

# Hospitals Transformation Programme

## Appendices to the Outline Business Case (OBC)

Please note that all documentation was correct at the time of OBC submission, and the appendices referenced below do not include any revisions received subsequently. Therefore, some documents may be out of date or superseded.

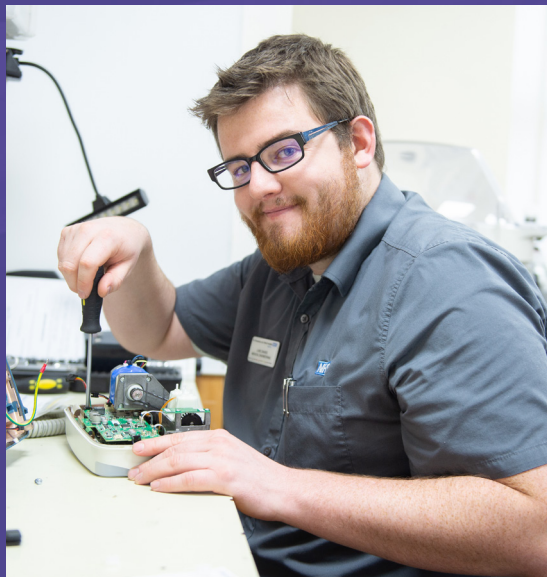
	Reference	Appendix Title	Link
Appendices	<b>Strategic Appendices</b>		
	S-01	Pre-Consultation Business Case	<a href="#">Pre Consultation Business Case V0.19 FINAL DRAFT Sept 2017.pdf (shropshire.gov.uk)</a>
	S-02	Consultation Response and DMBC	
	S-03	Strategic Outline Case	<a href="#">shropshiretelfordandwrekin.ics.nhs.uk/wp-content/uploads/2022/09/HTP_SOC_FINAL_v5_23.07.22.pdf</a>
	S-04	Integrated Care Partnership Strategy	<a href="#">PowerPoint Presentation (ics.nhs.uk)</a>
	S-05	Digital Strategy	<a href="#">Trust-Digital-Strategy-2022-25.pdf (sath.nhs.uk)</a>
	S-06	Digital Roadmap	
	S-07	Green Plan	<a href="#">244.21-Green-Plan.pdf (sath.nhs.uk)</a>
	S-08	Social Value Strategy	
	S-09	Recruitment and Retention Strategy	<a href="#">Recruitment-and-Retention-Strategy-2020-A4L_32pp-FINAL_flat-WEB-comp.pdf (sath.nhs.uk)</a>
	S-10	Trust Equality and Diversity Policy	<a href="#">sath.nhs.uk/wp-content/uploads/2021/01/EDI-Strategy_A4-L-8pp-v1-FINAL_flat-WEB.pdf</a>
	S-11	Regional and ICS Estates Strategy	
	S-12	Trust Estates Plan	
	S-13	Change Control Process	
	S-16	Trust Clinical Services Strategy	<a href="#">Clinical-Services-Strategy-A4-FINAL-v2-18.12.23.pdf (sath.nhs.uk)</a>
	S-17	ICS Letter of Support	
	<b>Economic Appendices</b>		
	E-01	Long List Appraisal	
	E-02	Risk Appraisal	
	E-03	Qualitative Options Appraisal	
	E-04	CIA Model	
	E-05	OB Forms	
	E-07	Meeting Arrangements for Option Agreement	
	E-08	Lifecycle Costs	
	E-09	Quantitative Appraisal PowerPoint	
	<b>Commercial Appendices</b>		
	C-01	Commercial and Procurement Strategy	
	C-02	RIBA Stage 2 Design Report	
	C-03	Letter from Local Planning Authority	<a href="#">Initial document template (shropshire.gov.uk)</a>
	C-05	Procurement Documentation	
	C-06	Travel and Transport Plan	
	C-07	Completed NHS Premises Assurance Model	
	<b>Management Appendices</b>		
	M-04	Communications and Engagement Strategy and Activity	

	M-05	NHSE Business Case Checklist	<a href="#">NHS England » Capital investment and property business case approval guidance for NHS trusts and foundation trusts</a>
	M-08	Governance Groups Terms of Reference (ToR)	
	M-09	People and Change Plan	<a href="#">A4-People-Strategy-2024-2030-FINAL-11.06.24.pdf (sath.nhs.uk)</a>
	M-10	Local Care Transformation Programme	<a href="#">Local Care Transformation Programme (LCTP) - STWICS</a>
	M-12	Risk Management Strategy	
	M-13	Evidence of Compliance with Government Soft Landings	
	M-15	Trust Operational Plan	<a href="#">068.23-Operating-Plan-23-24-and-final-budget.pdf (sath.nhs.uk)</a>





**Integrated  
Care System**  
Shropshire, Telford and Wrekin



# STRATEGIC APPENDICES



**The Shrewsbury and  
Telford Hospital**  
NHS Trust





# Decision-making Business Case

**V6.6.1**  
**January 2019**



**VERSION CONTROL**

Version and file name	Date	Nature of revision	By whom	Amended version shared with
V0.3	27.11.2018	Table of contents added / page number and header formatting	Haley Barton	Debbie Vogler
V0.4	28.11.2018	Updates to all sections	Debbie Vogler	
V0.5	03.12.18	Additions to section 6 re survey response quotations	Debbie Vogler	FF Programme Team
V0.6	04.12.2018	Full review of format and sense check: minor amends/ update Update Executive Summary to reflect changes	Niki McGrath  Debbie Vogler	FF Programme Team
V6.1	05.12.18	All Appendix referencing updated. Amend to section 8.1 Joint Board event output; section 9.3 Description of Services; section 10.1 trauma plan	Rebecca Dolbey  Niki McGrath  Debbie Vogler	
V6.2	06.12.18	Addition of 4.4, revision of TOC	Debbie Vogler  Rebecca Dolbey	Boards of Shropshire and Telford and Wrekin CCGs
V6.3	12.12.18	Minor amends/ typo corrections to text post CCG Boards. Including rewording sections 5.1; 5.11; section 6 page 50.	Debbie Vogler	Programme Board
V6.4	28.12.18	A number of minor amendments to txt made that were requested by CCG Boards. In addition note specific changes made to sections: 2. Executive summary updated with the recommendations and Tables 2.0 and 2.3 added; 5.4 T&W Council response narrative 6. Hyperlink to Sheffield study included; 9.1.4 Addition of digital narrative ; 10.2 reference added to		Boards of Shropshire and Telford and Wrekin CCGs Programme Board

		<p>WMQRS mapping for paediatrics;10.3 more detail on workforce plans; 11.1 Benefits realisation plan updated; Section 14 table 14.1 Section 15 recommendations added Section 16 conclusions added</p>		
v.6.5	10.1.19	<p>Minor amends and typo corrections resulting from full proofread and feedback from Boards and NHSE, and material changes as follows: Executive Summary:</p> <ul style="list-style-type: none"> <li>• p. 25: mitigations table added identifying the 5 mitigations from the recommendations</li> <li>• p.17: full table from section 3 added setting out actions from Joint Committee</li> <li>• p.23: Recommendations wording now reflect those approved by the Programme Board on 17th December 2018</li> </ul> <p>Section 2.2</p> <ul style="list-style-type: none"> <li>• p.14-16: Amendment to CQC reference</li> <li>• p.14-16: Additional wording around Long Term Plan included</li> <li>• p.15: amendments to reflect that "NHSI has now placed the Trust into special</li> </ul>	Future Fit team	Programme Board

		measures”		
		Section 3.0		
		<ul style="list-style-type: none"><li>• p27: Additional information on nursing workforce included</li></ul>		
		Section 5.4:		
		<ul style="list-style-type: none"><li>• p.55 Amendment to T&amp;W Council response to only include comments that were included in their formal response to the consultation</li><li>• p56: Joint HOSC Response: updated to reflect that the Joint HOSC response has now been received by the CCGs (further update may be added pre-Programme Board to reflect CCGs’ response to Joint HOSC)</li><li>• p57: Powys CHC Response: updated to reflect meeting on 08.01.18.</li></ul>		
		Section 5.11:		
		<ul style="list-style-type: none"><li>• p58: Amendment made relating to reference to Campaign Groups</li></ul>		
		Section 6.0:		
		<ul style="list-style-type: none"><li>• p.59: “Golden Hour” patient quote deleted and replaced by another patient quote</li><li>• p.60: Hyperlink</li></ul>		

