHS capital projects is expected to offer best value for money and help us move quickly to implementation and build, while also aligning with guidance from NHSEI and the wider public sector.

We will investigate these further during the OBC stage before deciding the appropriate procurement route.

The commercial case sets out the services required to implement the Preferred Way Forward identified within the economic case and then describes the potential commercial options available to support the next phases of the project. It goes on to make recommendations on how the commercial approach should be explored and assessed in more detail during the OBC stage.

At SOC stage, we must outline the services required, the main commercial issues to be considered, the procurement strategy and timetable. During the detailed design phase (OBC) we will need to make further decisions about the commercial arrangements needed to deliver the scheme. Principally, these decisions should be made in a way that delivers the greatest value to the UK public sector and shares risk appropriately with third party organisations.

The key criteria for the procurement strategy are that the contractor must take single-point design responsibility once the works begin. The most pivotal of these responsibilities is the decision on procurement route, for which current available guidance provides a clear default position that the NHS ProCure23 (P23), managed by NHSEI and hosted by Crown Commercial Services should be used unless a clear justification is available for an alternative. This framework outlines the requirement for a single point of responsibility, and a guaranteed maximum price (GMP) to manage the risks relating to the delivery of the scheme.

The latest ProCure23 iteration is expected to be live from April 2022, and the framework call-off guidance will be reviewed following the SOC stage with pre-market engagement plans finalised from OBC stage.

These two options have been carried forward onto the scheme's short-list and the most suitable procurement route will be selected at OBC stage.

3.1 Required services to implement the project

To implement the preferred option and a new model of care, a number of goods and services need to be provided.

These include:

- professional services
- furniture and equipment (F&E)
- temporary facilities
- design and build of new facilities
- maintenance services

3.2 Procurement routes for professional services, equipment and temporary facilities

3.2.1 Professional services

As set out in the management case, we have an experienced and capable in-house HTP team. The HTP team ensures clear ownership and co-ordination of the project at both a strategic and a detailed level within the local health system. The team can lead on business case production, clinical planning and workforce development.

Our internal service improvement team will also provide support to the HTP team as the project progresses towards implementation, as detailed in the management case. We were selected as one of five hospitals trusts nationally to partner with the Virginia Mason Institute in Seattle, USA to implement lean methodologies based on the Toyota Production System. The knowledge and skills gained from this partnership will be valuable in supporting the clinical service changes required to underpin the physical reconfiguration within the HTP.

We are also engaging with a number of peer Trusts that have completed major reconfigurations to ensure that we have captured key learnings, including Northumbria Healthcare NHS Foundation Trust and Worcestershire Acute Hospitals NHS Trust, and Trusts that are planning major reconfigurations, including University Hospitals of Leicester NHS Trust, Calderdale and Huddersfield NHS Foundation Trust, and University Hospitals Dorset NHS Foundation Trust.

External specialty support has also been sought and will continue as we develop the detailed capital reconfiguration plans through to OBC, full business case (FBC) and implementation.

These services will be procured through the NHS Shared Business Services (SBS) Construction Consultancy and Consultancy Support frameworks where appropriate.

Any further specialist advice required throughout the completion of the HTP process will be purchased either through the SBS Framework, or via local appointment in line with our Standing Financial Instructions.

When engaging the Principal Supply Chain Partner (PSCP), it will be essential that the incumbent HTP design team has the knowledge and experience of working with the New Engineering Contract (NEC) suite of model construction contracts appropriate to the scale of the option being procured, the Trust design team will continue to work independently of the PSCP to drive through the Trust requirements in the final design to ensure a successful GMP is achieved.

3.2.2 Equipping

We have identified a need to procure new specialist equipment as part of the implementation of the Hospitals Transformation Programme to support the new clinical model. This would be purchased using existing NHS buying arrangements and implemented via turnkey specialist fit out packages and will be included and identified within the PSCP works as specialist fit out areas. The Trust as part of this process will also review if any managed service contract vehicle could be used to purchase and install this specialist equipment. The Trust has the in-house skills and track record to lead and manage this particular turnkey specialist fit out process.

New furniture and equipment (F&E) would be procured through the existing NHS buying arrangements. The PSCP will include and install all identified group 1 items with the trust retaining control over the purchases and supply of the identified group 2,3 & 4 items. Both Group 3 & 4 items will be fitted or installed by the trust near completion of the works with Group 2 being provided to the PSCP for installation during the build.

We have identified that temporary facilities are likely to be required to support the implementation phase of HTP. Wherever possible the requirement for temporary accommodation will be minimised. If temporary accommodation is required, it will be incorporated within the proposed new building footprint if possible or be re-provided across the site or used to enhance existing services.

There may be benefits of temporary facility provision being included in the main contract, as this would place the responsibility for procurement and co-ordination with the PSCP, which could have financial, contractual and programme benefits.

The specific requirements for this additional temporary accommodation will be further developed during the OBC and FBC stages.

3.3 Procurement routes for design and build services

3.3.1 Key procurement considerations

We have identified several important factors that will influence the appointment of the main contractor procurement routes for design and build services. The following additional critical factors must be considered to provide the best value procurement solution for the HTP scheme:

- HTP scope and deliverables
- early engagement of the market
- contractor ability
- constraints such as funding allocation and timeframe for delivery
- management of risk
- our capability of delivering a project of this type
- resources and expertise we require
- the level of influence required for planning, risk, design, construction and project interfaces
- the routes to market (framework agreements) available to us
- the use of the Social Value Model award criteria and evaluation questions (as confirmed by the ProCure23 Implementation Advisor)

3.3.2 Local tender using standard building contracts

The procurement route appropriate to the requirement will be used to ensure the best value is achieved through appointment of suppliers with the necessary capability and capacity. This means that some appointments may be

made via local tender process for specific work packages and using opportunities to include Social Value evaluation criteria where it is relevant to the subject matter of the contract.

3.3.3 The NHS ProCure23 Construction Procurement Framework route

This route to market is the framework for the design and construction of NHS capital projects and is managed by NHSEI and hosted by Crown Commercial Services.

It enables NHS clients to quickly access experienced and proficient partners and their supply chains to support excellence in all aspects of NHS capital project delivery, including business case development/approval, sustainability (including carbon reduction targets and social value), design, construction (including modern methods of construction) and whole life and operational costs to improve healthcare delivery and patient outcomes.

The previous iteration of the framework was utilised for pre-market engagement sessions that enabled the HTP team to understand – from the commercial marketplace perspective – and subsequently develop thinking around the phases within the HTP, and how best to construct the commercial activity and packages of work to best manage value and risk.

The phasing of HTP is to be further developed during the OBC stage with the key considerations of ensuring value for money and risk optimisation from the supplier base informing the procurement strategy.

The ProCure23 framework ensures consistency with Government Policy, Government Construction Strategy, the Public Contracts Regulations 2015 and the National Audit Office guidance on use of centralised frameworks. Additionally, the NHS Improvement business case core checklist requires that the Procure23 framework is the default option for procurement:

> *"P21+ [and successor frameworks] should be the default option for construction projects. Where it is not used, sufficient justification must be provided as to why as this alternative approach contributes to the aims and outcomes of HM Government Construction Strategy."*
>
> ***NHSI Business case checklist (2016)[29]***

The project team has conducted early engagement with CCS and the P23 framework teams to ensure the suitability of this framework for this investment.

At this stage, ProCure23 is likely to be the preferred route for design and build services, unless alternatives offer greater value for money.

3.3.4 Other national frameworks

Through the OBC, we will actively review whether any benefit can be obtained from other frameworks, notably those hosted by Crown Commercial Services, NHS Supply Chain and NHS Shared Business Services, such as those relating to:

- modular buildings,
- car park infrastructure, and
- construction consultancy services.

At OBC, a market options assessment and criteria scoring matrix will be completed to underpin the selection of the preferred route (both framework choice and contract) that will drive value for money and quality.

3.4 Hard and soft facilities management post implementation (maintenance services)

We operate in-house hard and soft facilities management (FM) services. This SOC assumes that our current facilities management arrangements will continue once the capital works have been completed.

3.5 Determining the procurement route at OBC (actions required at OBC stage)

It is acknowledged that the ProCure23 framework route should be the default option for construction projects and that where it is not used, sufficient justification must be provided as to why as this alternative approach contributes to the aims and outcomes of HM Government Construction Strategy.

Furthermore, the Infrastructure and Projects Authority's Common Minimum Standards for Construction[30] states "procurement strategies and contract types should support the development of collaborative relationships, enable early contractor involvement, and support innovative approaches."

Therefore, the routes will be re-appraised at OBC stage in terms of the risk of each and against the following criteria:

[29] https://www.england.nhs.uk/financial-accounting-and-reporting/capital-regime-investment-and-property-business-case-approval-guidance-for-nhs-providers/
[30] https://www.gov.uk/government/publications/common-minimum-standards-for-construction

- cost certainty,
- quality,
- time, and
- flexibility.

In addition, the procurement route moving into FBC will be further assessed to ensure the ProCure23 route still provides the following advantages in relation to risk and economic efficiency.

- Ability to respond to the emerging clinical pathway design requirements of HTP,
- Flexible in approach
- Efficient and economical management control of change mid-process,
- Fast-track start with reduced tendering process costs.
- Ability to achieve programme delivery to schedule,
- Cost certainty in advance of construction (and contract engrossed),
- Competitively tendered rates and margins from the outset,
- Reduced risk of clinical incident and clinical impact, and
- Reduced risk of health and safety failures that could impact patients, visitors, staff or contractors.

In conclusion, the ProCure23 procurement route is an open book process that provides the Trust with speed to market, flexibility in approach, cost surety, and utilises the NEC suite of contract forms. It is the preferred process to deliver a healthcare construction scheme of this scale and will be managed and monitored throughout both the OBC & FBC processes.

3.6 Optimising the management of risk (potential for risk transfer)

This section provides an initial assessment of how the associated risks might be apportioned between the Trust and the contractor delivering the facility. The general principle is to ensure that risks should be passed to the party best able to manage them, subject to value for money.

The diagram below demonstrates the indicative risk allocation for the differing procurement routes available.

Figure 20: Indicative risk allocation for the different procurement routes

The form of contract used within each procurement route as indicated above will also be considered to further mitigate the risk to us from construction.

Table 50 below outlines the anticipated allocation of risk at this stage.

The choice of available procurement route – discussed above – may impact the allocation of risks.

Table 50: Risk transfer matrix

Risk category	Allocation of risk		
	Trust	Supplier	Shared
Design risk		●	
Construction and development risk		●	
Transition and implementation risk			●
Availability and performance risk		●	
Operating risk	●		
Variability of revenue risks	●		
Termination risks			●
Technology and obsolescence risks			●
Control risks			●
Residual value risks	●		
Financing risks	●		
Legislative risks			●
Other project risks			●

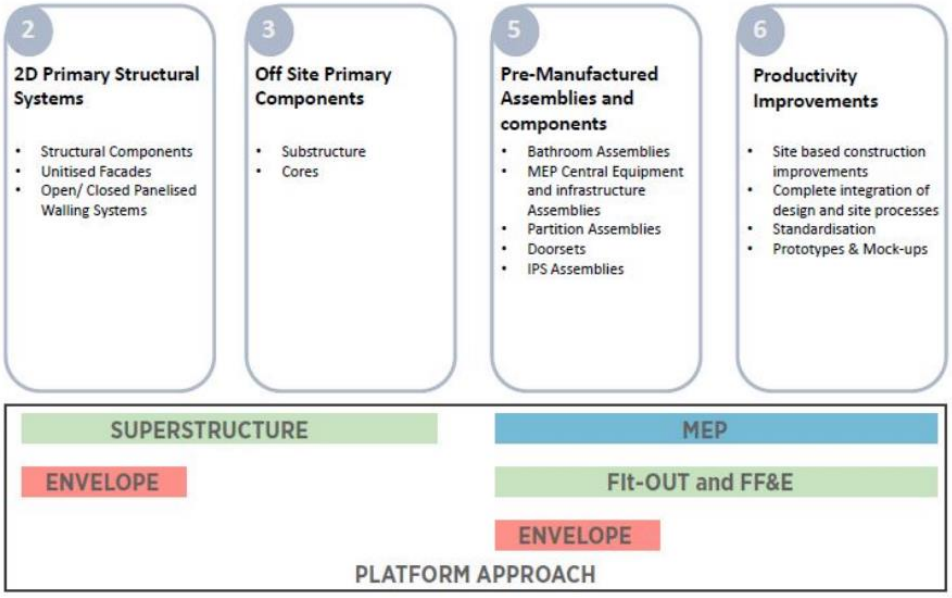
3.7 Modern methods of construction

Modern methods of construction (MMC) are offsite manufacturing and onsite techniques that provide alternatives to traditional building design, including manufacture and assembly. Whilst difficult to accurately calculate the exact pre-manufactured value (PMV) at SOC stage across the MMC categories, the scheme will aim to achieve the 70% benchmark used as a standard measurable across the industry. At this SOC stage the project has ambitions to replace traditional trade-based building methods with factory created and assembled components, which are assembled on site using modern assembly methods which will enhance our Pre-Manufactured Value (PMV) percentage.

We are fully committed to MMC, and this will be embedded within the design principles in the development of the SOC. This approach will also be used when engaging the PSCP to assist in finalising the FBC. The appointed design team will consider all options to accelerate delivery and reduce carbon impact.

We welcome the forthcoming guidance on MMC, and repeatable elements will incorporate these at OBC. The preliminary design work undertaken for this SOC assumes that the default position is to exploit MMC, and this is included within the time and cost projections within this SOC. We will also, as part of pre-market engagement, discuss buildability options so that MMC opportunities can be fully exploited through early engagement and ensure it is administered by the PSCP when appointed.

Figure 21: MMC approach



The design has been developed from the outset to maximise the opportunities for **MMC** (Modern Methods of Construction and **DfMA** (Design for Manufacture and Assembly). Platform approaches will be developed with the selected contractor.

A blend of MMC solutions unlock maximum value for SaTH

3.8 Key procurement milestones

Table 51 highlights the key procurement process milestones. These will be explored in more detail as the OBC is developed and a more developed schedule of works is available.

Section 5.2.1 summarises the overall programme milestones, including these key commercial milestones. The phasing is defined in Section 5.2.

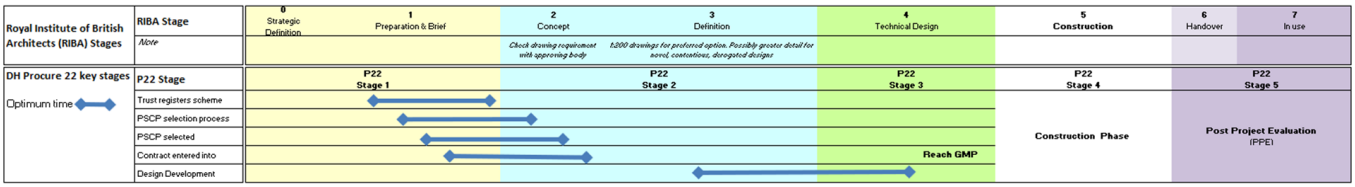
These dates are dependent on the review of the SOC and will be reviewed and refined.

Table 51: Procurement process milestones

Key decision/approval	KEY DATES
SOC Submission	Q1 2022/23
Joint Investment Committee approval of SOC & agreement to proceed to OBC	Q2 2022/23
PSCP Initial Engagement	Q3 2022/23
Trust issue P23 Expressions of Interest Document issued to PSCPs	Q3 2022/23
P23 Expressions of interest (EOI) document Evaluation	Q4 2022/23
PSCP Interview Process	Q4 2022/23
Trust appoint preferred PSCP	Q4 2022/23
Completion of OBC	Q1 2023/24
Trust & PSCP work towards completion of OBC and FBC	Q1 2023/24
Joint Investment Committee approval of OBC	Q2 2023/24
Completion of FBC (Including PSCP GMP)	Q2 2023/24
Joint Investment Committee approval of FBC	Q3 2023/24
Begin Implementation of the Preferred Way Forward	Q3 2023/24
Completion of the Preferred Way Forward	Q3 2026/27

It is expected that the P23 PSCP will be appointed against qualitative and price criteria and will subsequently work with the Trust to develop a target price, bridging RIBA stages 3 and 4. It is the intention that the Trust-appointed design team will develop the project to the end of RIBA stage 3, while engaging the PSCP towards the second half

of Stage 3 (end of P23 stage 2) to enable overlap between Trust design team and the PSCP team – the diagram below describes the alignment between RIBA stages and P22 stages, which are expected to be consistent with P23.