		<p>to Sheffield paper and amended words to reflect abstract</p> <ul style="list-style-type: none"><li>• p.62: Quote inserted from West Midlands Clinical Senate around Trauma Unit</li></ul> <p>Section 9.1.4:</p> <ul style="list-style-type: none"><li>• p85: Additional section on use of digital technology as part of T&amp;T plan</li></ul> <p>Section 9.3.1:</p> <ul style="list-style-type: none"><li>• p.97: Amended wording to Ambulatory Care bullet point</li></ul> <p>Section 10.2:</p> <ul style="list-style-type: none"><li>• p.107: Additional reference to mapping paediatric skills and pathways at UCC planned care site to WMQRS standards</li></ul> <p>Section 10.3,</p> <ul style="list-style-type: none"><li>• p.107-111: More detail on workforce plans added in</li></ul> <p>Section 11:</p> <ul style="list-style-type: none"><li>• p.112-116: Original Benefits realisation set out in Future Fit Programme in 2015 referenced. Final OBC benefits tracker will reflect these.</li></ul> <p>Section 12:</p>		
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		<ul style="list-style-type: none"> <li>• p.117: Refresh of 12.1, 12.2 and 12.3 to accurately reflect the ongoing discussions regarding the Implementation Oversight Group and the governance post-decision making</li> <li>• p.122: Table 12.2 has been amended to create an updated timeline</li> </ul> <p>Section 14:</p> <ul style="list-style-type: none"> <li>• p.128: Amendment to table 14.1 to signpost to mitigations</li> </ul> <p>Section 15:</p> <ul style="list-style-type: none"> <li>• p.129: Recommendations wording now reflect those approved by the Programme Board on 11th December 2018</li> </ul> <p>A number of appendices have also been updated: Appendix 3: Travel and Transport Report Appendix 4: Draft Travel and Transport Report Appendix 5: Urgent Care Centre Specification</p>		
V.6.6	21.01.19	<p>Material changes as follows: Section 2.4 Summary of Recommendation</p> <ul style="list-style-type: none"> <li>• p.28: Section renumbered to Section 2.5</li> <li>• p.29: footnote added to</li> </ul>	Future Fit programme team	NHSE

		<p>Recommendation 5, point 5.3 re Powys.</p> <p>Section 2.5 Conclusions and Next Steps</p> <ul style="list-style-type: none"> <li>• p.29: Section renumbered to Section 2.6</li> </ul> <p>Table 3.1</p> <ul style="list-style-type: none"> <li>• p.38: Text on purpose of Workforce Transformation and Impact Mitigation modified to refer to 'the move towards delivering more services in the community'</li> </ul> <p>Section 3.5.6</p> <ul style="list-style-type: none"> <li>• p.43 Text relating to Northumbria Urgent Care Centres corrected to reflect non-24/7 opening</li> </ul> <p>New section 4.4 inserted p.53 re engagement with Powys CHC</p> <p>Section 4.4 p.53 Consultation Assurance renumbered to Section 4.5</p> <p>Section 5.4</p> <ul style="list-style-type: none"> <li>• p.59: Post-consultation feedback from WMAS included</li> <li>• p60: Powys CHC Response amended to reflect formal final response received on 9.1.19.</li> </ul> <p>Section 6</p> <ul style="list-style-type: none"> <li>• P.67: deletion of sentence: Whilst not material for NEPT or for emergency transport in</li> </ul>		
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		<p>Wales, the commissioners recognise that they will need to commission the appropriate capacity to support the new model of care.</p> <p>Section 8:</p> <ul style="list-style-type: none"> <li>8.1 p.83: paragraph re Stage 4 updated to reflect status after CCG and Programme Board meetings in Jan '19</li> <li>8.3 p83: Powys CHC Response amended to report formal final response received on 9.1.19.</li> </ul> <p>Section 9.1.4</p> <ul style="list-style-type: none"> <li>p.89 replaced bullet 2 to provide more information on the use of technology to access guidance on self-care and decision making</li> </ul> <p>Section 12</p> <ul style="list-style-type: none"> <li>p.121 Revision of all Section 12 to reflect the proposed post-decision-making Governance Structure</li> </ul>		
v.6.6.1	23.01.19	<p>Minor formatting corrections prior to publication</p> <p>Section 12 Table 12.2 p.127, Revision of milestone dates for SOC and OBC</p> <p>Removal of Draft status</p>	Future Fit Programme Team	Publication

## Contents

1.0	Supporting Information .....	13
1.1	<i>Glossary</i> .....	13
1.2	<i>List of tables</i> .....	15
1.3	<i>List of figures</i> .....	16
1.4	<i>List of appendices</i> .....	17
2.0	Executive Summary.....	18
2.1	<i>Purpose</i> .....	18
2.2	<i>Introduction</i> .....	18
2.3	<i>Addressing issues raised previously by the CCG Boards and/or NHSE</i> .....	20
2.4	<i>Decision-making Process</i> .....	24
2.5	<i>Summary of Recommendations</i> .....	27
2.6	<i>Conclusions and Next Steps for the Decision-Making Process</i> .....	28
3.0	Introduction .....	30
3.1	<i>Overview of process to date</i> .....	31
3.2	<i>Pre-Consultation Public and Patient Engagement</i> .....	31
3.3	<i>The Model of Care</i> .....	32
3.3.1	<i>Principles</i> .....	32
3.3.2	<i>The Proposed Changes</i> .....	33
3.3.3	<i>Improved Outcomes</i> .....	34
3.3.4	<i>Developing and Evaluating the Options</i> .....	34
3.3.5	<i>Integrated Impact Assessments</i> .....	35
3.3.6	<i>IIA Steering Group</i> .....	36
3.3.7	<i>Equality Impact Assessment</i> .....	38
3.4	<i>The Pre-Consultation Business Case</i> .....	38
3.5	<i>Independent Expert Advice and Assurance</i> .....	41
3.5.1	<i>West Midlands Clinical Senate</i> .....	41
3.5.2	<i>North Midlands and North Wales Trauma Network</i> .....	41
3.5.3	<i>NHS Transformation Unit</i> .....	41
3.5.4	<i>KPMG Review</i> .....	41
3.5.5	<i>Learning from Others</i> .....	42

3.5.6	<i>Northumbria Healthcare</i> .....	42
3.5.7	<i>Alignment with best practice guidance</i> .....	43
3.5.8	<i>NHSE Assurance Process</i> .....	43
3.6	<i>Capital Investment</i> .....	45
3.7	<i>Decision to proceed to consultation</i> .....	45
4.0	<i>The Consultation Process</i> .....	46
4.1	<i>Introduction</i> .....	46
4.2	<i>The Consultation Process</i> .....	47
4.2.1	<i>Consultation materials</i> .....	47
4.2.2	<i>Communications activities</i> .....	48
4.2.3	<i>Engagement activities</i> .....	51
4.2.4	<i>Staff Engagement</i> .....	51
4.3	<i>Joint Health Overview and Scrutiny Committee</i> .....	52
4.4	<i>Powys Community Health Council CHC</i> .....	53
4.5	<i>Consultation Assurance</i> .....	53
5.0	<i>The Consultation Findings</i> .....	55
5.1	<i>Survey Response Rate</i> .....	55
5.2	<i>Survey Data Feedback</i> .....	55
5.3	<i>Overall Themes</i> .....	58
5.4	<i>Feedback from Key Stakeholders</i> .....	58
5.5	<i>Travel and Transport Themes</i> .....	61
5.6	<i>Emergency Care/Urgent Care</i> .....	61
5.7	<i>Planned Care</i> .....	61
5.8	<i>Women and Children's</i> .....	61
5.9	<i>Stroke</i> .....	61
5.10	<i>Cross-cutting Stakeholder Themes</i> .....	61
5.11	<i>Campaigns Shropshire, Telford &amp; Wrekin Defend our NHS</i> .....	62
6.0	<i>Consideration of Common Themes</i> .....	63
7.0	<i>Integrated Impact Assessments</i> .....	73
7.1	<i>Integrated Impact Assessment 2016</i> .....	73
7.2	<i>Women and Children's Impact Assessment 2017</i> .....	74
7.3	<i>Developing IIA Mitigation Plans</i> .....	75
7.4	<i>Equality Impact Assessment</i> .....	76
7.4.1	<i>Recommendations from the EIA</i> .....	77

7.5	<i>Quality Impact Assessments (QIAs)</i> .....	80
8.0	Conscientious Consideration of the Consultation Responses .....	82
8.1	<i>The Approach</i> .....	82
8.2	Joint HOSC Response .....	84
8.3	Powys CHC Response .....	84
9.0	Addressing Key Mitigations.....	85
9.1	<i>Travel and Transport</i> .....	85
9.1.1	<i>Ambulance Impact Modelling</i> .....	86
9.1.2	<i>Safe Transfer of Patients</i> .....	88
9.1.3	<i>Travel and Transport Mitigation Plan</i> .....	89
9.1.4	<i>Use of Technology</i> .....	90
9.2	<i>Out of Hospital Care</i> .....	91
9.2.1	<i>Shropshire CCG/local authority area</i> .....	91
9.2.2	<i>Telford &amp; Wrekin</i> .....	95
9.2.3	<i>North Powys</i> .....	99
9.3	<i>Description of services on each site and in particular Urgent Care</i> .....	100
9.3.1	<i>Urgent Care</i> .....	102
9.3.2	<i>Emergency Care</i> .....	103
9.3.3	<i>Women and Children’s Services</i> .....	104
9.4	<i>Addressing Equality Impacts</i> .....	105
9.5	<i>Review of Affordability</i> .....	106
10.0	Addressing Other Issues Raised by the CCG Boards and/or NHSE .....	107
10.1	<i>Trauma Mitigation Plan</i> .....	110
10.2	<i>Paediatric cover in the urgent care centre on the planned care site</i> .....	111
10.3	<i>Developing Workforce Solutions and New Roles</i> .....	112
11.0	Benefits Realisation of Service Change.....	117
11.1	<i>Benefits Realisation Plan</i> .....	117
12.0	Implementation Governance .....	122
12.1	<i>Future Fit Programme Board</i> .....	122
12.2	<i>Role of the STP</i> .....	122
12.3	<i>Implementation Oversight Group</i> .....	124
12.4	<i>Sustainable Services Programme</i> .....	124
12.5	<i>Implementation Timetable</i> .....	125
13.0	Analysis of Proposals and Recommendation Formation .....	128

13.1	<i>Local Criteria for Service Reconfiguration</i> .....	128
13.2	<i>National Tests for Service Reconfiguration</i> .....	130
14.0	Decision-making .....	132
15.0	Recommendations .....	134
16.0	Conclusions and Next Steps for the Decision-making Process .....	136

## 1.0 Supporting Information

### 1.1 Glossary

<b>A&amp;E</b>	Accident and Emergency
<b>ACP</b>	Advanced Clinical Practitioner
<b>AEC</b>	Ambulatory Emergency Care
<b>BAME</b>	Black, Asian and Minority Ethnic
<b>BPT</b>	Best Practice Tariff
<b>BRP</b>	Benefits Realisation Plan
<b>CCG</b>	Clinical Commissioning Group
<b>CDG</b>	Clinical Design Group
<b>CDU</b>	Clinical Decision Unit
<b>CT</b>	Computerised Tomography
<b>DGH</b>	District General Hospital
<b>DH</b>	Department of Health
<b>DMBC</b>	Decision-making Business Case
<b>DVT</b>	Deep Vein Thrombosis
<b>EC</b>	Emergency Centre
<b>ED</b>	Emergency Department
<b>EIA</b>	Equality Impact Assessment
<b>EMS</b>	Emergency Medical Services
<b>FBC</b>	Full Business Case
<b>GP</b>	General Practitioner
<b>HEE</b>	Health Education England
<b>HOSC</b>	Health Overview and Scrutiny Committee
<b>IIA</b>	Integrated Impact Assessment
<b>IT</b>	Information Technology
<b>JHOSC</b>	Joint Health Overview and Scrutiny Committee
<b>LHE</b>	Local Health Economy
<b>LMC</b>	Local Medical Committee
<b>LMS</b>	Local Maternity Systems
<b>LOS</b>	Length of Stay
<b>LPC</b>	Local Planned Care
<b>LSOA</b>	Lower Super Output Area
<b>LWAB</b>	Local Workforce Action Board
<b>MDT</b>	Multi-Disciplinary Team
<b>MSK</b>	Musculoskeletal
<b>NEPT</b>	Non-emergency Patient Transport
<b>NHS</b>	National Health Service
<b>NHSE</b>	NHS England
<b>NHSI</b>	NHS Improvement
<b>NICE</b>	National Institute for Clinical Excellence

<b>OBC</b>	Outline Business Case
<b>ODP</b>	Operating Department Practitioner
<b>OOH</b>	Out of Hospital
<b>PCBC</b>	Pre-Consultation Business Case
<b>PCI</b>	Percutaneous Coronary Intervention
<b>PDC</b>	Public Dividend Capital
<b>PEP</b>	Programme Execution Plan
<b>PRH</b>	Princess Royal Hospital
<b>PTHB</b>	Powys Teaching Health Board
<b>PTS</b>	Patient Transport Service
<b>QIA</b>	Quality Impact Assessment
<b>RHIC</b>	Regional Health Infrastructure Company
<b>RJAH</b>	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
<b>RSH</b>	Royal Shrewsbury Hospital
<b>RTT</b>	Referral to Treatment
<b>SaTH</b>	The Shrewsbury and Telford Hospital NHS Trust
<b>SOC</b>	Strategic Outline Case
<b>SSP</b>	Sustainable Services Programme
<b>STP</b>	Sustainability and Transformation Plan
<b>T&amp;W</b>	Telford and Wrekin
<b>TU</b>	Trauma Unit
<b>UCC</b>	Urgent Care Centre
<b>UK</b>	United Kingdom
<b>W&amp;C</b>	Women and Children
<b>WAST</b>	Welsh Ambulance Services NHS Trust
<b>WM</b>	West Midlands
<b>WMAS</b>	West Midlands Ambulance Service
<b>WMQRS</b>	West Midlands Quality Review Service
<b>WTE</b>	Whole Time Equivalent

1.2 List of tables

Table No.	Title
2.0	Recommendations from the NHSE Assurance Process and/or actions agreed by the Joint Committee
2.1	Evidence against local criteria for service reconfiguration
2.2	Evidence against national tests for service reconfiguration
2.3	Mitigations referred to in Recommendation 5
3.1	“Expectations from the Programme Board” the priority areas for mitigation
3.2	Recommendations from the NHSE Assurance Process and/or actions agreed by the Joint Committee
3.3	NHSE Action/Mitigation requirements
7.1	Summary of potential disproportionate impacts of the proposed reconfiguration on people with protected characteristics
9.1	Impact of each option on each of the Emergency Service providers
9.2	Impact Summary: Restoring Performance to Baseline Position
9.3	Optimity admission avoidance figures against resources required to meet need
9.4	Revised predicted activity and financial reductions associated with neighbourhood work streams
9.5	The impacts identified within the EIA
10.1	Progress on issues raised as part of the NHSE Assurance process and by the CCG Boards and Joint Committee at the point of approval of the PCBC
10.2	Proposed workforce changes
11.1	Benefits Realisation Plan
11.2	Draft benefits tracker for acute reconfiguration of hospital services
12.1	Indicative timeline for Future Fit decision-making
12.2	Indicative timeline to implementation
13.1	Local criteria against which recommendations within this DMBC must be tested
13.2	Evidence against local criteria for service reconfiguration
13.3	Evidence against national tests for service reconfiguration
14.1	Rating of recommendations against local criteria and national tests for service reconfiguration in each service area