3.9 Personnel implications (including TUPE)

Personnel implications, including workforce, are described in more depth throughout the SOC. We are not anticipating any Transfer of Undertaking Protection of Employment (TUPE) at this stage although as plans develop in relation to the FBC and the wider system changes this position may change.

3.10 Accountancy treatment

The accounting treatment of our proposal will be undertaken by applying the current accounting guidance as laid out in the Green Book. Currently we recognise that the assets will be recognised on our balance sheet along with the corresponding PDC funding.

3.11 Travel and transport

Detailed modelling to understand the impact of the proposed clinical model has been completed as part of the public consultation process and is detailed in the pre-consultation business case and decision-making business case. This included a full impact assessment, which included specific mitigations for travel and transport impacts resulting from the reconfiguration of services (see Section 5.6).

The development of the OBC will include a review and refresh of the approved travel and transport plan.

We have identified the need to consider professional removal services to ensure the reconfiguration of services is completed with minimal disruption; this will be explored in more detail in subsequent stages.

3.12 Conclusion

We have explored multiple options surrounding the HTP scheme, we are confident the current proposal as defined at this SOC stage, can be delivered to achieve the outputs of the clinical model.

The trust, over the last few years, has had a successful track record of delivering large complex schemes at pace, each delivered to time and on budget. These projects include improvements to urgent and emergency pathway reconfiguration, CT and MRI installation and the reconfiguration of the endoscopy department.

We are confident that we can successfully put in place both the internal and external technical expertise that will ensure that we continue to deliver large and complex programmes of work on behalf of the Trust and the wider local system.

The current commercial view of the most cost effective and efficient procurement route is the utilisation of the ProCure23 framework, which is also in alignment with the latest NHSEI guidance.

The timescales identified above following SOC approval, outline the Principal Supply Chain Partner (PSCP) appointment during the OBC process, who will work collaboratively with the trust its partners across the system and the in-house design team to identify and achieve a gross maximum price (GMP) for the HTP scheme, agreed by all parties prior to construction commencement.

This partnering and collaborative approach will minimise risk and cost pressure to the trust and other partners across the local system during the construction phase of the HTP Scheme.

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NHS Trust

Integrated Care System
Shropshire, Telford and Wrekin

4 Financial Case

4 Financial case

Implementation of the Preferred Way Forward requires capital investment of £312m over 2022/23 – 2026/27. As described in the economic case, this investment is essential to delivering the clinical model, necessary improvements to quality and safety, dedicated capacity, and COVID-19 resilient hospital facilities.

The trust's financial challenges include c. £14.6m p.a. of revenue costs driven by duplication and inefficiencies in our clinical model. This contributes to a growing Trust and system deficit that has led to national intervention to support rapid improvement.

The phasing of the capital requirement has been aligned where possible to existing commitments and is estimated at c. £6m in 2022/23, £57m in 2023/24 and £83m per annum until 2026/27, totalling £312m as per the commitment in the Hospitals Upgrade Programme.

This capital will incur revenue costs of c. £15.8m a year (by 2031/32) because of depreciation and PDC charges. The option will generate financial revenue benefits of c. £15.8m a year (by 2031/32). This includes the benefits of a more efficient workforce, improved layout and patient pathways, improved patient flow and reduced length of stay, and a better quality estate.

This means the overall scheme is affordable and contributes c. £3.3m p.a. more than business-as-usual, which creates costs from required investments.

Through the outline business case, there will be a focus on further improving the affordability of the scheme within the local health and social care system. This will include further consideration of modern methods of construction and repeatable design elements to reduce capital cost; further validating the size of the development and identifying other areas of opportunity with system partners.

This section addresses the core question of whether and how we can afford the Preferred Way Forward and the financial implications on the Trust.

As at the end of September 2021, we have an estimated underlying deficit of £62m. Under the business-as-usual position, in 2031/32 this position significantly improves to a c. £34m deficit, despite increasing costs driven by demand and the cost of running the existing estate. This improvement trajectory results from the delivery of business-as-usual efficiency plans, including significant reductions in agency spend, which are being developed and discussed with regional and national regulators.

Despite this improvement, the business-as-usual comparator is not sustainable and there will be an increasing risk that material additional non-recurrent costs will be incurred to address future service challenges. Furthermore, it will be extremely difficult to deliver the levels of efficiency required without some of the changes to the physical estate layout, clinical pathways and ways of working. It will also become increasing difficult to attract key staff groups that would be unlikely to want to work in the current environment at the Trust.

The total capital requirement for the Preferred Way Forward is £312m. The capital funding requirement is expected to be provided from public divided capital (PDC).

The preferred way forward will bring a step change in clinical care for patients across Shropshire, Telford & Wrekin and Powys, delivering the improvements in emergency and planned care we committed to in 2018. It will help ensure we can provide our patients with safe and high-quality emergency and planned care in a timely and accessible fashion, from modern fit-for-purpose buildings.

The Preferred Way Forward is expected to improve the Trust's deficit by c. £3.3m from the business-as-usual model. There are further unidentified transformational efficiencies that will need to be met to deliver the system sustainability plan and it is expected that the preferred way forward and the opportunities that it provides will be pivotal to the realisation of those further efficiencies.

In line with most longer-term financial planning exercises and similar redevelopment programmes, the financial information used to support this financial case focusses on the recurrent underlying position and develops forecasts on that basis. The recurrent deficit represents the position excluding specific investments and impacts related to the short-term financial regime which has prevailed during the pandemic, whilst the forecast assumes a return to the pre-COVID-19 financial regime going forwards, and system income being driven through an intelligent fixed payment system.

If we do not implement the Preferred Way Forward, there will be an increasing risk that material additional non-recurrent and potentially recurrent costs will be incurred to address future service challenges.

4.1 Introduction

This financial case assesses whether the preferred way forward is affordable. It carries out a comparison between the Preferred Way Forward, and the business-as-usual option. The impact of the scheme on the Trust income and expenditure, balance sheet and cash flows are outlined in Section 4.4 to 4.6.

4.2 Financial context and business-as-usual

As at the end of September 2021, we have an estimated underlying deficit of £62m for 2021/22. This is part of a wider recognised system underlying deficit within STW of £115m, predicated on the system understanding of the financial position as of September 2021. The finance case is constructed prior to 2022/23 allocations and the detail of the convergence glide path target adjustment for the ICB, this will be updated once there is an agreed 2022/23 ICB financial plan. However, this update will not impact on the relative revenue assessments of the options.

The system is currently in the National Recovery Support Programme with a specific requirement to develop an approach to recovering the deteriorating financial position. This is also in the context of the quality and safety challenges that the system faces. As part of the development of an ICS sustainability plan, the system has been working closely together, including with regulator colleagues, to develop challenging and stretching plans that will improve system financial sustainability and reduce underlying deficits locally.

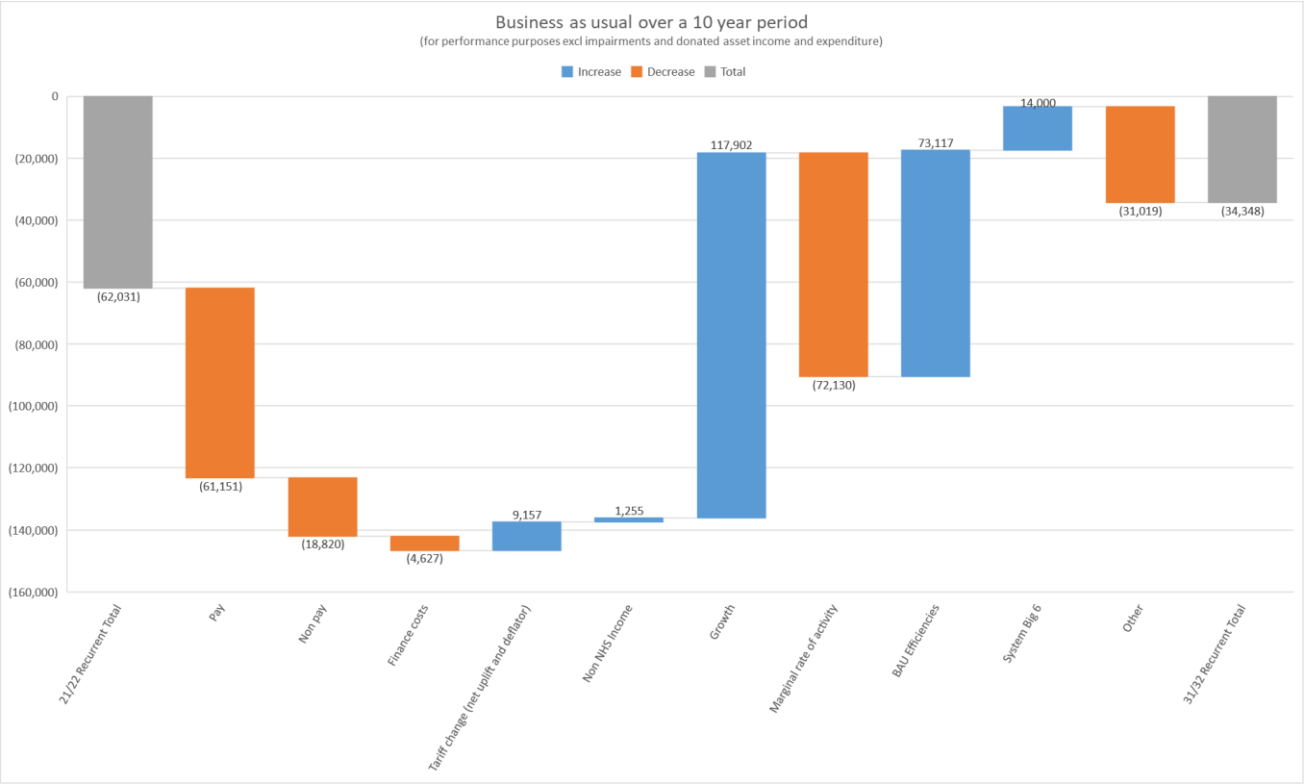
The system sustainability plan aims to bring the system into financial balance within five years. There are a number of components to the delivery of the plan including the delivery of business-as-usual efficiencies amounting to 1.6% per annum up to 2026/27 by 1.1% per annum from then until 2031/32 the delivery of targeted savings plans across six ‘big ticket items’ including workforce as well as the HTP plans discussed in this case. Together these plans are expected to help achieve a business-as-usual financial deficit of c. £34m for the Trust (see Figure below).

The sustainability plan also contains unidentified system-wide transformational schemes to close the remaining financial gap. The system unidentified gap is not included within the financial modelling for this case. We are committed to the system financial ambition to deliver financial balance although it is difficult to imagine how the required level of transformational changes can be identified without implementing the Preferred Way Forward.

The planning assumptions as part of this SOC, as well as the wider system plans, have been developed and agreed as part of the ICS sustainability programme, which is part of the overall system governance structure, and includes an ICS CFOs group to report on progress and agree assumptions. As such, all planning assumptions have been jointly agreed and are consistent with system planning assumptions to create a projection of our business-as-usual financial position. The same assumptions are also used in the ICS sustainability plans, Trust plans and this case to ensure full alignment and consistency across the system.

In line with most longer-term financial planning exercises and similar redevelopment programmes, the financial information used to support this financial case focusses on the recurrent underlying position and develops forecasts on that basis. The deficit position represents the position excluding specific investments and impacts related to the short-term financial regime which has prevailed during the pandemic, whilst the forecast broadly assumes a return to pre-pandemic arrangements. There is an intelligent fixed payment programme in place which will take effect in 2022/23. This will stabilise income and expenditure expectations between providers and commissioners.

Figure 22: Business-as-usual financial projection to 2031/32 (£000s)



After the removal of the 2021/22 non-recurrent sources of income (e.g., financial recovery funding), and as at the end of September 2021, we have an estimated underlying position is a £62m deficit. In the business-as-usual comparator, the Trust's financial position in 2031/32 is expected to be a deficit of c. £34m. Figure 22 shows the contribution of each component; starting from the 2021/22 position, to the forecasted deficit in 2031/32.

Overall:

- Pay inflation: National guidance of 1% pay inflation plus system estimate of 1.1% incremental drift reducing to 0.7% from 23/24 onward. Although likely to be higher, it is assumed to be fully funded and therefore cost neutral. Assumptions will be updated if there is a change in national guidance.
- Non-pay inflation: non-pay inflation (1% p.a.) is consistent with both national and system assumptions.
- Finance costs: Additional financing costs of £4.6m are included. These relate to inflation at 1.8% and depreciation and PDC charges on the additional c. £72m capital investment which is expected to be required to maintain the delivery of current services. In line with HMT and DHSC guidance, the business-as-usual comparator includes a level of investment which is greater than the current run rate of reactive maintenance, to ensure essential works are completed including the needed energy centre, and that the critical estates risk is addressed.
- Tariff change: Tariff has been modelled in line with both national and system planning assumptions, with a net uplift of £9.2m (0.2%) derived from an uplift of 1.3% (Default assumption of 1% for non-tagged expenditure uplift -agreed by system finance deputies) and an efficiency deflator of 1.1%. Non-NHS income has been based on a growth figure of 1% for the next 5 years and then no growth for the final 5 years of this plan. This is in line with system assumptions.
- Growth: Activity is forecast to grow at 2.8% Trust wide, accounting for ONS forecast demographic growth, the clinical impact of age and geographic impact of this growth and the non-demographic growth set out in long term planning assumptions.
- Marginal rate of activity: The financial model assumes that the marginal cost of delivering additional activity is 75% of the additional income that would be generated from the activity increase. This rate has been agreed across the STW system and is aligned to all system plans.
- Business-as-usual efficiencies (cost improvement plans): The financial projection includes a business-as-usual recurrent cost improvement plan of £73m, delivered by 2031/32. National guidance for systems in a deficit situation is 1.6% during years 1-5 reducing to 1.1% once system in surplus. This is a significant undertaking, representing 1.6% of current expenditure in line with NHSEI guidance of a base 1.1% and an additional 0.5% for trusts with an underlying deficit. Alongside the OBC, we will develop an efficiency delivery plan for the forward years, which will be aligned to and delivered alongside the scheme's benefits and the system sustainability plan.

- The business as usual efficiency assumptions described above have been agreed with the system and form part of the wider system plans to return to a sustainable position. This rate of efficiency delivery will be challenging without some of the changes to the physical estate, clinical pathways and ways of working as well as the ability to attract key staff groups that would be difficult to recruit to the business-as-usual model.
- System Big 6 Ticket items: This reflects savings of £14m generated by the Trust towards system wide plans particularly against the reduction of agency premium. It is expected that the increase required in substantive workforce will be challenging within the landscape of the business-as-usual model to prospective candidates. The remaining system transformational schemes are not included within the financial modelling for this case. The Trust is committed to the system financial ambition to deliver financial balance although it is difficult to imagine how the necessary transformational changes will be made without implementation of the Preferred Way Forward.

A full set of assumptions, tables and sources are included in the Appendix C.

4.3 Impact of the investment on income and expenditure

Within the STW system Development Plan (see Appendix B1), HTP is expected to contribute to reducing the Trust deficit and support overall system sustainability. HTP is one of the STW priority Big Ticket items and included in the financial plan for the next ten years.