1.3 *List of figures*

Figure No.	Title
3.1	Phases of the Future Fit programme
3.2	Options development timeline
4.1	The Future Fit website
4.2	Social media communications
4.3	Media coverage
5.1	Survey feedback re: Option 1 by locality
5.2	Overall survey feedback re: Option 2
5.3	Survey feedback re: Option 2 by locality
5.4	Key themes used to analyse key stakeholder responses
7.1	Progress of impact assessment work
7.2	Governance structure for development of Quality Impact Assessments for operational change
9.1	Shropshire Care Closer to Home, Case Management Model
9.2	Neighbourhood working across Telford and Wrekin, progress in 18 months
9.3	Breakdown of services by site
10.1	SaTH workforce transformation to date
12.1	The Future Fit programme governance structure
12.2	Current SSP governance arrangements November 2018

1.4 *List of appendices*

Appendix No.	Title
<b>1</b>	2018 Future Fit Programme Equality Impact Assessment
<b>2</b>	2018 Equality Impact Assessment Mitigation Action Plan
<b>3</b>	2018 Travel and Transport Report
<b>4</b>	2018 Travel and Transport Mitigation Action Plan
<b>5</b>	SaTH Urgent Care Centre draft specification
<b>6</b>	SaTH Draft Operational Policy for the Transfer of Patients between the Emergency site and the Planned Care site
<b>7</b>	PICU 7a – PICU Time Transfer vs.1 7b – PICU Transfer vs8 7c - Transfer of Children
<b>8</b>	2018 Future Fit Consultation Findings Report
<b>9</b>	2018 ORH – Modelling Options for Change
<b>10</b>	2018 Summary of Key Stakeholder Responses
<b>11</b>	2018 Telford and Wrekin Neighbourhood Update
<b>12</b>	2018 Shropshire Care Closer to Home Update
<b>13</b>	2018 Powys Teaching Health Board Annual Plan
<b>14</b>	2018 Northumbria Comparator Summary Report
<b>15</b>	2018 Summary of Individual Responses
<b>16</b>	IIA Mitigation plan
<b>17</b>	Key QIAs 17a) Corporate QIA 17b) Scheduled Care 17c) Support Services 17d) Women and Children's QIA 17e) Unscheduled Care QIA 17f) QIA IA Update 25.10.18
<b>18</b>	2018 Joint Committee Terms of Reference
<b>19</b>	Review of Consultation methodology and compliance with statutory engagement
<b>20</b>	2018 Stakeholders responses in full
<b>21</b>	Benefits Realisation Plan

## 2.0 Executive Summary

### 2.1 Purpose

The purpose of this decision-making business case (DMBC) is to support the Shropshire and Telford & Wrekin CCGs in their final decision-making process for determining reconfiguration of acute hospital services. Clinicians, patients and members of the public have actively participated in the Programme since the Call to Action in 2013. Five years later, from long list to short list, from options appraisal to preferred option, following due process and independent assurance of that process and from engagement through to formal consultation, the CCGs believe it is now necessary and appropriate to draw their final conclusions from all of this work.

This DMBC has been developed post consultation and primarily updates the information set out in the Pre-Consultation Business Case (PCBC). It therefore must be read in conjunction with this document. This DMBC demonstrates how the Programme has conscientiously considered the consultation feedback in the final proposals and how it will address key concerns raised by the public and stakeholders through a series of mitigations.

Further detail supporting this DMBC is available in a series of documents that the Programme has previously considered as well as a small number of additional documents that have been produced to ensure the Joint Committee is fully informed. These documents are referenced throughout this report and are either listed as appendices or, for convenience, as links to a folder on the Future Fit website: <https://nhsfuturefit.org/key-documents>.

### 2.2 Introduction

The Joint Committee of Shropshire and Telford and Wrekin Clinical Commissioning Groups (CCGs) will meet on 29<sup>th</sup> January 2019 to make decisions on the proposed changes to acute hospital services, as set out in the NHS Future Fit public consultation. The proposals describe the realisable patient benefits from consolidating and strengthening specialist clinical teams to improve patient outcomes, quality of care and timely access to services. This will be achieved through changing the way hospital services are provided by the Shrewsbury and Telford Hospital NHS Trust (the Trust) at the Royal Shrewsbury Hospital and the Princess Royal Hospital so that one hospital provides emergency care services and the other hospital provides planned care services (with both providing 24/7 urgent care).

Local acute hospital services have struggled to continue to develop over many years with clinicians, managers and staff trying to keep pace with changes in demand, improvements in medicine and technology and increased expectations of the populations served. All stakeholder partners recognise now that the current acute hospital configuration is not sustainable.

Workforce is the primary driver for the proposed changes and the situation has become critical. There are serious recruitment challenges across a number of specialties due to poor employee experience related in part to the duplication of services across two sites and the resulting onerous staffing rotas. Linked to this there are currently high levels of locum cover resulting in premium costs and the potential for sub-optimal care. Staffing levels do not meet those recommended for A&E, critical care and emergency care. This is not sustainable and clinical standards in care have now been deemed inadequate by the CQC. A number of improvement notices have been served on the Trust from an inspection in 2018 and NHSI has now placed the Trust into special measures.

After five years of developing proposals and deliberation, the CCGs must now support the Trust to reconfigure its services and consolidate specialists who can deliver high quality emergency care onto one site and protect planned care activity on the other site, therefore

providing a high-quality patient experience whilst keeping as many services as possible locally.

These changes are in line with the NHS Long Term Plan, which was published on 7<sup>th</sup> January 2019 and has a vision for a new service model for the 21st century. The model for acute care and the interdependent activities support the five major practical changes to:

- 'boost out of hospital care'
- redesign and reduce pressure on emergency hospital services
- offer more personalised care and control over our own health
- mainstream digitally-enabled primary and outpatient care
- increase focus on population health through Integrated Care Systems (ICSs)

NHS and local authority organisations in Shropshire, Telford and Wrekin are now working together with other partners to 'translate' the plan into local action.

The timing of the decisions made regarding Future Fit and the ongoing interdependent activity, such as the out of hospital and community programmes, coincides with the release of the Long Term Plan and therefore the decision on the Future Fit proposals will be pivotal to the local 'translation' of the Plan.

This reconfiguration requires a significant capital investment which is desperately needed in the facilities and buildings across both acute sites for them to continue to deliver 21st century healthcare. Significant amounts of the existing Trust estate do not achieve a satisfactory standard and a substantial number of areas were unacceptable in a recent survey, particularly at the Shrewsbury site.

Additionally, the local health system is in deficit, it spends more in a year than the funds allocated to it. To be able to respond to increasing demand and to reduce the deficit is one of the goals of the change programme and will require both the public and those who work within the health system to view the delivery of acute services differently in the future.

The CCGs believe that the proposals set out in this document can result in a number of measurable improved outcomes for patients:

- Improved clinical safety and effectiveness through patients being cared for by the right clinician with access to senior decision makers and enhanced ambulatory emergency care and fewer unnecessary admissions
- Improved experience of care through well-designed appropriate capacity and physical settings, promoting more healing for patients and improved patient experience through improved privacy and dignity
- Separation of emergency and planned care resulting in fewer delays and cancellations of operations
- Better support for people with long term conditions and for people living independently through early access to a consultant opinion, fewer admissions and reduced length of stay and less decompensation in frail, older people
- Equitable access to services through patients waiting less time in A&E, waiting less time for operations and avoiding cancellations

Through this DMBC, the Joint Committee of Shropshire and Telford & Wrekin CCGs is asked to make decisions in relation to the proposed service reconfiguration changes across the two acute hospitals.