The Preferred Way Forward will have several impacts on our income and expenditure account in 2031/32 that contribute to making these improvements.

Figure 23: Preferred Way Forward income and expenditure

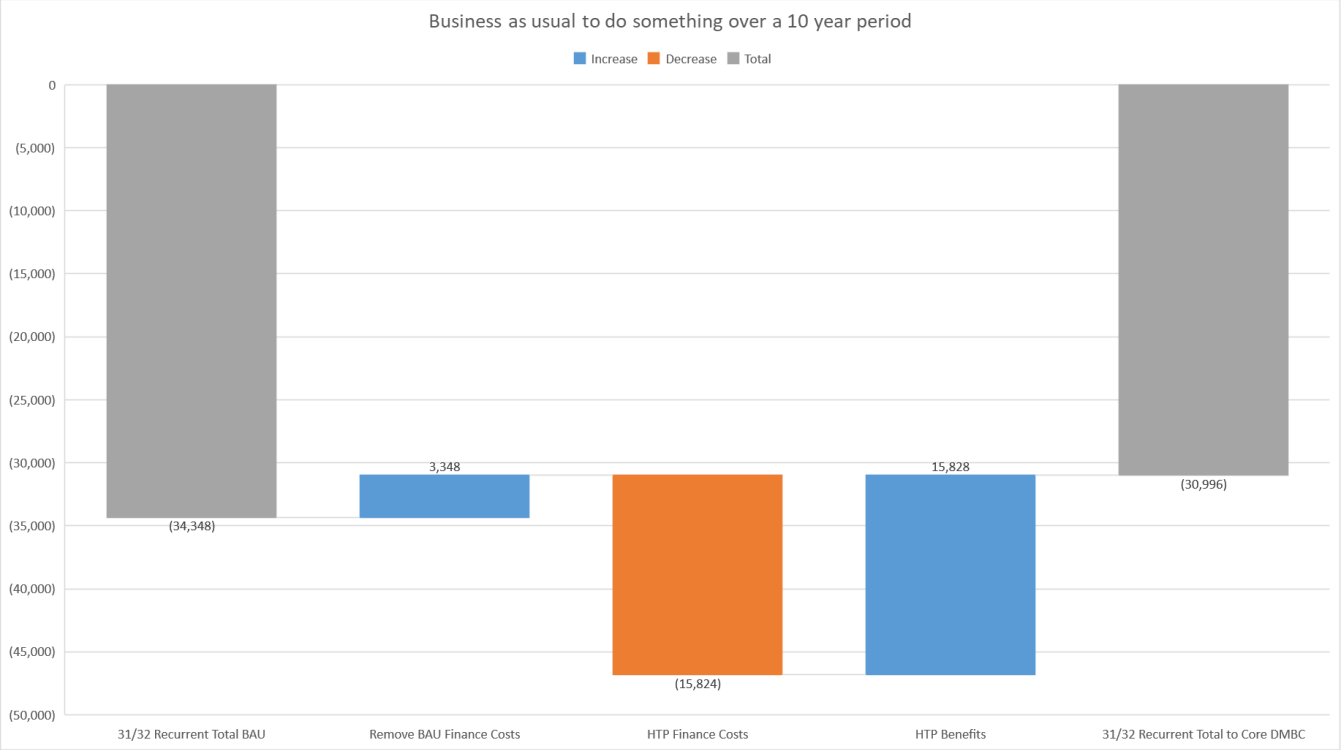


Figure 23 shows the I&E movements between the business-as-usual and preferred option in 2031/32:

- Business-as-usual capital charges: This reflects the removal of the additional capital charges associated with the £72m capital investment required in the business-as-usual comparator.
- HTP finance costs: This includes the revenue impact of the c. £312m capital investment associated with the preferred option. This includes PDC charges on the capital (excluding donated assets) and additional depreciation, assuming 3.5% PDC charges p.a. and a useful asset life of 60 years for new buildings, 40 years for refurbishment and 7 years for equipment based on broad assumptions that are in line with similar projects at this stage. This will be refined at OBC stage. An impairment of 15% on the £312m capital investment has been assumed. Reducing the asset value in 2027/28 worsens the I&E in year due to the impairment but provides a benefit of c. £2.8m p.a. on the Trust I&E position in future years due to lower PDC and depreciation costs. The base level of impairment (15%) is considered prudent in the context of other redevelopment programmes (several NHP schemes include impairment values of over 20% and up to 30%). However, it should be noted that impairment values are typically greater for new build developments, compared to schemes such as this one which include a higher level of refurbishment. At this stage this impairment has not been signed off by the Trust's valuer and is therefore at risk until this is the case. The review and sign-off will be undertaken as part of the OBC submission. The impact of a higher impairment value has been tested as part of sensitivity analysis.

- HTP benefits: In 2031/32, following the completion of the phased redevelopment, c. £15.8m p.a. of cash releasing financial benefits are expected to be realised. These benefits are net of additional estates costs, where a lower cost per metre squared driven by new buildings are offset in part by the greater costs associated with servicing a larger footprint. There are also expected to be significant length of stay savings delivered by adopting the preferred way forward due to the change in clinical pathways and new ways of working with system partners.

Table 52: Cash-releasing benefits in 2021/22 prices

Benefit area	Description	Cashable (£k)
Maintenance	More efficient estate resulting in reduced maintenance costs, net of additional area requiring maintenance	(2,439)
Waste mgmt. & portering	Improved waste management and portering as a result of the redevelopment	262
Same day emergency care	Improved ambulatory emergency care system with multidisciplinary input and increased efficiency of referrals and specialist input	462
Energy and utilities	More efficient estate reducing energy and utility costs	(541)
Workforce	Consolidation of sites will lead to staffing efficiencies, in particular across medical rotas. Includes contributions associated with reduced travel on call premia.	8,500
Infection control	Reduction in HCAI where design supports improved infection prevention and control	6.5
Adverse drug events	Reduction in adverse drug events where design improves physical working environment improving oversight and reducing distractions	348
Staff sickness / satisfaction	A new facility can improve sickness and absence rates, and reduced injuries	153
Agency saving	Improved condition facilities will support attraction and retention of substantive staff, avoiding the need for agency support	1,691
Length of Stay	Reduced costs associated with new pathways resulting from length of stay improvements vs the business as usual. The reduced LoS results from improved flow, better facilities (including increase single room provision), improved adjacencies helping to improve urgent and emergency care pathways and reduce delays, and better integration across services.	5,129
Escalation savings	Reduction in escalation costs due to winter pressures (seasonal variation).	2,256
Total (excluding inflation)		**15,824**

A detailed discussion and breakdown of benefits is included in the economic case and benefits register (Appendix G). The benefits are incremental to the Trust's business-as-usual efficiency programme and should be viewed in this context. The trust has reviewed these benefits to ensure there is no double counting, in particular the benefits associated with reductions in workforce costs. These will be re-visited during the OBC, where further detailed workforce modelling will be undertaken.

Overall, the additional net cash-releasing financial benefits linked to the capital investment (net of the additional revenue costs (PDC charges and depreciation) associated with the investment) lead to a c. £3.3m p.a. improvement compared to the business-as-usual model.

If we do not implement the Preferred Way Forward, there will be an increasing risk that material additional non-recurrent costs and potentially recurrent costs will be incurred to address future service challenges.

4.3.1 Capital funding requirements

The total capital requirement for the preferred option is £312m. This includes planning contingency at 6%, and optimism bias at 22.25%.

There is also an allowance for inflation, equipment cost at 11% of departmental costs and fees of 13% of works costs. More detailed work will be undertaken to refine these values to feed in to the OBC.

Table 53: Capital phasing (Option 2, do minimum inc. VAT)

£m	2021/ 22	2022/ 23	2023/ 24	2024/ 25	2025/ 26	2026/ 27	TOTAL
Capital funding requirement		6	57	83	83	83	312

Within this allocation, this business case seeks drawdown of £9.9m (for 2022/23 and part of 2023/24) in capital funding for the completion of the OBC and associated design work. These costs support the high-level technical design input required to inform the clinical model and to enable the completion of a conceptual layout that delivers the requirements of the preferred way forward. £5.9M has been identified in line with industry standards for the technical design for the OBC, to provide a detailed design that can be used to procure a P23 PSCP, and £1.5m to support the engagement of the PSCP to support pre-construction activities. The funding also includes the engagement of a strategic delivery partner (£1.5m) to support the development of the business case and the Trust's internal project team (£1m). The funding is assumed to come initially from the remainder of the £6m of allocated seed funding, with the residual assumed to come out of the £312m of funding allocated to this scheme. A further £1.8m of external fees are expected to be needed to complete the FBC stage of the programme (in addition to internal costs).

The costs are driven by the tasks associated with the technical aspects of delivering a detailed and considered OBC as articulated through the relevant RIBA Stages & Greenbook guidance. Each technical advisor appointed by the nationally recognised SBS framework has line by line fee allocation for the completion of tasks in the completion of the OBC as defined in the stated guidance.

The capital requirement is based around a timeline that has been constructed taking into account the expected approval processes and whilst ambitious, it ensures that the £312m of allocated capital delivers as much value as possible. Any further delay would likely to result in greater inflationary pressures, adjustments to PUBSEC calculations and a potential reduction in scope of what can be delivered. The detailed delivery plan will be provided at the OBC stage when the preferred solution will be worked up in greater detail. Initial discussions with Shropshire Council about planning applications have taken place to make them aware of the scheme, they are supportive and will engage further when we have detailed plans to discuss.

One of the key risks to the timeline is associated with timely progression through approval to proceed gateways, a risk that could potentially delay the delivery of the scheme and result in additional inflationary capital pressures. The financial implications of a 12-month delay have been forecast to be £14.3m additional capital requirement. This estimate is based on 4-7.5% annual inflation applied to construction costs.

4.3.2 Financial mitigations and sensitivity analysis

The robustness of the findings has been tested through initial sensitivity analysis at SOC stage, in which the value of key cost and benefit drivers have been varied within a reasonable range to determine the impact on income and expenditure of the preferred option. This analysis suggests that while the I&E position is robust to changes in several key assumptions; the position is sensitive to some key material planning assumptions – for example PDC dividend rate, impairment and financial benefits achieved.

One significant sensitivity is related to the PDC dividend rate. This rate is currently above the cost of servicing debt (c. 1.5% higher than current yields) and is higher than other public sector charges (e.g., local authority borrowing through the Public Works Loans Board) – as such, the rate is under review nationally. To reflect the potential reduction in the rate, a 1.5% PDC scenario has been modelled, in line with other NHS capital programmes. This would support the affordability of the preferred option, by helping to improve the forecast I&E deficit from c. £31m deficit to a c. £21m deficit. This could help to mitigate several challenging risk areas contained within the system plans.

A further key sensitivity tested is the level of impairment. If this were to be set at the average historic level (28% over the last 10 years of Trust schemes), this would reduce financing costs and improve the I&E by £2.4m, to a c. £29m deficit.

It is noted that the PDC mitigation relates to policy changes which are not within the control of the Trust and would need agreement with the regulators.

The purpose of this analysis is to demonstrate the impact on long term affordability of flexing key assumptions.

4.4 Impact on statement of comprehensive income

Our I&E is expected to steadily improve. The biggest driver of the position is the system sustainability work that we are an integral part of, and for which HTP is a key enabler as it will allow further delivery of several of the system transformational schemes, including workforce, local care and outpatient transformation.

The impact of the benefits of the case are equal to the additional costs incurred as a result of this development. This increases to a c. £3.3m benefit when compared to the business-as-usual comparator as additional capital costs are

avoided. This is because there is a £72m capital requirement in the business-as-usual model which would incur additional capital charges.

The BAU comparator includes the capital investment required to maintain the delivery of current service arrangements in their current configuration. If this capital was not made available and the associated financial implications were not included in the BAU statement of comprehensive income, then the incremental impact of each option (relative to BAU) would deteriorate up to a maximum annual value of circa £(3.3)m from 27/28 onwards. If the BAU capital was not made available, the increasing risk to the continuity of services would be likely to result in material additional revenue costs that would far exceed the cost of servicing that capital.

Figure 24 shows how employee expenses are maintained at a consistent level from both the benefits of the preferred option and the impacts of the system 'big ticket' workforce plans.

Figure 24: Statement of comprehensive income 2021/22 – 2031/32 (£000s)

	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating income from patient care activities	394,567	409,511	425,282	437,585	450,331	463,535	477,377	491,720	506,579	521,974	537,923
Other operating income	24,594	24,840	25,088	25,339	25,592	25,848	25,848	25,848	25,848	25,848	25,848
Employee expenses	(321,902)	(326,901)	(329,671)	(332,384)	(338,180)	(328,757)	(336,763)	(345,024)	(353,426)	(362,421)	(370,700)
Operating expenses excluding employee expenses	(157,106)	(155,555)	(158,293)	(162,477)	(167,207)	(228,464)	(186,672)	(191,717)	(197,136)	(202,223)	(207,458)
OPERATING SURPLUS/(DEFICIT)	**(59,846)**	**(48,104)**	**(37,594)**	**(31,936)**	**(29,463)**	**(67,838)**	**(20,210)**	**(19,172)**	**(18,135)**	**(16,822)**	**(14,387)**
FINANCE COSTS											
Finance income											
Finance expense											
PDC dividends payable/refundable	(7,122)	(7,432)	(8,532)	(10,980)	(13,887)	(15,975)	(16,609)	(16,609)	(16,609)	(16,609)	(16,609)
NET FINANCE COSTS	**(7,122)**	**(7,432)**	**(8,532)**	**(10,980)**	**(13,887)**	**(15,975)**	**(16,609)**	**(16,609)**	**(16,609)**	**(16,609)**	**(16,609)**
Other gains/(losses) including disposal of assets											
Share of profit/(loss) of associates/joint ventures											
Gains/(losses) from transfers by absorption											
Movements in fair value of investments, investment property and financial liabilities											
Corporation tax expense											
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(66,968)**	**(55,537)**	**(46,126)**	**(42,916)**	**(43,350)**	**(83,813)**	**(36,819)**	**(35,781)**	**(34,744)**	**(33,431)**	**(30,996)**
Prior period adjustment											
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR PER ACCOUNTS	**(66,968)**	**(55,537)**	**(46,126)**	**(42,916)**	**(43,350)**	**(83,813)**	**(36,819)**	**(35,781)**	**(34,744)**	**(33,431)**	**(30,996)**
Adjusted financial performance											
Add back all I&E impairments/(reversals)	4,937	0	0	0	0	46,800	0	0	0	0	0
Adjusted financial performance surplus/(deficit)	**(62,031)**	**(55,537)**	**(46,126)**	**(42,916)**	**(43,350)**	**(37,013)**	**(36,819)**	**(35,781)**	**(34,744)**	**(33,431)**	**(30,996)**

Figure 25: Incremental statement of comprehensive income 2021/22 – 2031/32 (£000s)

	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating income from patient care activities	0	0	0	0	0	0	0	0	0	0	0
Other operating income	0	0	0	0	0	0	0	0	0	0	0
Employee expenses	0	0	(1)	97	124	16,793	17,431	18,004	18,601	19,216	19,845
Operating expenses excluding employee expenses	0	854	2,664	1,281	3,004	(54,570)	(6,236)	(8,640)	(7,635)	(9,257)	(9,354)
OPERATING SURPLUS/(DEFICIT)	**0**	**854**	**2,663**	**1,378**	**3,128**	**(37,776)**	**11,195**	**9,364**	**10,965**	**9,959**	**10,491**
FINANCE COSTS											
Finance income	0	0	0	0	0	0	0	0	0	0	0
Finance expense	0	0	0	0	0	0	0	0	0	0	0
PDC dividends payable/refundable	0	(31)	(833)	(2,984)	(5,593)	(7,383)	(7,720)	(7,482)	(7,304)	(7,140)	(7,140)
NET FINANCE COSTS	**0**	**(31)**	**(833)**	**(2,984)**	**(5,593)**	**(7,383)**	**(7,720)**	**(7,482)**	**(7,304)**	**(7,140)**	**(7,140)**
Other gains/(losses) including disposal of assets	0	0	0	0	0	0	0	0	0	0	0
Share of profit/(loss) of associates/joint ventures	0	0	0	0	0	0	0	0	0	0	0
Gains/(losses) from transfers by absorption	0	0	0	0	0	0	0	0	0	0	0
Movements in fair value of investments, investment property and financial liabilities	0	0	0	0	0	0	0	0	0	0	0
Corporation tax expense	0	0	0	0	0	0	0	0	0	0	0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**0**	**824**	**1,830**	**(1,606)**	**(2,465)**	**(45,160)**	**3,475**	**1,882**	**3,662**	**2,819**	**3,351**
Prior period adjustment	0	0	0	0	0	0	0	0	0	0	0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR PER ACCOUNTS	**0**	**824**	**1,830**	**(1,606)**	**(2,465)**	**(45,160)**	**3,475**	**1,882**	**3,662**	**2,819**	**3,351**
Adjusted financial performance											
Add back all I&E impairments/(reversals)	0	(750)	(2,250)	(750)	(2,250)	46,050	(2,250)	(150)	(1,650)	0	0
Adjusted financial performance surplus/(deficit)	**0**	**74**	**(420)**	**(2,356)**	**(4,715)**	**890**	**1,225**	**1,732**	**2,012**	**2,819**	**3,351**

Please note that expenditure is presented as a negative number (in brackets) and income is presented as a positive number.

The £54.6m benefit in 2026/27 is an expense associated with depreciation and impairment as in the preferred way forward the working assumption is that the entire asset will be brought into use and depreciated from the end of the project. For performance purposes, the impairment change is added back giving rise to an adjusted financial performance surplus in 2026/27. This analysis will be further refined throughout the OBC stage.

4.5 Impact on statement of cashflows

The figure below shows our cashflow to 2031/32.

Figure 26: Trust statement of cashflow 2019/20 – 2031/32 (£000s)

	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Net cash generated from / (used in) operations	(53,328)	(32,469)	(21,425)	(15,210)	(12,157)	4,970	6,709	8,691	10,709	13,040	16,533
Net cash generated from/(used in) investing activities	(31,961)	(21,635)	(73,019)	(99,776)	(100,356)	(109,058)	(26,918)	(27,863)	(28,843)	(29,862)	(30,919)
Net cash generated from/(used in) financing activities	71,584	54,104	94,444	114,986	112,513	104,088	20,210	19,172	18,135	16,822	14,387
Increase/(decrease) in cash and cash equivalents	**(13,705)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(0)**
Cash and cash equivalents at start of period	15,405	1,700	1,700	1,700	1,700	1,700	1,700	1,700	1,700	1,700	1,700
Cash and cash equivalents at end of period	1,700	1,700	1,700	1,700	1,700	1,700	1,700	1,700	1,700	1,700	1,700

Figure 27: Incremental Trust statement of cashflow 2019/20 – 2031/32 (£000s)

	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Net cash generated from / (used in) operations	0	(2)	(13)	80	(9)	15,348	15,949	16,443	16,566	17,467	18,267
Net cash generated from/(used in) investing activities	0	(894)	(41,423)	(77,502)	(67,163)	(85,124)	7,996	(6,229)	3,749	(7,508)	(7,776)
Net cash generated from/(used in) financing activities	0	896	41,437	77,422	67,172	69,776	(23,945)	(10,214)	(20,315)	(9,959)	(10,491)
Increase/(decrease) in cash and cash equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash and cash equivalents at start of period	0	0	0	0	0	0	0	0	0	0	0
Cash and cash equivalents at end of period	0	0	0	0	0	0	0	0	0	0	(0)

Over the period, cash is maintained at a minimal level to provide cover for expenses in line with NHSEI guidance.

The two main requirements for PDC in this period are for:

- deficit support, which reduces over the period because of the improved position, and
- capital support for the Preferred Way Forward.

The phasing of cash is in line with capital expenditure phasing. For the OBC stage, a more detailed phasing of cash impacts will be developed.

The net cash generated from operations is derived from the operating surplus/deficit less depreciation, amortisation and impairments. To maintain a £1.7m cash balance, an increase in creditors has been incorporated (again, as listed in the assumptions).

4.6 Impact on statement of financial position

The proposed expenditure will create a new asset on the balance sheet, with a value of £265m, post 15% impairment in 2027/28. This has been considered in the analysis above.

The new buildings will be accounted for in line with IFRS guidance, with the fair value of the asset recognised as property, plant and equipment on the Trust balance sheet. The balance sheet assumes a useful asset life of 60 years for new buildings, 40 years for refurbished areas and 7 years for equipment, based on broad assumptions in line with similar projects at this stage of development. This will be refined at OBC stage once further work is undertaken to determine capital by specific asset class.

All impairments related to the building are taken to the I&E rather than the revaluation reserve.

It has been assumed that as assets depreciate, we will reinvest at the same rate to maintain the value/quality of our non-current assets.

Figure 28: Balance sheet position 2021/22 – 2031/32 (£000s)

	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Non-current assets	263,646	269,646	326,496	409,546	492,596	528,846	528,846	528,846	528,846	528,846	528,846
Current assets	33,553	33,553	33,553	33,553	33,553	33,553	33,553	33,553	33,553	33,553	33,553
Current liabilities	(49,376)	(49,376)	(49,376)	(49,376)	(49,376)	(49,376)	(49,376)	(49,376)	(49,376)	(49,376)	(49,376)
Total assets less current liabilities	**247,823**	**253,823**	**310,673**	**393,723**	**476,773**	**513,023**	**513,023**	**513,023**	**513,023**	**513,023**	**513,023**
Non-current liabilities	(1,292)	(1,292)	(1,292)	(1,292)	(1,292)	(1,292)	(1,292)	(1,292)	(1,292)	(1,292)	(1,292)
Total net assets employed	**246,531**	**252,531**	**309,381**	**392,431**	**475,481**	**511,731**	**511,731**	**511,731**	**511,731**	**511,731**	**511,731**
Financed by											
Public dividend capital	401,522	463,059	566,035	692,002	818,402	938,465	975,283	1,011,064	1,045,808	1,079,240	1,110,236
Revaluation reserve	70,814	70,814	70,814	70,814	70,814	70,814	70,814	70,814	70,814	70,814	70,814
Income and expenditure reserve	(225,805)	(281,342)	(327,468)	(370,385)	(413,735)	(497,548)	(534,366)	(570,147)	(604,891)	(638,323)	(669,319)
Non-controlling interest	0	0	0	0	0	0	0	0	0	0	0
Total taxpayers' and others' equity	**246,531**	**252,531**	**309,381**	**392,431**	**475,481**	**511,731**	**511,731**	**511,731**	**511,731**	**511,731**	**511,731**

Figure 29: Incremental statement of financial position 2021/22 – 2031/32 (£000s)

	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Non-current assets	0	1,750	45,850	124,650	194,950	226,950	214,200	213,350	204,000	204,000	204,000
Current assets	0	0	0	0	0	0	0	0	0	0	0
Current liabilities	0	0	0	0	0	0	0	0	0	0	0
Total assets less current liabilities	**0**	**1,750**	**45,850**	**124,650**	**194,950**	**226,950**	**214,200**	**213,350**	**204,000**	**204,000**	**204,000**
Non-current liabilities	0	0	0	0	0	0	0	0	0	0	0
Total net assets employed	**0**	**1,750**	**45,850**	**124,650**	**194,950**	**226,950**	**214,200**	**213,350**	**204,000**	**204,000**	**204,000**
Financed by											
Public dividend capital	0	926	43,196	123,602	196,367	273,527	257,302	254,570	241,558	238,739	235,388
Revaluation reserve	0	0	0	0	0	0	0	0	0	0	0
Income and expenditure reserve	0	824	2,654	1,048	(1,417)	(46,577)	(43,102)	(41,220)	(37,558)	(34,739)	(31,388)
Non-controlling interest	0	0	0	0	0	0	0	0	0	0	0
Total taxpayers' and others' equity	**0**	**1,750**	**45,850**	**124,650**	**194,950**	**226,950**	**214,200**	**213,350**	**204,000**	**204,000**	**204,000**

4.7 Enabling and transition costs

To enable the stated timelines to be met, there are two elements of enabling work requiring funding approval at RSH for c. £30m, these key packages are scheduled to commence once the OBC has been approved and the scheme moves into the FBC. This enabling cost is included within the overall cost plan but requires approval prior to FBC sign off.

This key approval will enable the Temporary Accommodation package to be completed for the relocation of several operational departments currently within the footprint of the main build at RSH, such as Stores, Catering and Facilities. This package is c. £10m and will see these operational departments move into either modular or temporary accommodation on the RSH site, ensuring the main build area is clear and ready for works from the outset.

In addition to this another key enabling package will see the existing RSH main underground duct network and associated infrastructure be cleared of Asbestos and its redundant plant underneath the initial main build area this package is c. £20m and assists with ensuring the site is clean and clear ready for construction from day one.

These enabling works would be required for any option involving a similar type of development at the Shrewsbury site in the proposed areas.

The two packages of work are intrinsically linked to the delivery timescales of (Option 2 - £312m) to ensure that the services affected by the new build can be relocated and that the enabling package is in place on a clean site ready for the new build - this approach will optimise the delivery timescales for the project. Detailed design work and associated costings will be completed during the OBC stage with the works planned to commence on OBC completion.

These plans will be refined further as part of the next stage of the business case process, with the request for enabling fees set out in the OBC for approval to drawdown.

4.8 VAT treatment

VAT treatment is consistent with 2021/22 NHS / HMRC accounting rules.

VAT at 20% is included on the capital scheme, except for VAT on fees which is assumed to be 100% recoverable. All revenue is based on current costs and income which includes VAT.

4.9 Sources of capital funding

The Preferred Way Forward has an overall capital cost of £312.4m. This is proposed to be funded through the PDC allocated to this scheme (£312.0m) and internally generated capital funding (£0.4m). A significant PDC injection (through CDEL) is the only viable funding mechanism for this project and the system have confirmed their support for funding £0.4m of the overall cost from the system's capital allocation in 2026/27.

4.9.1 Surplus land sales and demolition

There are no plans to demolish or sell any current buildings as part of the plans for the preferred option, however several buildings within the existing estate are being re-purposed and optimised to help minimise the capital investment required. As such, depreciation charges continue to be incurred on the current buildings and there are no identified opportunities to sell surplus land as part of this case.

4.10 Conclusion

The Trust currently has an underlying deficit of £62m. Under the business-as-usual position, in 2031/32 the deficit is expected to improve significantly by up to £28m, to a £34m deficit, despite increasing costs driven by demand, agency spend and the cost of running the existing estate. Despite this improvement, the business-as-usual comparator is

not a sustainable solution and there is a risk that the financial position will deteriorate further if we do not change the way we operate.

We remain committed to the system financial ambition to deliver financial balance although it is difficult to imagine how the necessary transformational changes included within the system sustainability plan can be delivered without implementation of the Preferred Way Forward.

Implementation of the Preferred Way Forward requires capital investment of £312m over 2022/23–2026/27. As described in the economic case, this investment is essential to delivering the clinical model, necessary improvements to quality, safety and staffing, dedicated capacity, and pandemic resilient hospital facilities.

This capital will incur revenue costs of c. £15.8m a year (by 2031/32) because of depreciation and PDC charges. The option will generate financial revenue benefits of c. £15.8m a year (by 2031/32). This includes the benefits of a more efficient workforce, improved layout and patient pathways, improved patient flow and reduced length of stay, and a better quality estate.

This means the overall scheme is affordable and contributes c. £3.3m p.a. more than business-as-usual, which creates costs from required investments.

As the scheme progresses to OBC, further detail will be developed, including an updated financial position, incorporating the latest guidance, refined benefits and an updated set of system plans.

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Integrated Care System
Shropshire, Telford and Wrekin

5 Management Case

5 Management case

Through the business case process, we have developed clear plans to develop and then implement the Preferred Way Forward. This includes strong governance arrangements, a robust delivery plan, and extensive stakeholder engagement plans which gives us confidence that we can deliver this investment successfully.

Through the next stages of the process, including OBC development, we will continue to refine and improve our proposals and respond to feedback on this SOC.

Governance

We have a clear governance structure and risk management approach as part of the HTP, which builds on the learnings from many other large NHS capital schemes.

Clear roles and responsibilities have been established within both the trust and health system executive teams, and governance groups have been mobilised to continue into the outline business case phase. A HTP Medical Director has been identified, and a Clinical Working Group has been set up to provide clinical leadership of the design process.

Delivery plans

The Preferred Way Forward is planned to be delivered in a single phase of work with future phases building on these foundations subject to further funding.

With rapid approvals supported by the availability of capital, the Preferred Way Forward could be delivered by the end of 2026 and begin offering benefits, including reduced cancellations and planned care waiting times, additional emergency and planned care capacity, and improved clinical quality/experience.

Risks and inter-dependencies will be rigorously managed to ensure that any impacts on the scope, cost or timelines of this project are identified and mitigated as soon as possible.

Following the completion of the preferred way forward, we will have delivered the agreed clinical model and configuration of services and improved the quality and experience associated with these services for our patients across Shropshire, Telford & Wrekin and mid-Wales.

Stakeholder engagement

The project is engaging with local stakeholders through a number of routes. These will continue to be leveraged during the outline business case stage, augmented by a comprehensive stakeholder engagement approach.

This plan to engage and involve local people and local stakeholders will be rolled out in the next steps to deliver the proposed redevelopment of our estate. Patients and service users were involved through the NHS Future Fit process where full public consultation took place. The options in this SOC have not deviated from the outcomes of the consultation and ensuing DMBC or proposed any other service changes that would require further public consultation.

Management of key inter-dependencies with other programmes of work (these programmes are not within the scope of the HTP)

The successful delivery of this project is dependent on the timely delivery of a number of outputs included in other key health system programmes of work. Collaborative working arrangements have been established with each of those programmes to ensure that the impact of any changes to assumptions and/or timings can be assessed and mitigated as quickly as possible.

Key inter-dependent programmes include:

- transformation of Local Care Pathways
- implementation of a day case unit at PRH
- development of a new Energy Centre (zero carbon)
- digital transformation programme

The management case sets out how the redevelopment will be managed and how the proposed changes will be delivered.

5.1 Managing project delivery with confidence (project management, performance management and governance arrangements)

Effective project management is vital to the success of this project. A project management structure hierarchy and performance monitoring framework has been drafted providing confidence and assurance to all stakeholders. The project management structure ensures engagement and continuity of resources that have a track record and experience of delivering large healthcare projects in the NHS. These resources are ring-fenced to ensure there is the necessary capacity, focus and support to drive the project forward successfully. These resources are in-house and will be responsible for the management of the design team and PSCP as well as ensuring effective contract management and quality management throughout the life of the project. A gateway programme with detailed phased sub-projects will be developed with clear monitoring of outputs, outcomes and benefits throughout the life of the project. In addition to this standard progress reporting (including risks and issues) will form a key part of the assurance framework reporting to both SaTH and ICS boards.

To ensure that the Future Fit consultation outcome is developed and implemented, we established a Hospitals Transformation Programme to manage delivery. We have thorough arrangements in place for the on-going management of the scheme and are committed to ensuring its successful outcome.

5.1.1 Governance arrangements to support successful delivery

The governance structure, including the Trust as the lead organisation on behalf of the system, builds on the success of the Future Fit consultation and ensures ongoing partner engagement and co-ordination throughout the development and approval process. This includes the Project Board, which is the main vehicle for wider system assurance and check and challenge, which reports to the STW ICS CE Group / Board.

To support the development of the SOC a robust set of governance arrangements have been put in place. These have been developed in discussion with the relevant clinical and management teams and reflect the need to support and maintain clinical leadership. Terms of Reference are in place to confirm detailed membership, objectives and reporting arrangements.