The meeting of the Joint Committee of Shropshire and Telford & Wrekin CCGs and the recommendations it is being asked to consider are now critical. It is a key step in the process to deliver a high quality, sustainable and affordable health and care system for the

population of Shropshire, Telford & Wrekin and mid Wales. The recommendations arise from a lengthy development process beginning in 2013, involving discussion and engagement with partner organisations, patients, professionals and the public. This document sets out the context in which these recommendations have been developed and provides detail on all sources of information and evidence that have been considered in generating them, enabling the Joint Committee of Shropshire and Telford & Wrekin CCGs to make decisions in line with its terms of reference, and the constitutions of the individual constituent CCGs.

Accordingly, this DMBC includes:

- Section 4: A description of the public consultation process methodology
- Section 5: A summary of the consultation findings
- Section 6: Consideration of the common themes from the consultation
- Section 7: The health, access, equality and quality impact assessments
- Section 8: The approach taken to conscientious consideration
- Section 9: Addressing issues raised through developing key mitigation plans
- Section 10: Update of work undertaken for CCGs and NHSE since PCBC approval
- Section 11: The approach to benefits realisation going forward
- Section 12: The proposed approach to implementation governance
- Section 13: An analysis of proposals and recommendation formation
- Section 14: Setting out decision-making
- Section 15: Setting out draft conclusions and recommendations

This DMBC should be read in conjunction with the PCBC published in November 2017 and the public consultation documents published on 30th May 2018, which provide the background to the proposals and the content of the consultation.

### **2.3 Addressing issues raised previously by the CCG Boards and/or NHSE**

Within the PCBC a number of additional recommendations for further work pre-final decision-making were set out, that were either recommendations from the NHSE Assurance Process and/or actions agreed by the Joint Committee of Shropshire and Telford & Wrekin CCGs. These are also reflected in the Consultation Document and are set out below:

- further develop the model of care in the community
- look at mitigation plans to lessen the negative impact for women and children and older people, their families and carers, particularly around travel
- understand more how the Urgent Care Centre at the Planned Care site will be staffed by skilled professionals to deliver the high level of care required for children
- understand the effect of the proposed changes on the demand for both emergency and non-emergency ambulance and patient transport
- consider new ways of working in the future, including new staff roles
- further test affordability, specifically around the availability and source of capital
- more detail on proposals for any repatriation of patient services including any relevant QIAs

These have all been captured in Table 2.0 below. Additional assurance has been received for all elements. The table references where more detail can be found within this DMBC for each individual theme.

Reference	Action/Mitigation requirement	Deadline for completion	Action progress update
NHSE Assurance Oct/Nov 2017	<b>Trauma Mitigation Plan</b> - Detailed plans to mitigate potential negative impacts of the final proposal in relation to trauma patients should be agreed and included in this post consultation DMBC.	Pre DMBC	Specialised commissioning (as leads in commissioning major trauma, critical care and neonates) submitted its letter of support for consultation on both options. A number of potential mitigations for further exploration were listed in the PCBC, were option 2 to be implemented. Clinical engagement with ambulance service is ongoing through SSP process. Recent discussions with the Trauma Network and the ambulance service are described in 10.1 below.
NHSE Assurance Oct/Nov 2017	<b>DMBC</b> -NHSE to assure the decision-making business case.	Pre-decision-making meeting	Checkpoint on 20th December 2018.
NHSE Assurance Oct/Nov 2017	<b>Benefits Realisation</b> - Detail on the expectation of improvements in performance that the proposals will drive and the key underpinning milestones to achieve such improvements.	OBC	Captured in Future Fit PCBC. Updated detail set out in section 11 of this DMBC  Further and final development during OBC compilation. Updated benefits tracker received from SATH Oct 18.
NHSE Assurance Panel Oct/Nov 2017	<b>Engagement with Specialised Commissioning</b> - Ensure robust engagement with Specialised Commissioning on potential impacts on Neonates, Cancer and Trauma.	Pre DMBC	Regular contact with Specialised Commissioning is in place and its input will form part of the decision-making process in relation to all 3 areas. SMT meeting in January to confirm no further information or assurance required should there be no material change to preferred option. Letter of support for this DMBC to be included in NHSE checkpoint.
NHSE Assurance Panel Oct/Nov 2017	<b>Ambulance services</b> - Impact on ambulance service requires modelling.	Pre DMBC	Travel and Transport modelling completed by ORH and is included within this DMBC section 9 and Appendix 9.

Table 2.0 Recommendations from the NHSE Assurance Process and / or Actions Agreed by the Joint Committee



Reference	Action/Mitigation requirement	Deadline for completion	Action progress update
CCG SOC/PCBC approvals 2016/17	<b>Workforce</b> - Further testing of workforce model detail through the Clinical Development Group pre-implementation.	OBC	Updates received from Chair of STP Workforce Group at Programme Board and IIA meetings on the progress against recruitment into new roles. Update included in section 10.3 below.
CCG SOC/PCBC approvals 2016/2017	<b>Repatriation</b> - Clarification on any proposed repatriation including Quality Impact Assessments (QIAs).	Pre DMBC	QIAs to be completed where appropriate. Currently no assumptions around repatriation of new service QIAs found in section 7.5 and appendix 17.
CCG SOC/PCBC approvals 2016/17	<b>Out of Hospital Care</b> - potential impact on primary care and community services in activity shifts, and changes in financial flows.	Pre DMBC	Forms part of the Out of Hospital Care Programmes now established by both CCGs. Significant work has taken place in each CCG. CCG executive leads will need to assure their Boards of the plans. This DMBC has updated progress and any change in assumptions in Section 9.2.
CCG SOC/PCBC approvals 2016/17	<b>Affordability</b> needs further testing, including the assumptions around investments and efficiency savings.	Pre DMBC	Post consultation and the decision on any preferred option, assumptions to be tested if material changes proposed to the model set out in the PCBC and any material changes set out in this DMBC. No material changes.
Joint Committee PCBC approvals 2017	<b>Paediatric Cover</b> - appropriate paediatric cover in place at the urgent care centre on the Planned Care site.	Pre DMBC	Paediatric cover was set out in the PCBC. Clarification on skills will be further set out in this DMBC and will include: A summary of a joint agreement by Unscheduled Care Group Medical Director, Clinical Director Emergency Department, Consultant Paediatrician and GP leads from both CCGs on the Planned Care site UCC and the assessment and treatment of adults and children with minor illness. How the workforce model in the UCC will meet the Royal College of Paediatrics and Child Health guidance (June 2018). See section 10.2 below.

Table 2.0 continued: Recommendations from the NHSE Assurance Process and / or Actions Agreed by the Joint Committee

Reference	Action/Mitigation requirement	Deadline for completion	Action progress update
Joint Committee PCBC approvals 2017	<b>Travel and Accommodation</b> - mitigation is put in place for travel and accommodation needs for women and children using the Emergency Care site and for older people particularly using the Planned Care site.	Pre DMBC	Assurances given around <i>like for like</i> accommodation requirements included within specifications and costs for paediatrics facility. Travel and Transport Group established to consider impacts and mitigations in relation to public transport. Taking account of consultation feedback, a high-level Mitigation Action Plan has been developed and is included in this DMBC in Section 9.
Joint Committee PCBC approvals 2017	<b>Ambulance Services</b> - carefully balanced ambulance services need to be put in place.	Pre DMBC	Ambulance modelling for emergency and non-emergency activity completed by ORH, summarised in section 9 and included in this DMBC in full in Appendix 9.
Joint Committee PCBC approvals 2017	<b>Workforce Solutions</b> - the local NHS needs to be innovative with developing workforce solutions and new roles.	Pre DMBC	SaTH has produced a 5-year Workforce Plan and progress has been made on recruitment to new roles. This is set out in this DMBC. Progress on developing the wider system workforce solutions will emerge from the out of hospital care plans for both CCGs and for the STP system as a whole and will need to be set out in the OBC and FBC prior to approval. Update in section 10.3.