Governance arrangements are regularly reviewed and updated where required to reflect the development of the project and to allow for the increase in activity and detail which will be required through to OBC and beyond (see chart below).

By reporting through the STW ICS CE Group / Board, we have ensured full alignment to the delivery of the Long-Term Plan, system recovery plan (including immediate priorities) and changes in local pathways. This will continue through the next stages of this redevelopment and ensure that we remain aligned as system plans continue to mature.

Figure 30: HTP governance structure

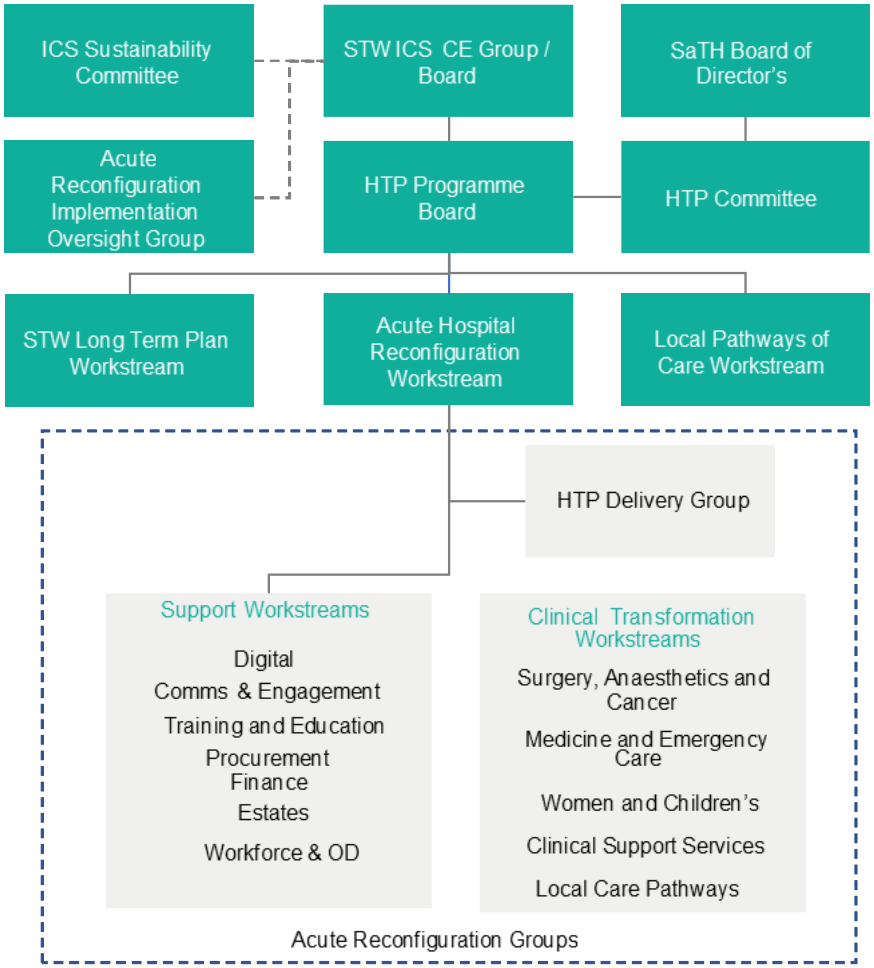


Table 54: Governance group responsibilities

Governance group	Responsibility
STW ICS CE Group / Board	• Maintaining strategic oversight and accountability. It will provide support to the Chief Executives Group in carrying out their functions, including helping remove any barriers they are unable to resolve. The responsibility for major decisions rests with the Chief Executives Group
Trust Board	• The Board is the statutory body responsible for major decisions and formally supporting/approving documents (on behalf of the ICS) at key milestones, including the SOC, OBC and FBC
HTP Board	• To ensure ongoing alignment of the programme with system strategy and plans • To drive forward the implementation of the HTP in line with agreed plans, delivering required scope (and benefits) to time and within budget • To monitor the delivery of key objectives and the achievement of milestones/outcomes across all work streams and activities (including the acceleration of HTP pathways), ensuring that risks and/or issues are managed proactively and escalated in a timely fashion (if required) • To make decisions on what is in and out of the programme, particularly in relation to the quality and safety impact of emerging service changes • To ensure stakeholders are fully engaged in (and support) the development and delivery of the programme (including through the Acute Reconfiguration Implementation Oversight Group) • To oversee the management of risk and issues within HTP and support their mitigation
HTP Committee	• To oversee all aspects of the implementation of the HTP, including those aspects led by other system partners, ensuring ongoing alignment with both Trust and health system objectives and change plans • Constructively challenge and seek assurance in relation to our performance as the prime provider for the HTP (on behalf of the health system) • Constructively challenge and seek assurance in relation of key objectives and the achievement of milestones/outcomes across all work streams and activities (including the acceleration of HTP pathways), ensuring that risks and/or issues are managed proactively and escalated in a timely fashion
ICS Sustainability Committee	• To oversee the development of the ICS's plan for financial sustainability, and assure the ICS Board of alignment between the HTP scheme and the ICS's wide plan for financial sustainability
STW Long Term Plan Workstream	• Ensure the HTP scheme is aligned to the aims and objectives of the STW long term plan
Acute Hospital Reconfiguration Workstream	• Provide direction to the Project Team and oversee delivery of the work in the Acute Reconfiguration Groups • Make key decisions on the scheme at Executive level to support delivery of pathway changes and implementation of the new clinical model
Local Pathways of Care Workstream	• Develop local pathways of care, integrating services across the ICS, and supporting the movement of services out of hospital • Ensure that the assumptions used in the development of the HTP business case are aligned to the wider ICS plans, and are underpinned by realistic delivery plans • Put in place a robust OBC development process and implementation plan to deliver the health system's out of hospital ambitions (timescales to align with HTP development)
Acute Reconfiguration Steering Group	• Deliver the outputs and deliverables required of their workstreams • Report progress through the PMO, and escalate issues to the HTP Acute Delivery Group

To deliver the acute reconfiguration required for the project, a combination of supporting workstreams and clinical transformation workstreams are required. These are outlined below.

Table 55: Non-clinical workstreams

HTP Support Workstream	Key activities and deliverables
Estates	• Overall estates strategy and planning • Developing the detailed design of the preferred option, securing planning approval and management of the build • Responsible for procurement activities and management of the design and construction phases, including any enabling works
Workforce	• Leading workforce modelling to define future requirements and identify people change requirements • Developing and implementing the change management approach
Finance	• Responsible for providing financial, economic and activity expertise and oversight on the project • Responsible for the design and delivery of the financial plan associated with the reconfiguration • Developing and updating finance, benefits and activity forecasts • Leading development of the Finance and Economic Cases of the OBC and FBC • Managing the financial implications of the scheme
Digital	• Responsible for working with estates and hospital design teams and clinicians to understand how to best integrate technology into the infrastructure and design of the new/refurbished buildings and to enable delivery of new model of care. Digital working will be a key enabler across all workstreams • Developing and delivering the digital strategy and plan
Communications & Engagement	• Developing and delivering the communication and engagement strategy and plan • Ensure timely and open sharing of information, grounded in a clear, consistent and accurate narrative for the project across stakeholder groups to build trust and confidence in our approach and plans for reconfiguration • Continue to build effective two-way relationships with all key stakeholder groups and facilitate user input and co-design, with the aim to create the best possible, user-focused reconfiguration plans with high levels of patient, public and staff ownership and support
Training and Education	• Responsible for the development and implementation of training and education plans
Non-clinical Services	• Leading the design and transformation of non-clinical service activities • Ensuring adequate provision of non-clinical services is in place to support the transformation, utilising best practice and maximising new ways of working

Table 56: Clinical Transformation Workstreams

Workstream	Key activities and deliverables
Surgery, Anaesthetics and Cancer	• Leading the design and transformation of the surgery, anaesthetics and cancer division, e.g., delivering the surgical model • Defining requirements, specifications, adjacencies and co-dependencies • Defining principles and pathways • Managing areas of concern
Medicine and Emergency Care	• Leading the design and transformation of the medicine and emergency care division, e.g., developing approaches to transfers, discharges and inpatients • Defining requirements, specifications, adjacencies and co-dependencies • Defining principles and pathways • Managing areas of concern

Workstream	Key activities and deliverables
Women and Children's	• Leading the design and transformation of the Women and Children's division • Defining requirements, specifications, adjacencies and co-dependencies • Defining principles and pathways • Managing areas of concern
Clinical Support Services	• Leading the design and transformation of the Clinical Support Services division • Defining requirements, specifications, adjacencies and co-dependencies • Defining principles and pathways • Managing areas of concern
Local care pathways	• Delivering out of hospital services that will moderate the need for additional acute capacity (ISI beds)

5.1.2 Experienced project team to support delivery

We recognise the significant resourcing required to take the reconfiguration forward successfully and are committed to sourcing the right resource capacity and capabilities necessary to deliver the project. The Hospitals Transformation Team has been set up to provide a dedicated project team, with sufficient experience and capacity to undertake the work and activities required. Collectively, the core team has a wide range of knowledge and experience, including:

Table 57: Project team skills

Area	Skills within the project team
Project management	• Experienced project managers with history in healthcare service reconfiguration • NHS management experience • Operational and project management experience • PRINCE2 and MSP qualifications (where appropriate)
Clinical	• Clinical background / experience • Clinical design and planning experience • Experience delivering the reconfiguration of clinical services
Business cases / capital programmes	• Capital project business case experience • Experience delivering high profile capital strategic programmes • Better Business Cases Foundation/Practitioner qualifications (where appropriate)
Communications & engagement	• Communications and engagement specialists • Experience leading on national and regional campaigns, events and partnerships

To support the development of this SOC and the progression of the project, we have engaged PA Consulting as a key strategic partner who have provided experience of delivering Green Book compliant cases, including many within the NHS.

The team has the appropriate skills for:

- developing, maintaining and implementing project plans,
- co-ordinating working groups as required,
- monitoring progress and reporting to the scheme's governance,
- managing issues as they arise and escalating as necessary,
- managing project advisors, ensuring that their contribution is well understood and that we obtain best advice and value,
- contract management and the management of multiple third parties,
- managing risks in line with scheme's risk management strategy, and

- planning and facilitating change management and ensuring effective development and delivery of the Stakeholder Engagement and Communications Plan.

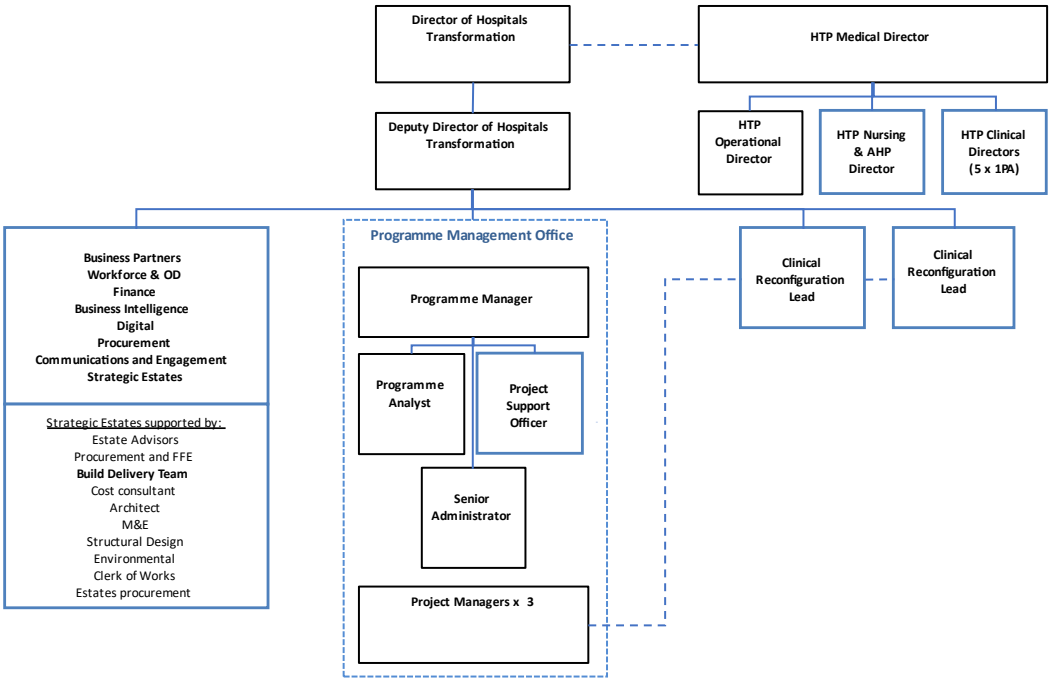
For activities that cannot be delivered by the internal team, external advisors are engaged as required. The use of these advisors is detailed in Section 5.1.4.

The team structure has been recently reviewed and will be augmented so that it remains fit for purpose as the project proceeds and will ensure sufficient resources throughout the project. Additions to the project team include:

- dedicated digital resource,
- dedicated financial modelling resource,
- additional project management resource to co-ordinate clinical design activities, and
- additional external support.

The dedicated HTP resources required are shown below in Figure 31: .

Figure 31: Hospitals Transformation project team structure



The funding required to support the team will be requested through the established drawdown structure, following discussions with our regulators. The structure above reflects the spine of the team and will be supplemented with temporary resources where needed.

5.1.2.1 Management of key inter-dependencies with other programmes of work (these programmes are not within the scope of the HTP)

The successful delivery of this project is dependent on the timely delivery of a number of outputs included in other key health system programmes of work. Collaborative working arrangements have been established with each of those programmes to ensure that the impact of any changes to assumptions and/or timings can be assessed and mitigated as quickly as possible.

Key inter-dependent programmes are described below, along with the relevant assumptions/deliverables required to support the successful delivery of the HTP:

- Transformation of Local Care Pathways
    - Development of Community Diagnostic Hubs
    - Expansion of community and primary care services
    - Better integration of pathways between Acute, Community and Primary Care
    - This will moderate the increase in demand for acute services (and avoid the need for an additional 151 acute beds)

- Implementation of a Day Case unit at PRH
    - Delivers four new operating theatres and associated recovery and ward facilities
    - Establishes a ringfenced planned care 'bed' base
    - Planned to be fully operational by Spring 2023
- Development of a new Energy Centre (zero carbon)
    - Requirement for new build components of HTP to comply with latest national requirements / energy efficiency targets, brings forward longer term Trust energy efficiency plans
    - Trust needs to be compliant with longer term NHS ambitions for net zero emissions for the care we provide (the NHS Carbon Footprint) by 2040
    - Will help to reduce energy usage in areas of new build
- Digital transformation programme
    - Successful delivery of the health system's digital transformation programme will support the implementation of the new integrated models of care and reconfigured patient pathways
    - Digital transformation programme is funded through alternative NHS capital sources

5.1.3 Key roles and responsibilities

The project is being led and driven by senior members of the Trust Executive and management team, all of whom have previous experience of business case development and project delivery across the NHS.

Table 58: Key roles and responsibilities

Role	Responsibilities
Director of Hospitals Transformation **Executive Lead (SRO)**	• Overall accountability for the delivery of the Hospitals Transformation Project (SRO) • Secure business case approval for the Project following and complying with National requirements and protocols • Leading the development and delivery of the agreed reconfiguration of clinical services and associated new models of care, ensuring compliance with National Standards • Collaboratively working with system partners and other organisations to ensure the successful delivery of the Project
Deputy Director of Hospitals Transformation	• Responsible for the day-to-day management of the Hospitals Transformation Project and the line management of the core project team • Work closely with the Director, managing the development of good business case documentation, which complies with National protocols/requirements, to support timely approval • Working closely with NHSEI, the Department of Health and Social Care and HM Treasury to support approval of the business cases • Utilising best practice management and implementation methodologies to govern the delivery of the project, ensuring that risks/issues are addressed in a timely way and that key stakeholders always have a clear understanding of project status/progress • Ensuring that the project remains on track to deliver the planned changes to the required quality standards and that appropriate mechanisms are in place to fully realise the targeted benefits • Managing the delivery of detailed project communication, ensuring clear communication and feedback to wider stakeholders, which includes the wider health economy and public, demonstrating the importance, activities and objectives of the project
HTP Medical Director	• Provide overall clinical leadership • Responsible for ensuring the clinical components of HTP are comprehensively developed and safely delivered • Lead the team of clinical staff that form the vital links between the project, the Divisions and the technical team for design and construction
HTP Nursing & Allied Health Professional (AHP) Director	• Ensure that clinical objectives inform and drive effective delivery of the project • Ensure engagement with nursing and AHP colleagues and leadership of the detailed design process • Provide a clinical voice, and ensure alignment with wider clinical priorities and developments
HTP Operational Director	• Ensure service objectives inform and drive effective delivery of the project • Ensure engagement with operational teams in the detailed design process

Role	Responsibilities	
HTP Clinical Directors	• Responsible for clinical staff engagement and ensuring clinical leadership of the detailed design process and alignment with wider clinical priorities and developments • Conduct regular clinical working sessions with clinicians, to provide the clinical voice, as well as lay partners and patient representatives to feed into the design phase of the hospital and ensure that facilities are built for quality patient care and safety	
Project Management Office (PMO)	Programme Manager	• Lead in the support, facilitation and monitoring of the progression and implementation of the project and workstreams • Managing risks, including the development of contingency plans, and highlighting any significant changes in risk status to the Project Director • Ensure that the project is managed in accordance with best practice and provide project coordination and planning capability to support the Project Director • Identifying and obtaining support and advice required for the management, planning and control of the project • Management of benefits realisation reporting and plans
	Project Managers	• Support the delivery of the Reconfiguration Programme through the management of component projects, including managing specific work streams and projects to achieve the intended benefits of the overall programme • Responsible for the day-to-day management of a project; start up, maintaining, supporting, facilitating, monitoring progress, closing and evaluating of the work streams
	Project Analyst	• Provide analytical support to the Project Management Office, including risk management, project status reports and associated report and actions logs • Monitor and escalate project progress and risks
	Project Support Officer	• Providing programme support to workstreams and project managers • Maintaining/supporting project/workstream documentation • Providing administrative support to workstream teams • Organising and minuting workstream meetings
	Senior Administrator	• Administrative support to the Project Management Office. Diary management, meeting minutes and general support
Implementation Leads	Surgery, Anaesthetics and Cancer	• Responsible for working with clinicians to deliver the key milestones and outputs • Ensuring plans align to the agreed clinical model, utilising best practice to meet the needs of patients, staff and visitors • Assist in the execution of workstream-specific tasks or duties • Liaising with design team on all matters relating to the clinical design of the buildings across all Trust sites
	Medicine and Emergency Care	
	Women and Children's	
	Clinical Support Services	
	Community and Local Care	
Business Partners	Workforce and OD	• Liaising with design team on all matters relating to the clinical design • Responsible for the delivery of the Workforce and OD workstream and its outputs which will be validated through governance arrangements

Role	Responsibilities	
		• Support Divisions with Workforce requirements and changes
	Communications & Engagement	• Responsible for creating and over-seeing key workstream communication material including plans and workstream updates • Responsible for developing communications that enable sound public and stakeholder understanding of the project
	Digital	• Lead the delivery of workstream outputs and digital support to enable the Clinical Model to be enacted.
	Strategic Estates	• Provide management and direction of workstreams and external resources • Liaise with technical advisers to ensure delivery of the project objectives
	Finance, procurement & Business Intelligence	• Lead the delivery of the workstream outputs

5.1.4 Use of specialist advisors

Specialist advisors have been appointed to support internal resources and are outlined below in Table 59:

Table 59: Specialist advisors used for this SOC

Area	Advisor
Architects	AHR
Mechanical and Electrical Engineering	DSSR
Structural and Civil Engineering	WSP
Cost Consultants	Edmond Shipway
Healthcare Planners	Strategic Healthcare Planning
Business Case Support	PA Consulting

In addition to the external resources utilised during the SOC stage, we are taking early action to identify the resources that will be required through the Business Case stages and into delivery, taking into consideration the procurement process and the lead time required to commission specialist advisors.

Previous work has been undertaken by some of these advisors throughout the HTP and Future Fit processes. In those cases, it may make sense for these advisors to be instructed to expand their contributions to support the OBC process, so that we can proceed at pace and minimise duplication. The arrangements for procuring the support needed to OBC and FBC stages, and enabling works, is provided in the Commercial Case.

5.1.5 Project management methodology

The project is being managed in line with PRINCE2 and MSP methodologies which are the de facto standard for the public sector in the UK. It is primarily resourced from within the Trust, with a dedicated project team – the Hospitals Transformation Team – which is supplemented by external specialist consultants where appropriate and necessary. The governance of the project is carefully structured with clearly defined roles for individuals; this ensures all team members understand their role and responsibilities and provides a clear and auditable route for decision making and the escalation of risks and issues.

The project structure and activity requirements are informed by a set of objectives which were agreed from the outset as outputs of the Future Fit consultation:

- to develop the best model of care that will deliver the outputs of the consultation and meets the needs of the urban and rural communities in Shropshire, Telford & Wrekin and mid-Wales,
- to prepare all business cases required to support the proposed clinical and service changes,
- to secure all necessary approvals for any proposed changes, and
- to implement all agreed changes.

5.1.6 Building Information Modelling (BIM)

The Project will fully utilise the NHS 3D BIM Model Principle across all its design packages to ensure continuity and efficiency in its design process and beyond. The initial design phase will be coordinated to ensure future PSCP contractor appointments can smoothly transition into the already established BIM design model with a recognised industry standard of practice.

5.2 Project plan and milestones

5.2.1 Key approvals

Key approvals for this scheme will include:

- ICS and Trust Board support of business cases (including design, procurement outcomes, contractor appointment, proposed deal, contracts and timelines),
- NHSEI (region and national) and Joint Investment Committee approval of business cases,
- NHSEI (region and national), DHSC and Joint Investment Committee approval of funding, and
- ICS and Trust Board sign-off of design for phased works (as appropriate).

The HTP team will manage delivery of these decisions to a clear and robust plan.

5.2.2 Key milestones and critical path

The key milestones for the preferred way forward, along with the dates by which they are anticipated to be achieved, are outlined in Table 60.

This is an ambitious timeline that seeks approval following OBC through FBC so we can begin to deliver benefits as quickly as possible. It is dependent on national support to make rapid progress through the relevant approval processes and to resolve the issues we face; dates post SOC submission is dependent on NHSE, DHSC and HMT reviews.

We will need support to progress quickly through the Joint Investment Committee to secure approval for the overall investment and to progress with the implementation of the preferred way forward.

Table 60: Summary of key milestones

KEY DECISION/APPROVAL	KEY DATES
SOC Submission	Q1 2022/23
Joint Investment Committee approval of SOC and agreement to proceed to OBC	Q2 2022/23
Appoint PSCP	Q4 2023/24
Completion of OBC	Q1 2023/24
Joint Investment Committee approval for OBC	Q1 2023/24
Joint Investment Committee approval of £30m Temporary works funding	Q2 2023/24
Completion of FBC (Including PSCP GMP)	Q2 2023/24
Joint Investment Committee approval of FBC	Q3 2023/24
Begin implementation of the Preferred Way Forward	Q3 2023/24
Completion of the Preferred Way Forward	Q3 2026/27

At the point of OBC approval, to enable the targeted implementation timelines for the preferred way forward to be met, the Trust will also be seeking early release of c.£30m for two additional elements of enabling work at RSH. The enabling work includes the delivery of temporary accommodation for the relocation of several operational departments currently within the footprint of the main build at RSH, such as Stores, Catering and Facilities; and the removal of asbestos from various areas of the RSH site (including the main underground duct network and other plant underneath the initial main build area). The costs associated with the enabling works are included within the overall capital costs of the preferred way forward (£312m).

If an alternative option on the short-list was chosen as the preferred option, this will affect the timing of enabling works and construction. Further work will be undertaken during development of the OBC to refine and expand this timeline.

The timeline has been constructed to take into account the expected approval processes and whilst ambitious, it ensures that the £312m of allocated capital can deliver as much value as possible. Any further delay would be likely to result in greater inflationary pressures, adjustments to PUBSEC calculations and a potential reduction in the scope of change that can be delivered. The detailed delivery plan will be provided at the OBC stage when the preferred solution will be worked up in greater detail. Initial discussions with Shropshire Council about planning applications have taken place to make them aware of the scheme, they are supportive and will engage further when we have detailed plan to discuss.

One of the key risks to the timeline is associated with timely progression through approval to proceed gateways, a risk that could potentially delay the delivery of the scheme resulting in additional inflationary capital pressures.

5.2.3 Project management costs

An allowance for project fees of 11% of works cost (for Preferred Way Forward) is included in the capital cost of the scheme, to which location factor, inflation, optimism bias and other allowances are applied.[31] This figure excludes the costs associated with the wider project management office for the transformation project.

Based on completed schemes, this is expected to be a sufficient budget to develop the scheme and manage it to successful delivery. The decision to include a fees allowance based on a typical scheme, reflects a prudent approach to make the scheme budget resilient to unforeseen requirements during later business case stages.

The overall expenditure on the SOC is less than is typical for a major capital investment, and reflects the historic work undertaken on the scheme which has been leveraged. We expect to make similar use of historical work as the OBC is developed and finalised.

The funding required to complete the OBC phase has been estimated at £9.9m. This includes the engagement of the design team to support all elements of the design work (£5.9m), the engagement of a strategic delivery partner (£1.5m) to support the development of the business case and other key strategic priorities, the engagement of the PSCP to support pre-construction activities (£1.5m) and the Trust's internal project team (£1m).

The funding required to complete the FBC phase has been estimated at £2.5m. This includes the continued engagement of estates contractors to support the finalisation of the FBC (£0.3m), the continued engagement of a delivery partner (£0.3m), the continued engagement of the PSCP to support pre-construction activities (£1.5m) and the Trust's internal project team (£0.4m).

The costs are driven by the tasks associated with the technical aspects of delivering a detailed and considered OBC as articulated through the relevant RIBA Stages & Greenbook guidance. Each technical advisor will be appointed through the nationally recognised SBS framework and has a line-by-line fee allocation for the completion of tasks that will support the development of the OBC, as defined in the stated guidance.

Estate's advisor fees for all pre-construction activities are in line with industry standards for the size and complexity of this type of multi-faceted scheme delivered across two live NHS sites. The costs have also been reviewed by the regional NHSEI team who recognise the challenges of developing two ageing sites and combining with new build requirements.

5.3 Benefits realisation and post project evaluation

5.3.1 Benefits realisation arrangements

We recognise the importance of benefits realisation to successful project delivery, so it is essential that we identify the benefits of the proposed changes and how these will be made real, so that a tangible improvement for patients can be seen, felt and measured.

As part of the investment planning a robust process will be established to monitor benefits realisation of which Trust Board will receive updates on progress and the key milestones and benefits mapped against the programme of work as we plan and implement proposals.

Responsibility for the operational and clinical delivery of the identified benefits outlined in the Strategic Case will lie with the HTP Delivery Group, which will report to the HTP Board, in line with the existing governance arrangements. These governance arrangements will be kept in place following the completion of the capital build to monitor and manage the delivery of the planned benefits. The HTP Committee and ICS Sustainability Committee will provide assurance in relation to the realisation of benefits and receive monthly updates, which will also be reported through to the Trust Board and the STW ICS CE Group / Board.

The HTP team will take responsibility for ensuring that the metrics for realisation of scheme benefits are measured and reported. They will also ensure that the measures which relate to wider system delivery are reported on, for

[31] This value is an allocated and typical design team percentage at this stage on a project, calculated using industry standard framework rates. This is a lump sum allocation at the SOC stage (a typical project manager or quantity surveyor cost within this overall allowance would typically be about 1–1.5% of the total allocation).

example, in relation to the overall financial sustainability of the Trust. The detailed understanding of the benefits and how these link to the service specific benefits will be captured on a benefits tracker. Two types of benefit will be tracked:

- one-off improvements which will be measured on opening (facilities) or three months after opening (feedback to ensure refinement of service), and
- underlying performance delivery improvement.

The benefits and associated benefits realisation plan will be further developed as part of the OBC. This will include specific owners, metrics and timescales for benefits realisation to support assurance and delivery as we move towards implementation.

Risks to the realisation of benefits are being considered and managed as part of the standard approach to risk management on the project. Risks are identified in two ways:

- the identification of risks by reviewing progress towards benefits realisation, and
- considering the impact of product/activity/project/work stream risks upon benefits realisation.

To ensure that benefits become part of the ongoing metrics, they will transition to business-as-usual reporting following the conclusion of the benefit realisation and measurement period, aligned to the trust's existing performance reporting. This will be outlined in more detail in the Outline Business Case.

5.3.2 Government Soft Landings

Government Soft Landings (GSL) will form part of the design and engagement process throughout the scheme.

The five stages of GSL across the construction lifecycle from inception to operational use and aftercare have been incorporated into the initial design discussions at inception stage for this SOC. Further work on soft landings will be incorporated into the detailed design elements of the scheme as we progress through OBC and FBC.

5.3.3 Post project evaluation arrangements

We recognise that there are a series of post-project activities which need to be undertaken following completion of the main build elements, include ongoing defects management, managing in-use issues, and undertaking appropriate post-project review and analysis. We are committed to undertaking a post-project evaluation after all key HTP stages through a formal evaluation methodology, with involvement from all appropriate internal and external stakeholders. These post project evaluations will be undertaken as an integral part of the monitoring of benefits realisation and ProCure23 requirements and will follow best practice.

These arrangements will be developed further though OBC and FBC as the benefits, commercial arrangements and timelines increase in certainty. The proposed process is in four stages:

Table 61: Post project evaluation review process

PPE Stage	Timing	Activities	Outputs
Setup	Delivered during FBC stage	• Validating benchmark period parameters • Collecting benchmark data (quantitative and qualitative) • Thematic analysis of qualitative data	• Evaluation framework • Benchmark data • Benchmark report
Documentation	Within 6 months of completion	Initial documentation issued to all parties to re-state the initial project objectives and what was intended to be achieved and then what was achieved	N/A
Evaluation session	Within 6 months of completion	Evaluation and feedback session with all key staff, including lessons learnt (typically held within 6 months of completion) to comprise a walk-round of the new facilities and then a series of structured sit-down workshops	Formal post-project evaluation report, including lessons learnt, formal KPI recording, and benefits realisation
Follow up evaluation session	Within 2 years of completion	Re-evaluation of achievements against aims and objectives	Formal post-project evaluation report

The evaluation will cover all aspects of the project, including the end product and the process, reviewing what was achieved against the original aims and objectives, recording actual performance (benefits, KPIs etc.), discussing what went well and what didn't go well, and ensuring any lessons can be learnt for future phases of the HTP and for future projects. The outcome of the evaluation will be reported through the Programme Board, to the ICS and Trust Board for noting or further action.

5.4 Managing risk (approach to risk management)

5.4.1 Risk management arrangements

The HTP Board oversees robust arrangements for the on-going management of risk associated with the programme are in place. Current strategies for the active and effective management of risk include:

- Identifying risks in advance and putting mechanisms in place to minimise the likelihood of them materialising with adverse effects,
- Having rigorous processes in place to manage the risks, supported by reliable, up to-date information, and including overall risk owners,
- Having agreed actions to control or mitigate against the adverse consequences of the risks with owners identified for each mitigating action, and
- Putting in place a risk management framework that ensures timely and appropriate monitoring and decision-making, supported by the right escalation protocols (utilising the project governance arrangements described earlier).