Table 2.0 continued: Recommendations from the NHSE Assurance Process and / or Actions Agreed by the Joint Committee



## 2.4 Decision-making Process

The Gunning Principles are a set of rules applicable to all public consultations that take place in the UK and are designed to make consultation fair to both consultor and consultee. Failure to follow the four Gunning principles may lead to a judicial review. The fourth principle states that the product of consultation must be conscientiously taken into account when finalising the decision. Our approach to the decision-making process has been designed based on best practice and legal advice to ensure this is adhered to.

Therefore, recommendations within this DMBC have been tested against the local criteria (as defined in the PCBC and used in the non-financial appraisal of options) and the prescribed national tests for reconfiguration. Sections 13 and 14 consider these tests and bring together the consultation findings and other recent work completed since the PCBC approval in 2017.

The tables below summarise the evidence that has been reviewed pre- and post-consultation to support decision-making and the development of recommendations to the Joint Committee of Shropshire and Telford & Wrekin CCGs. Where appropriate, appendices to this DMBC are referred to. References to other documents are in italics and can be found on the Future Fit website in full or as links to external websites.

Local Criteria	Pre-consultation evidence considered	Post consultation evidence considered
<b>Access</b>	Non-financial Appraisal September 2016: access impact for emergency, planned and Women & Children (car and public transport) <i>Integrated Impact Assessment 2016</i> <i>Integrated Women &amp; Children's Impact Assessment 2017</i> IIA Steering Group <i>IIA Mitigation Priorities Plan</i>	Equality Impact Assessment (EIA) 2018 (Appendix 1) EIA Mitigation Plan Response to Consultation Findings (Appendix 2) Travel and Transport Report (Appendix 3) Travel and Transport Mitigation Plan (Appendix 4)
<b>Quality:</b> <b>Time critical</b> <b>Journeys</b> <b>Safety</b> <b>Effectiveness</b> <b>Patient Experience</b>	<i>Non-financial Appraisal briefing pack</i> Compliance with best practice guidance set out in PCBC <u><a href="#">WM Clinical Senate Stage 2 and review of progress against recommendations</a></u> Professor Sir Keith Porter support for Trauma Unit at RSH Trauma Network letter support for Option 1 Specialised Commissioning letter of support Ambulance service conveyance times Task and Finish Group UCCs Pre-consultation engagement report	UCC draft specification (Appendix 5) <u><a href="#">Urgent Treatment Principles and Standards NHSE 2017</a></u> SSP Review of alignment with best practice updated in this DMBC section 3. Draft Transfer Policy (Appendix 6) PICU Time Critical Transfer Policy (Appendix 7) Response to Consultation Findings (Appendix 8) ORH ambulance modelling data (Appendix 9) Ambulance services and Trauma Network meetings Response from other providers (Stakeholder Response Analysis Appendix 10) Outcome of Programme Board event Nov 2018 Engagement with seldom heard groups during consultation <u><a href="#">Future Fit FAQs</a></u>
<b>Workforce</b>	<i>Non-financial Appraisal briefing pack</i>	SSP Staff engagement programme

	Future Fit Workforce workstream PCBC workforce plans	STP Workforce workstream Updates on recruitment progress to Programme Board Work of the LWAB
<b>Deliverability</b>	<i>Non-financial Appraisal briefing pack</i> Letters of support SaTH, Letter of support PTHB Letter of support WMAS Draft OBC	Report on Neighbourhoods T&W (Appendix 11) Report for Shropshire Care Closer to Home (Appendix 12) PTHB Annual Plan Summary (Appendix 13) Provider responses to consultation Deliverability statement SaTH (TBA)
<b>Financial Affordability</b>	Financial appraisal of options <i>Financial Feasibility Study 2014</i> PCBC financial and economic case NHSE stage 2 assurance process 2017	Review of financial plans within PCBC by STP Finance Group ORH ambulance modelling data Refresh of admission avoidance data Northumbria Comparator 2018 (Appendix 14) NHSE Assurance Process Dec 2018

Table 2.1 - Evidence against local criteria for service reconfiguration

National Criteria	Pre-consultation evidence considered	Post-consultation evidence considered
<b>Strong public and patient involvement</b>	Call to Action 2013 <i>Options Appraisal Report 2016</i> Patient representation on Programme Board and workstreams <i>Pre-consultation Engagement Report</i> <i>Consultation Plan</i> Consultation Methodology Engagement with CHC and JHOSC Stakeholder Reference Group	Seldom heard groups engagement and EIA Report Participate Consultation Report: Stakeholder Response Report Individual Response Report (Appendix 15) Patient representation during conscientious consideration events with CCG Board and Programme Board Engagement with CHC and JHOSC
<b>Consistency with current and prospective need for patient choice</b>	Clinical Model set out in consultation: many services remaining on both sites; some services already exist on one site Out of county flows for specialist care will remain same as now 80% will continue to go to where they go now for urgent and emergency care	Strategies around care closer to home Development of clinical model for maternity community hubs Ambulance modelling assurance around capacity UCC both sites 24/7
<b>Clear clinical evidence base</b>	Clinical consensus for the model Alignment with best practice guidance <i>WM Clinical Senate Stage 2 Review</i> Trauma Network View <i>NHS Transformation Unit Review</i>	Clinical consensus for the model Programme Board event Nov 2018 SSP Review of alignment with best practice guidance (DMBC) UCC draft specification Urgent Treatment Centres Guidance 2017 Ongoing engagement with SSP, ambulance services and Trauma Network Engagement with Specialised Commissioning
<b>Support from clinical commissioners</b>	SOC and PCBC approval by CCGs Unanimous support for consulting on preferred option 1 and option 2 Caveats set out for further work	EIA and mitigation plan SSP QIAs (Appendix 17) Travel and Transport Report Paediatrics cover in UCC ORH ambulance modelling
<b>Bed/capacity</b>	Growth of 2.8% included	Refresh of Neighbourhoods and

<b>requirements</b>	Overall clinical spaces increase from 877 to 991 (PCBC) Assumptions around circa 5,000 avoided admissions over 5 years	Care Closer to Home strategies Admission avoidance assumptions retested in this DMBC NHSE Assurance process
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*Table 2.2 - Evidence against national tests for service reconfiguration*

Future bed requirements are based on the predicted number of patients that the hospitals will expect to see. This is as a result of more patients being cared for in their locality and the expected growth in population and demand. The increased number of beds is also partly associated with reducing the bed occupancy rate. This will help ensure that there are enough beds to be able to respond to peaks in demand and will avoid the situation currently faced, where patients are being cared for in corridors and in crowded wards where patient privacy and dignity is compromised.

The Joint Committee of Shropshire and Telford & Wrekin CCGs will need to take account of this wide-ranging information to enable a balanced approach to decision-making; no one source of information has priority over another. This information, to be considered by the Joint Committee of Shropshire and Telford & Wrekin CCGs, is contained within this DMBC and its associated appendices and includes:

- 2018 Future Fit Programme Equality Impact Assessment
- 2018 Equality Impact Assessment Mitigation Action Plan
- 2018 Travel and Transport Report
- 2018 Travel and Transport Mitigation Action Plan
- SaTH Urgent Care Centre draft specification
- SaTH Draft Operational Policy for the Transfer of Patients between the Emergency site and the Planned Care site
- PICU
  - 7a – PICU Time Transfer vs.1
  - 7b – PICU Transfer vs8
  - 7c - Transfer of Children
- 2018 Future Fit Consultation Findings Report
- 2018 ORH – Modelling Options for Change
- 2018 Summary of key Stakeholder Responses
- 2018 Telford and Wrekin Neighbourhood Update
- 2018 Shropshire Care Closer to Home Update
- 2018 Powys Teaching Health Board Annual Plan
- 2018 Northumbria Comparator Summary Report
- 2018 Summary of Individual Responses
- IIA Mitigation plan
- Key QIAs
  - Corporate QIA
  - Scheduled Care
  - Support Services
  - Women and Children’s QIA
  - Unscheduled Care QIA
  - QIA IA Update 25.10.18
- 2018 Joint Committee Terms of Reference
- Review of Consultation methodology and compliance with statutory engagement
- 2018 Stakeholders responses in full
- Benefits Realisation Plan
- The views and outcomes from the conscientious consideration events with CCG Boards on 14th November and with Future Fit Programme Board 22nd November

- The Integrated Impact Assessments and their recommendations from 2016 and 2017

## **2.5 Summary of Recommendations**

As a result of conscientious consideration of the consultation responses and consideration of the mitigation and other actions developed since the approval of the PCBC, a series of six draft recommendations were agreed by consensus at the end of the Programme Board event on 22nd November 2018 subject to an agreed set of five mitigations that were to be developed within the DMBC. These are set out below for approval.