To identify the specific risks the programme uses several approaches that include:

- Structured review meetings involving the HTP board, clinical and operational advisory teams. This will encourage participation and ownership of the risks by key personnel,
- Risk audit interviews – conducted by experienced managers and/or external specialist advisers, with all those involved in the programme,
- Risk workshops – including all members of the project team and wider staff and stakeholder partners, and
- External and independent assessment (where appropriate).

All risks are identified within the individual workstreams and in dialogue with all relevant stakeholders.

We have identified a range of key strategic risks, and these are documented in a standardised project risk register (see Appendix I) and appraised for the likelihood of occurring and the potential impact, resulting in an overall RAG rating.

The Risk Management process will help to:

- Improve the certainty of project delivery in terms of cost, time, quality and stakeholder expectations,
- Highlight the important issues and focus the team's efforts on these,
- Give the team clear oversight of the risks, enabling timely mitigation and escalation,
- Encourage improved communication and understanding of the project amongst the team and the project stakeholders by articulating the stakeholder requirements,
- Enable better, informed decisions, and
- Assess the appropriate level of contingency funds required to manage the various risks so that funds may be released for other project areas.

The project team review the risks on a weekly basis (or more frequently if required) with a formal review undertaken by the HTP Board. All project risks with a risk score of 15 or more (calculated by multiplying likelihood by consequence) are also received by the Trust Audit and Risk Committee, the HTP Board and the Trust Board. The role of the Trust Board will be to assure itself that all risks are being identified and appropriately mitigated.

Further detail on the approach to risk management will be outlined in the next stage of the business case process.

The recommended Design and Optimism Bias risk allowances are factored within the project costs, these allowances will form part of the overall risk contingency allocation for the project and will reduce as the detail progresses The final risk allocation amount will be finalised and agreed by the trust and the PSCP to enable the agreement of the GMP before work commences.

5.4.2 Trust Board Assurance Framework

This proposed reconfiguration of hospital services helps to address a number of the strategic risks on the Trust Board Assurance Framework. The risks related to not being able to progress service reconfiguration leading to delays in delivering the consultation outputs and in addressing important quality, safety and sustainability issues such as:

- BAF1: Poor standards of safety and quality of patient care across the Trust results in incidents of avoidable harm and / or poor clinical quality
- BAF3: The Trust is unable to attract, develop or retain its workforce in order to deliver outstanding services

- BAF4: A shortage of workforce capacity and capability leads to deterioration of staff experience, morale and well-being
- BAF6: Some parts of the Trust's buildings, infrastructure and environment may not be fit for purpose
- BAF8: The Trust cannot fully and consistently meet statutory and / or regulatory healthcare standards
- BAF9: The Trust is unable to restore and recover services post-covid to meet the needs of the community / service users
- BAF10: The Trust is unable to meet the required national urgent and emergency standards

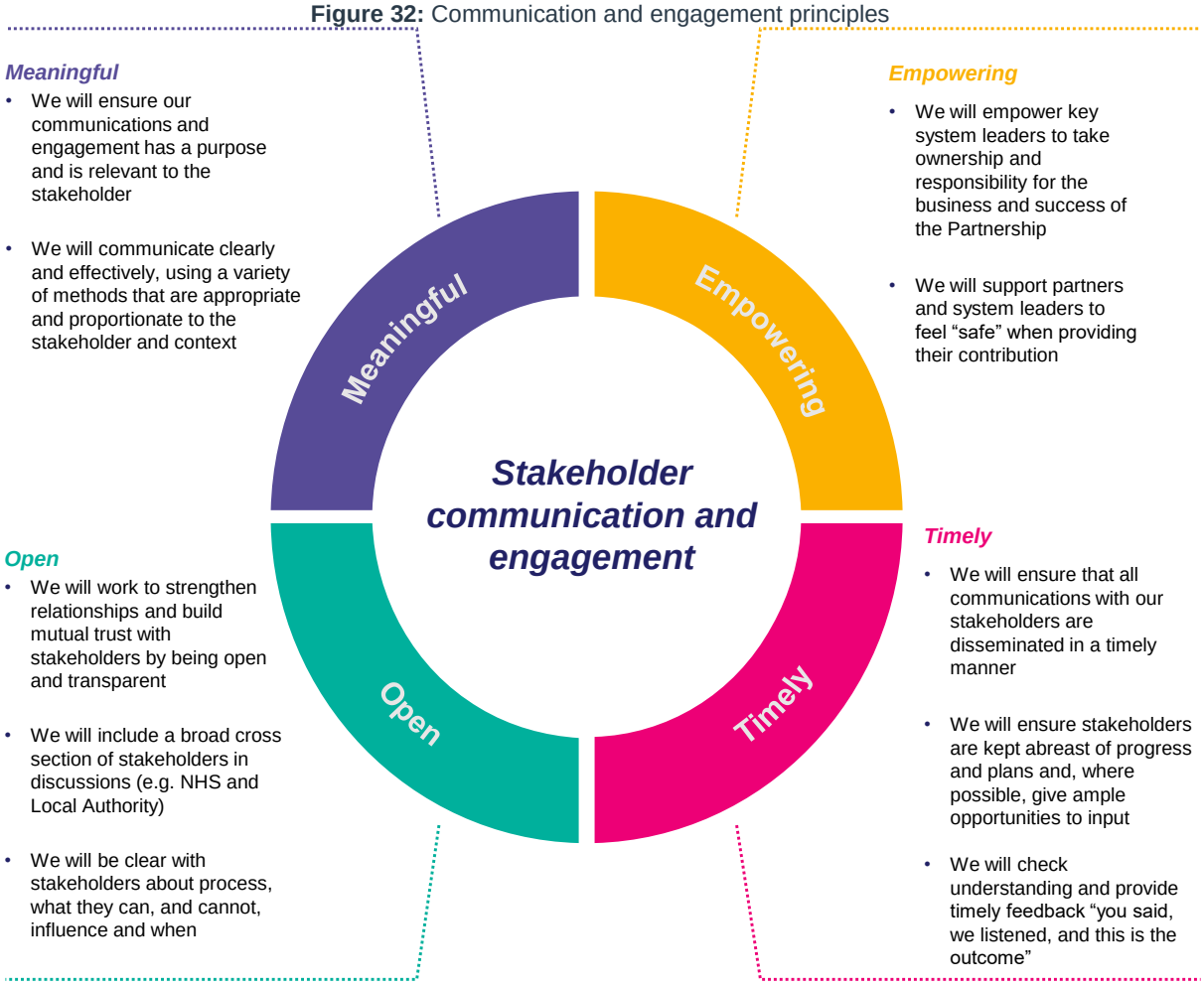
The Trust Board of Directors will continue to regularly review these risks and the interim necessary actions that are required to mitigate these risks as far as it is appropriate to do so.

5.5 Engaging our stakeholders

Good communication and engagement are integral to ensuring successful delivery. Our approach is centred on the following objectives:

- to demonstrate we are delivering a successful and innovative health care reconfiguration for our communities,
- to communicate the progress of HTP and its positive impact on the quality and safety of patient care,
- to involve and engage stakeholders with all aspects of the project
- to build public and internal support for HTP, and
- to work across the local healthcare network to develop effective relationships and to inform, engage and align communications messaging and outputs.

Figure 32: Communication and engagement principles



5.5.1 Summary of stakeholder engagement

Since 2019, there has been significant stakeholder engagement with our staff, public and system partners. The below table provides an indication as to the stakeholders and audience types involved. It also provides an indication of the type of engagement activities held and their content.

Table 62: Stakeholder groups and engagement approach

Stakeholder	Audience Type	Type of engagement
Internal Clinical and non-clinical	• Executive • Divisions • Clinical Leads • Clinical Departments • Staff groups	• Project development and design • Task and finish groups • Programme updates • Audit participation • Fact finding
External Public	• Healthwatch • Public panels • Community • Media • MPs	• Project updates
External System Partners	• ICS • Commissioners • GP's	• Project updates • Acute care provision and design • System wide programme integration

For HTP to be a success, ongoing effective, meaningful and timely, stakeholder communication and engagement is essential. It is fundamental to have a clear understanding of the interests of our key stakeholders and implement a strategy to address their needs, with an aim of alleviating concerns and ensuring the benefits for healthcare across the communities we serve are clearly communicated.

Table 63: Stakeholder plan

Stakeholder group	Details	Approach
Patients, service users and their families	We need to communicate and engage effectively with patients and service users and therefore will need to ensure it keeps patient experience at the forefront of plans and delivery. Involvement to focus on pathways and what this means for patients, particularly as part of OBC development.	• Newsletters • Community Engagement Meetings • Trust Public Assurance Forum • Social media • Traditional media • Creation of bespoke website • Attendance at local events • Development of marketing materials
General public	We need to ensure the locality is aware of the changes being made and how it may affect them, with the wide-ranging benefits across the area clearly communicated	• As above
Staff	We employ more than 6,000 members of staff, the majority of which live in-county meaning they and their families are also potential patients. We need our staff to be champions and advocates, which means it is vital to ensure that staff are informed and feel proud to back the scheme.	• Staff newsletters and bulletins • Roadshows • Workshops • Drop-in sessions • Development of marketing materials
Partners	We are working closely with a network of local organisation to deliver healthcare changes.	• Newsletters • Regular meetings – see HTP Governance structure • Update letters
Media	We need to work constructively with the media to ensure that the case for change is clearly communicated and why no change is not a viable option	• Media briefings • Regular press releases/updates

Stakeholder group	Details	Approach
Political	We need to engage and inform with all relevant political audiences and ensure they are fully and regularly briefed on the scheme, including progress towards implementation. As elected representatives, we will also need to be responsive to any concerns or issues raised through this engagement, regardless of whether they support or challenge the scheme.	• Briefings • Update letters
Seldom heard groups	We will need to ensure we are listening to and responding to people who fall within the below categories: Protected characteristics: • Age, sex, disability, gender reassignment, sexual orientation, race, religion or belief, marriage and civil partnership, pregnancy and maternity Further characteristics HTP will need to consider: • Language (where English is not the first language), Carers, Geography	• See patients, service users and their families and public

5.5.2 Stakeholder engagement approach

At OBC stage, the above stakeholder engagement plan will continue to progress. As we move through into OBC we will establish an HTP Communications and Engagement Steering Group, who will meet regularly to deliver the implementation of priority actions and ensure the communications and engagement workstream remains on track.

5.6 Impact assessment

5.6.1 Equality Impact Assessment

A full, refreshed Equality Impact Assessment (EIA) was developed in 2018. This took account of the recommendations from the original Future Fit impact assessments, particularly those that set out potential disproportionate impacts on certain groups within the nine protected characteristics.

This has been reviewed and remains current and relevant. This will be further refined at OBC and FBC stages to ensure the scheme is not detrimental to any protected group.

The EIA work examines if protected characteristic groups or other vulnerable groups, are likely to experience any disproportionate impacts from the proposals – either negatively or positively. The work paid particular attention to equality legislation and to showing how the Project is considering the needs and views representative of the nine protected characteristics under the Equality Act 2010 and the Public Sector Equality Duty 2011.

We specifically targeted four additional groups to engage during consultation:

- People living in rural areas
- People living in areas of deprivation
- Carers
- People whose first language is not English

Recommendations of this EIA and how they have been addressed to date are outlined below.

Table 64: EIA recommendations and actions

Recommendation	How this has been addressed
Develop an effective communications and engagement strategy	Detailed stakeholder mapping and engagement workshops have taken place, resulting in the communications and engagement strategy outlined in Section 1.5.2.
Develop a strong public awareness campaign	

Recommendation	How this has been addressed
Incorporate the potential impacts for access and travel on protected characteristics groups	Our approach to travel and transport is outlined in the commercial case. This will be further developed as the detailed design of the new estate emerges through the OBC process and we will work with local transport providers to make the new estate accessible for all groups.
Consider the impact of Out of Hospital Care Strategies and Neighbourhood Developments	We have worked closely with out of hospital providers in developing this SOC, which is outlined in the strategic case. The plans for the new estate and out of hospital plans are interlinked and interdependent. We will continue to develop these plans together over the OBC and FBC stages.
Address the areas of mitigation in the W&C Integrated Impact Assessment in 2017	Reviews of local midwifery care have been carried out. Most recently this involved listening to the views and experiences of hundreds of women and their families to understand how they want to be cared for and supported before, during and after having a baby. The review highlighted that the current model of midwifery care can be improved and a proposal for how we can transform the way midwifery care is delivered has been developed.
Ensure the on-going review of midwife led services	
Ensure the provision of appropriate accommodation for parents/carers	Parents and carers are considered in new hospital building standards, and the design as it is developed at the OBC stage will reflect these standards.

The findings of this report and draft recommendations and conclusions can be found in the full report in Appendix J.

5.6.2 Quality Impact Assessments

As part of the plan to put patients first and continually improve quality, we have implemented the widespread use of Quality Impact Assessments (QIA) for all service developments and plans. QIAs assess the impact any change will have on the quality of care that patients receive and aid the identification of risks within each clinical area.

These impacts and risks are then assessed and scored and form the basis of action plans and areas for further work. The Director of Nursing will receive a copy of each QIA when completed. The risks at service level are recorded on the service Risk Registers or escalated to the Corporate Risk Register where they rate 15 or above. The on-going monitoring of the QIAs is part of the Trust's governance and risk management process.

Project-specific QIAs have been developed and will continue to be updated and used as the basis for measuring impact and supporting the management of risk. These reviews identified key issues such as:

- Acutely ill patients arrive at the Planned Care Site requiring Emergency Care
- Our ability to maintain safe Emergency Services on both sites could be compromised whilst the sustainability plan is implemented
- We may not be able to recruit sufficient nursing and medical staff
- Hard to reach groups are not communicated or engaged with adequately

Every risk identified within the project QIAs were assigned mitigating actions which have been actively reviewed on an ongoing basis.

The production and implementation of the QIAs are the responsibility of the clinical workstreams, who will ensure these are up to date, adequately reviewed, and consulted on before the implementation of associated actions. Any key issues or risks which are identified within the QIAs will also be reflected within the project risk register and issues log as the scheme progresses. We have business continuity plans for safe, on-going delivery of patient care.

5.6.3 Net zero carbon

Achieving Net Zero Carbon in this proposal is dependent on the successful delivery of a new zero carbon energy centre. The scope of this project excludes the energy centre which is subject of a funding submission to the Public Sector Decarbonisation Scheme. Included within the scope of this project are all elements of the building fabric and the engineering infrastructure leading into and within the envelope of the various elements of the project but excluding the energy centre itself.

Relevant carbon emissions fall under three scopes:

- Scope 1 and 2: Greenhouse gas emissions that occur directly due to an organisation's activities or indirectly from its use of energy.
- Scope 3: Greenhouse gas emissions that occur due to our activities but which we have no direct ownership or control over.

Fossil fuels for heating, domestic hot water or standby power generation will not be used for the HTP development. The HTP development will provide electric vehicle charging facilities for Trust-owned vehicles which, in line with the NHS strategy, will have net zero emissions by 2032.

Removing Scope 1 emissions

The relevant Scope 1 site emissions that occur from sources that are controlled or owned by the Trust include the combustion of heating plant, catering and Trust-owned and operated vehicles.

The upgraded hospital will be fully electric, meaning direct Scope 1 emissions are removed. This full use of electricity will ensure that the carbon emissions of the building continue to fall with the expected reduction in carbon factors for grid electricity, with “true” zero carbon being secured by 2035 when the National Grid will be fully decarbonised.

Removing Scope 2 emissions

This electricity will be purchased from renewable sources, removing Scope 2 emissions. It is NHSEI England policy that from April 2021 only electricity with a full renewable energy guarantee of origin (REGO) will be purchased by NHS Trusts. This means our fully electric hospital, with no reliance on fossil fuels, would be deemed to be net zero carbon in terms of operational energy use as it would be powered from off-site renewable energy sources.