A seventh recommendation has been suggested by the Senior Responsible Officers (SROs) since the Programme Board event to ensure that post decision-making, governance arrangements are made clear to the CCGs and that there is robust arrangement for oversight of the mitigations and the development of the OBC and Full Business Case (FBC) which will be led by the Trust.

### **Recommendation 1: Consultation Process**

The CCG Joint Committee is asked to confirm that the Committee and its constituent Clinical Commissioning Groups have met their statutory duties and ensured that an effective and robust public consultation process has been undertaken and will be used to inform the decisions made. (See Appendix 8 Consultation Findings Report from Participate Ltd).

### **Recommendation 2: On-going Engagement**

The CCG Joint Committee is asked to support the need for the Clinical Commissioning Groups to continue to engage with and feedback to stakeholders the outcome of the consultation and the decision-making process, including those from seldom heard groups.

### **Recommendation 3: Principles of Consultation**

The CCG Joint Committee is asked to reaffirm the model underpinning the future provision of hospital services for Shropshire, Telford and Wrekin and mid Wales upon which the consultation process was based.

1. Our patients receive safer, high quality and sustainable hospital services by creating:
  - a. a separate emergency care site where specialist doctors treat the most serious cases
  - b. a single planned care site where patients would not have to wait as long and beds are protected for their operations
  - c. urgent care centres based at both hospitals providing care 24 hours a day, every day for illness and injuries that are not life-threatening but require urgent attention
  - d. a model where both sites provide most women and children's services
  - e. a model where both sites continue to provide the vast majority of outpatient services and diagnostic tests
2. Patients receive the very best care in the right place at the right time
3. Patients receive their care in better facilities
4. We can continue to have two vibrant hospitals in our county
5. We attract the very best doctors, nurses and other healthcare staff to work at our hospitals and have the right levels of staff working across both sites
6. We reduce the time people spend in our hospitals
7. We reduce the number of times patients need to come to hospital
8. We are more efficient with our resources.

### **Recommendation 4: Consultation Findings**

The CCG Joint Committee is asked to note that the Programme Board has confirmed by consensus that the consultation findings have presented no new viable alternative models or no new themes or key issues that might influence the preferred option.

**Recommendation 5: Preferred Option**

The CCG Joint Committee is asked to confirm the previous unanimous decision on the preferred option, Option 1, in accordance with (a) the recommendation from the Programme Board; and (b) the following mitigations within the final DMBC:

- 5.1 Travel and Transport Report and Mitigations Plan (Appendices 3 and 4 respectively)
- 5.2 Equality Impact Assessment recommendations and Mitigation Plan (Appendix 2) is aligned with the previous recommendations from the Integrated Impact Assessments (IIAs) carried out in 2016 and 2017, (Appendix 16).
- 5.3 Progress on out-of-hospital care strategies for both Shropshire and Telford & Wrekin CCGs to be described and to focus on co-dependencies in assuring the delivery of the acute model assumptions (Appendices 11 and 12 respectively).<sup>1</sup>
- 5.4 A clear description of the services on each site, particularly around service provision at the Urgent Care Centres (section 9.3).
- 5.5 Reconfirming affordability, including the patient flow assumptions since the PCBC was approved; noting that further refinement will be included within the Outline Business Case (OBC) which is expected for approval in July 2019.

**Recommendation 6: DMBC**

The CCG Joint Committee is therefore asked to receive and approve the contents of the DMBC, including its key appendices.

**Recommendation 7: Oversight Implementation**

The CCG Joint Committee is asked to note and approve the proposal for an Implementation Oversight Group (IOG) to be established under the STP governance structure to take forward oversight of the development of the OBC and FBC. All sponsor organisations will be represented on this group.

**2.6 Conclusions and Next Steps for the Decision-Making Process**

In conclusion the Future Fit Programme has, in collaboration with its sponsor organisations and stakeholders over the last five years, developed a number of proposals for changing the configuration of acute hospital services for the populations of Shropshire, Telford & Wrekin and parts of Powys that rely on the services of The Shrewsbury and Telford Hospital NHS Trust. These proposals will both improve the quality and safety of care for the whole population and increase the system sustainability for the next generation.

It has taken over five years to get to this point, longer than anticipated and to the frustration of many, including the public, whilst services have also become even more fragile. However, during this time the Programme has been able to develop additional assurances around its processes and decision-making that must now give confidence to the public and to the regulators that, taking account of the consultation findings, it is time to proceed to the final decision-making process.

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<sup>1</sup> The out-of-hospital care strategy for Powys has also been considered throughout the process and progress needs to be described.



Following the Future Fit Programme Board receiving the formal independent Consultation Findings Report, the Equality Impact Assessment Report and the content of key mitigation plans, it has made a series of final recommendations to the Joint Committee of Shropshire and Telford & Wrekin CCGs, as set out above. Section 9: Addressing Key Mitigations summarises how the five mitigations set out in Recommendation 5 above have been addressed. Table 2.3 below signposts to where more detail can be found.

Mitigations	DMBC Section
Travel and Transport Report	Section 9.1 Travel & Transport
Travel and Transport Mitigations Plan	Travel & Transport Report Appendix 3 Travel & Transport Mitigation Plan Appendix 4
Equality Impact Assessment recommendations and Mitigation Plan	Section 7.1 Integrated Impact Assessments Section 9.4 Addressing Equality Impacts EIA Report Appendix 1 EIA Mitigation Plan Response to Findings Appendix 2 IIA Mitigation Plan Appendix 16
Progress on out-of-hospital care strategies	Section 9.2 Care Closer to Home Telford and Wrekin Neighbourhoods Report Appendix 11 Shropshire Care Closer to Home Appendix 12 Powys Teaching Health Board Report Appendix 13
Clear description of services on each site	Section 9.3 Description of services on each site and in particular Urgent Care
Reconfirming affordability	Section 9.5 Review of Affordability

*Table 2.3 Mitigations referred to in Recommendation 5*

On behalf of the two CCGs, the Joint Committee will now act as the decision-making body to receive and approve or otherwise the recommendations set out in this DMBC.

### 3.0 Introduction

The Future Fit Programme for the reconfiguration of the acute hospitals to deliver sustainable services was established in 2013 from the outcome of the Call to Action. Over the past five years it has been very much a clinically-led and collaborative process as solutions have been developed for the health system's pressing need to address the serious shortfall in workforce across a number of specialties. Over 300 doctors, nurses and healthcare professionals, GPs and social care professionals, as well as members of the public were involved in the original clinical design work and all agreed that high quality, safe, efficient and sustainable hospital services can only be delivered if changes are made. Everyone agreed that doing nothing was not an option.

The new model of care began its development in 2014 and the foundations for this work are described in the [Clinical Design Workstream May 2014 Models of Care \(1\)](#). Whilst setting out a wider ambition for change, the Programme's focus quickly became the reconfiguration of acute hospital services because of the worsening position and vulnerable nature of some of the acute services related to workforce shortages.