Offsetting Scope 3 emissions from construction

The new construction and major refurbishment will generate indirect Scope 3 greenhouse gas emissions, including:

- emissions from construction materials used in a new building,
- emissions from the transportation of construction materials used for the HTP development, and
- emissions from the process of construction.

We will offset these unavoidable emissions from redeveloping our hospitals.

In line with current industry best practice guidance, RIBA 2030 Climate Challenge target metrics for non-domestic buildings will be used (subject to change once bespoke NHS benchmarks are provided). This target is for the embodied carbon emissions associated with the construction to be maximum 750 kg/CO2e/m2 determined at practical completion of the HTP. Based on the 27,998sqm2 GIA of the Preferred Way Forward, this would equate to an estimated residual carbon for offsetting for the construction of 20,000 tonnes of CO2e.

This carbon should be offset using a recognised offsetting framework, either through net export of on-site renewable energy or the purchase of offsets. On-site renewable energy generated from solar PV will be used on site, as such offsetting would need to be demonstrated using an offsetting framework such as the Clean Development Mechanism and Gold Standard.

Additionally, the new build will achieve BREEAM ‘Excellent’ and the net zero carbon ambitions align with the trust’s Green Plan (see Appendix P.

5.7 Supporting arrangements for change (change management)

Service change and organisational development are key considerations, as the services provided to patients, communities and the quality of working life for staff are improved. Whilst implementing the HTP, we are working closely with staff and colleagues to create a change management culture that supports our values, embraces diversity, and ensures that people are empowered and listened to through the entire project lifecycle. We will also explore partnerships and buddying models with other Trusts which are experienced in large capital builds to enhance our delivery capabilities.

5.7.1 Organisational change management

The reconfiguration to be delivered with this scheme is part of our broader transformation, and as such the change management associated with this project fits into our broader change management approach. As the scheme develops through OBC and FBC this Trust change management approach will continue to develop and be refined in response to the design decisions taken.

We are delivering a comprehensive change management approach to continue to improve the delivery of care for our patients. Change in the Trust is managed under the Trust’s Management of Organisational Change policy which sets out a framework and principles for delivering change within the Trust; it further aims to provide a positive and transparent approach that will facilitate the timely and successful implementation of change. We have ensured that staff and their representatives have been included in a process of dialogue, as described in Section 5.4.

We have recent experience of implementing major service changes and will be able to use this experience to the benefit of this scheme. The reconfiguration will be implemented in a staged and systematic way that causes the least amount of disruption to services. Plans for the management of the transition include:

- The clinical working groups will oversee the transition required within each clinical centre. Within each clinical area (e.g., ED, critical care, women and children’s), clinical implementation teams will progress change within each clinical specialty.
- Implementation will be driven within each clinical division, led by the divisional teams and centre managers but with full support from the transformation team and corporate leads. Implementation plans with a detailed critical

path will be developed for each service. These will be based on the phasing and decanting plans identified by the construction teams. Each implementation plan will be used as the basis for the formal management of change process and the communication and engagement activities within each service area.

- New ways of working and the implementation of new care pathways will be phased and appropriately project managed. We have also engaged with other Trusts who have undertaken similar major configuration process to seek lessons learnt and best practice from elsewhere.
- Work will be undertaken to ensure our clinical and digital teams are able to implement the new IT systems and processes.
- Communication and engagement internally within the Trust, with partners and stakeholders and with patients and the public will be managed by the HTP team.
- Close working with partners to ensure pathways are integrated with primary, community and third sector partners.

5.7.2 Changes to workforce and ways of working

To deliver the clinical model, our workforce will increasingly be:

- Working more autonomously and delivering a more complex case load,
- Working in more flexible ways across traditional professional groups,
- Developed to support new roles required,
- Upskilled to take on extended roles,
- Required to use new technology to deliver clinical care and non-clinical services, and
- Adopting different working patterns e.g., 24/7 on site presence, 7 day working and delivering routine services in the evening and at weekends.

As such a phased workforce change approach will commence from year 1:

Table 65: Workforce Change Approach

Service model	Key service change driving changes	Changes
Emergency Department (ED) /UTC/AEC/CDU	Increased use of urgent care and out of hours services alternatives will mean a higher proportion of patients attending the Emergency Department and the Acute Medicine Services (SAU/AMU/AEC) could have: • Higher acuity because of major illness/life threatening conditions • Exacerbation of an acute episode of a long-term condition that cannot be managed within the community environment	• New models of working. e.g., 7-day on site consultant presence in ED & Acute Medicine and 7-day working models • Requirement for rapid access to specialist and technical assessments, diagnosis, and treatment across 2 UTC and 1 ED • Shared workforce through ED/AEC/CDU • Increased demand for multi-disciplinary advance clinical practice roles and increase in Emergency Nurse Practitioners • Increased utilisation of new roles e.g., Allied Health Professional (AHP) roles, pharmacy ED practitioners • Efficient ancillary and administration systems – workforce practices driven by technology
Medical and Surgical bed rebalancing	• Greater focus on 7 day working to deliver consistent standards of emergency and IP services 24hrs, 7 days per week • Concentration of provision of Emergency IP services and intense focus on safe acute inpatient care • Enhanced rehabilitation/frailty/discharge to assess model on Planned Care Site • Reduction in admissions and LOS associated with long term conditions	• Enhancing and developing new models of working • Increase in day case provision • Workforce will become less generalist and increasingly specialist within more than one specialised care area to meet the demand and enable workforce productivity • Development of new roles crossing professional boundaries at advanced and support level • Introduction of a 'cluster 'approach to working such that surgical/medical workforce cross cover at subspecialty level • Efficient ancillary and administration systems - workforce practices driven by technology

Service model	Key service change driving changes	Changes
Outpatient transformation	• Outpatients: reductions in outpatient activity and improved outpatients' efficiency, highest impact changes are assumed to be with follow up attendances • Increased utilisation of virtual service models for OP appointments • Service users with long term conditions will be managed, within integrated care models that cross over between health primary, secondary and social care models	• A reduction in medical and non-medical clinical and non-clinical practitioners aligned to OPD acute outpatient services i.e., nursing staff (WTE/PAs) • Conversion of a number of medical led OP follow up clinics becoming non-medical led clinics, will occur an increase in demand for advanced and highly competent practitioners i.e., nurses, AHP • Increase in the number of our staff becoming more autonomous workers and therefore becoming increasingly knowledgeable in working within high safety governance models • Increased use of technology – e.g., self-check-in • Efficient ancillary and administration systems – workforce practices driven by technology
Day case	Increased volume of day surgery	• Scheduling/PAs • Increase in demand in advance assistant roles i.e., specialist nurses, physician associates - delivering and or supporting the delivery of minor surgery • Increase use of technology – telemetry, telescopic instruments

During the OBC stage, we will develop a detailed workforce model based on the model of care laid out, the activity levels anticipated and the agreed schedule of accommodation. Some of this work has already been undertake as part of historic OBC level work, so this work will be refreshed to align to the current business case criteria and updated schedules of accommodation.

5.8 Arrangements for contract management

Our contract management arrangements will develop throughout the life of the project. In the initial stages, site reviews and appraisals, will play a bigger part and will be responsible for the contractual arrangements with the relevant organisations eventually leading to the completion of the employer's requirements for the scheme. The project scope and brief will continue to be developed through OBC and FBC, being 'fixed' on the completion of FBC in partnership with the appointed PSCP using NEC4 suite of documents. All key project documentation will be approved and formally signed off at the appropriate points by the appropriate parties, including the Project Board, ICS and Trust Boards. The approval process will be led by the HTP team.

Once these documents have been signed off, any proposed changes will need to be carefully considered, including the potential impact, and if required taken back to the appropriate party for the change to be authorised. Any proposed or required changes to the scheme in relation to the contract will be managed under a formal change control process as identified under the ProCure23 process and the NEC4 suite of documents.

The Trust's ProCure23 project manager will own the change control process and administer a project change register and change approval form, which will document all significant proposed changes, the impact of the change, and who needs to authorise. They will then seek appropriate sign-off of the change, ensure that the change is implemented, and appropriate documentation is updated as required. Any potential change which may have an impact on the project will be included on the risk register.

In relation to the design and build elements, NEC contracts utilised under ProCure23 frameworks have a robust management process for dealing with change, using the early warning and compensation event process. Any changes which have a significant impact on project, cost, or quality will be escalated to the project team or HTP Board for approval as required.

A full contract management plan for the development will be detailed out in the FBC when negotiations are finalised with the appointed PSCP Contractor.

Our Contract Management process will ensure that our appointed contractor(s) deliver, and we as the client receives the goods and services required at the right price, at the right time, to the right place and to the agreed quality.

The Contract management arrangements will develop throughout the life of the project and, in the instance of the key contractual relationship with the PSCP, it will be supported by the established methodology of the NEC4 form of contract as used in ProCure23 procurement framework.

It is recognised that management of the PSCP contract is critical to successful delivery of HTP and as part of the project planning which will progress in further detail during OBC and FBC, Contract Management expertise and

capacity will be identified with any in-house or external support appointments made with particular focus on NEC4 Project Management best practice.

Management of contracts and suppliers of other commercial requirements, such as technical advisors and consultants, will similarly use the best practice and behaviours relevant to each requirement. This ensures the supplier/contractor and authority's roles, and responsibilities are clear and managed appropriately.

Contract obligations will also be tracked as an explicit activity along with the logging of contractual risks/issues.

Any changes considered and then taken forward will ensure risks are allocated to party best able to mitigate them, with change control process followed for new and updated provisions. These changes will be progressed in line with the HTP governance process to ensure approvals are made with the level of oversight appropriate to the change.

Contract payment mechanisms, including tracking of changes, will form part of the HTP Contract Management plan that be developed during OBC and FBC.

5.9 Gateway review arrangements

We will continue to operate within the standard DHSC/NHS gateway process.

Over the duration of the project, there will be several gateway reviews. Two health gateway reviews, Strategic Assessment (Gateway 0) took place between 2014–16, following on from which actions were taken to address the recommendations. Details of future review timing will be agreed during the OBC project planning.

5.10 Approval of the SOC (and following stages)

The HTP team will work with regional and national regulators following the Trust Board approval of the SOC to support the national assurance of the SOC and deliver to the planned timeline.

5.11 Summary

We have in place robust performance management and governance arrangements that give confidence that the project will be successfully delivered and reinforce the strong STW ICS commitment and support.

We have a clear plan, and the resources in place to progress at pace through the upcoming business case stages and transition successfully to delivery. We have established robust approaches to managing and mitigating risks through this process and a benefits realisation approach to ensure that the anticipated benefits are delivered and measured.

The Preferred Way Forward will deliver the core DMBC requirements and an improved layout and facilities – delivering significant benefits to our patients across Shropshire, Telford & Wrekin and Powys.

We have strong project management experience and disciplines in place throughout the project, with qualified and capable internal and external resources identified that have a successful track record of delivery within rigorous timescales to ensure delivery.

Following the approval of this SOC, we are confident that we can secure the right resource capacity and capability – both in house and through access to external parties – to deliver the scheme successfully.

6 Conclusion

This case clearly outlines the urgent need to address the challenges presented by the current configuration and layout of acute services in Shrewsbury and Telford and to support the provision of long term sustainable, high-quality care for our communities. It seeks approval to rapidly progress and begin implementing these critical changes.

This case clearly outlines the urgent need to address the challenges presented by the current configuration and layout of acute services in Shrewsbury and Telford and to support the provision of long term sustainable, high-quality care for our communities.

This is a significant milestone in the development of major plans to invest in healthcare facilities for the people of Shropshire, Telford & Wrekin and Powys. It will enable us to provide modern, safe and effective emergency and planned care from dedicated facilities, leading to substantial improvements in the health of our population and their experience of care. It will also make our Trust an attractive place for people to come and work.

This SOC appraises a number of strategic options that will deliver the service reconfiguration agreed through the Future Fit consultation, thereby addressing a number of the health system's most pressing acute challenges. These challenges arise principally from two inadequately sized emergency departments, split site delivery of key clinical services (including critical care), insufficient physical capacity (particularly impacting elective services), mixing of planned and unplanned care pathways and poor clinical adjacencies.

In assessing the available strategic options, this SOC seeks to explore the most appropriate way to balance a number of competing priorities and objectives:

- delivering the full ambition behind the extensive public consultation (Future Fit)
- implementing new national standards - including Net Zero and increasing the proportion of single rooms in response to the issues highlighted by COVID-19 to allow effective management of pandemics
- establishing a sustainable infrastructure to support the delivery of excellent healthcare
- the funding available to achieve those changes - the current allocation of funding for this scheme is based on costings, inflation assumptions and national standards from 2016

Our preferred way forward involves investing £312m in Royal Shrewsbury Hospital and Princess Royal Hospital to provide improved facilities that will better meet the needs of our patients. It will put in place the core elements of the service reconfiguration described in the Future Fit consultation, help us to address our most pressing clinical challenges, and establish solid and sustainable foundations upon which to make further improvements. A number of significant challenges will remain, particularly in relation to the standard of patient accommodation at the RSH site, and whilst these can be managed over the medium term, they will need to be addressed in the long term.

The preferred way forward is also fully aligned with local health system objectives and is one of a number of strategic initiatives that will transform the health and wellbeing of the population of Shropshire, Telford & Wrekin and Powys. One of the core local health system assumptions underpinning the design of the HTP relies on the transformation of out of hospital services, which will be delivered through the ICS's Local Care programme and is expected to lead to a much lower increase in acute bed requirements over the medium to long term.

Our proposals offer excellent value for money for taxpayers, with a higher benefit-cost ratio than many public sector schemes (3.7) and a significant positive net present social value. We will continue to test the value for money of this scheme and identify ways to improve it, through the business case process.

The Trust has established rigorous governance arrangements (which also involve system colleagues) to support the successful delivery of this project and has a track record of delivering complex infrastructure developments to time and budget. Project timelines are dependent on securing timely approval of SOC, OBC and FBC.

This document seeks approval to progress to the Outline Business Case (OBC) with the Core DMBC ('Do Minimum') option as the preferred way forward, with a capital funding requirement of £312m.

Timely regulatory review and approval processes will be essential to maintaining the timescales for implementation outlined in this SOC and to minimising additional inflationary impacts on the capital funding requirement.

This document also seeks approval for the drawdown of additional capital funding totalling £9.9m to support the development of the OBC, including the detailed design work.

7 Appendices

Reference	Appendix	Link
1. A	Future fit decision-making business case	https://nhsfuturefit.org/key-documents/joint-committee-meeting/688-decision-making-business-case/file
2. B	Supporting strategies and plans	B1: STW System Development Plan B2: STW Estates Strategy B3: Trust Estates Plan
3. C	Demand and capacity methodology and detailed outputs	
4. D	Site plans, descriptions of options and supporting OB Forms	D1: BAU OB form D2: Core DMBC ('Do minimum') OB form D3: Core DMBC +key estates risks OB form D4: Core DMBC + Key estates risks + integration OB form D5: HTP DCP 3D slides D6: Schedule of Accommodation D7: OB mitigation form
5. E	Qualitative options appraisal evidence	
6. F	Detailed benefits of the Preferred Way Forward	
7. G	Benefits register and detailed methodology	
8. H	Net present social value calculation and CIA model	
9. I	Risk register	
10. J	Equalities and quality impact assessment	https://www.nhsfuturefit.org/key-documents/impact-assessment/2018-2/649-equality-impact-assessment-v26/file
11. K	CCG and ICS letters of support	K1: CCG letter of support K2: ICS letter of support
12. L	Completed NHSI checklist: Fundamental criteria	
13. M	Terms of reference	M1: STW ICS Group/Board M2: HTP Programme Board M3: HTP Implementation Oversight Group
14. N	Net Zero Carbon Strategy	
15. O	Digital Roadmap	
16. P	Green plans	P1: SaTH Workforce Travel Plan P2: Shropshire Health Procurement Service Sustainable Procurement Strategy
17. Q	Premises Assurance Model	