However, the CCGs continued to recognise the clear interdependencies of community models of care to delivering the acute elements and set out at a high level in the PCBC the proposals for out-of-hospital care that support the acute model. The modelling work done at that stage provided sufficient confidence in the clinical evidence base, the assumptions and opportunity for admission avoidance and the investment required to support people in the community, particularly the growing frail older population. This work has now progressed through a separate Out-of-Hospital Care programme of the CCGs.

The public consultation carried out by the CCGs between 30<sup>th</sup> May 2018 and 11<sup>th</sup> September 2018 focused on services delivered at the Royal Shrewsbury Hospital and the Princess Royal Hospital and did not ask about services in the community settings.

Whilst workforce has, since the inception of the programme, been the primary driver, the situation has now become critical, with the emergency departments at the two hospitals becoming increasingly fragile. The Shrewsbury and Telford Hospital NHS Trust (SaTH) Board met on 27<sup>th</sup> September 2018 and agreed to temporarily suspend overnight A&E services at the Princess Royal Hospital (PRH). This was in response to not having the right staffing levels, as recommended by the Royal College of Medicine, to ensure services are safe for patients.

On 22<sup>nd</sup> November, after being able to contract an additional 15 specialist nurses, 11 middle grade doctors and recruit three substantive A&E consultants to start in early 2019, SaTH announced that it now had sufficient staffing levels for the A&E department at PRH to stay open 24 hours a day, seven days a week.

The ongoing fragility of both the nursing and medical workforce will remain until conditions improve and the substantive post vacancies are appointed to. SaTH acknowledges that a long-term solution to its recruitment challenges is dependent upon the outcome of the NHS Future Fit consultation. The near closure overnight of PRH A&E emphasises the need to finally conclude the long-term reconfiguration of our two hospitals which this DMBC sets out.

### 3.1 Overview of process to date

Figure 3.1 below summarises the different phases of the Future Fit Programme. Prior to consultation, considerable refinement of the clinical model has taken place over the years based on an iterative, clinically-led and engaging process. This work has more recently been led by SaTH through its Sustainable Service Programme (SSP) and has resulted in the current model that the CCGs have consulted upon.

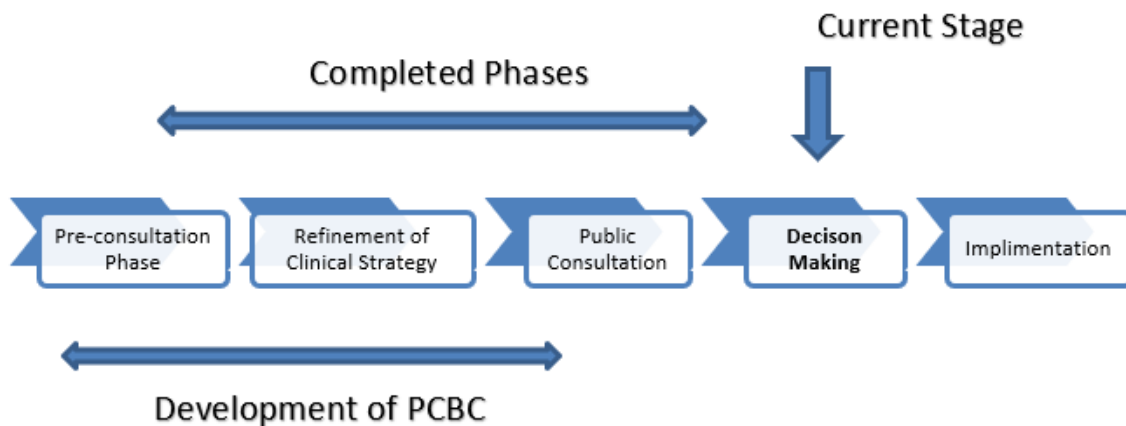


Figure 3.1 – Phases of the Future Fit Programme

### 3.2 Pre-Consultation Public and Patient Engagement

The proposals for consultation were influenced very strongly by staff and local people. Between 2013 and 2018 ongoing engagement has helped to shape these.

In July 2013, NHS England called on the public, NHS staff and politicians to engage in an open and honest debate on the future shape of the NHS in order to meet rising demand, introduce new technology and meet the expectations of its patients. In response to this national initiative, Shropshire and Telford & Wrekin CCGs agreed to undertake a joint Call to Action engagement process. Almost 3,000 people took part in a short survey which asked for people's views on healthcare across the region.

The Call to Action closed in November 2013 with a conference where the results of the survey were shared and discussed. There was agreement from those taking part on the need for radical change within the local NHS. The CCGs pledged to undertake a programme of work called Future Fit which would look at how the need for change could be translated into local safe and sustainable NHS services for the future. In making any decisions about future services, the following principles were developed at the conference, which we continue to adhere to:

- Patients are at the heart of everything we do
- All factors have been taken into account
- All decisions must be based on accurate or best available information
- There is shared confidence that problems and issues will be addressed
- Decisions will be objective and rational, but also compassionate
- Processes will be transparent



- Decisions will be based on shared principles
- There must be two-way, honest and accurate communication with affected people
- Easily understandable language must be used
- Everyone affected by a decision must have an equitable opportunity to be involved in helping shape the decision
- A decision must attempt to address the problem for as many people as it can
- Any risks arising from the decision must be identified and mitigated as far as possible
- There must be access to specialist advice to help make the decision
- Ongoing monitoring must be in place to ensure the outcome of a decision is as expected.

The Future Fit Pre-consultation Engagement Report was presented to the Programme Board in July 2018. It is available on [the Future Fit website](#). This document summarises the engagement that has been carried out since 2013 around the Future Fit Programme until the start of the formal public consultation in 2018. It details how we have developed our communication and engagement process based on feedback from stakeholders, patients their families and carers, members of the public, clinicians and GPs. A full list of engagement activities can be found in the report.

### 3.3 *The Model of Care*

#### 3.3.1 *Principles*

In 2014, the following principles and practices emerged from the clinical design work across all areas of care and specialties as being necessary and fundamental components of an efficient, safe, resilient and integrated health and social care system. These principles continue to be reflected in 2018 through the work of the STP partners:

- **'Home is normal'** describes the principle of matching people's needs with the correct level of care
- **Empowerment** where patients who want to be empowered can remain autonomous and independent, even when they are ill; clinicians who want to do the job they were trained to do, and not spend too much of their time trying to navigate a poorly designed and inefficient system on behalf of their patients; communities who want to be empowered so that citizens can help each other to live 'a life well lived' in an environment that minimises isolation, vulnerability and inequality
- **Sustainable workforce solutions** with consolidation of some services to make posts more attractive by improving the quality of work; development of novel roles to fill gaps created by recruitment issues and new models of care; and working in an integrated and collaborative way to accommodate patient journeys.
- **Needs-led services** in which patient access to care is dependent on the level of care they require. Quality, safety and achieving the best outcomes may come before choice.
- **Integrated care** that improves the co-ordination, collaboration and consistency of care across time and care settings.
- **Digital-enabled** working practices as a fundamental component of an efficient, safe resilient and integrated health and social care system.

### 3.3.2 The Proposed Changes

The proposed changes to the configuration of acute hospital services described in this document ensure that the future system secures and invests in two vibrant hospitals with consolidation of Emergency Care on one site and Planned Care on the other. Key components are:

- One Emergency Care site with an Emergency Department (ED)
- One Planned Care site
- Two Urgent Care Centres
- Local Planned Care (outpatients, diagnostics) on both hospital sites

There will be an Urgent Care Centre (UCC) on each site open 24 hours a day, seven days a week for those patients that have an injury or illness that is urgent and cannot be treated by primary care services. It is anticipated that approximately 60% of the patients that go to the current A&Es requiring urgent care could carry on going to their nearest hospital to receive the care they need under this proposed new configuration of services.

Patients will access the service on both sites as a 'walk-in' or via ambulance if it is considered by paramedic staff to be clinically appropriate. The UCCs will be staffed by a multi-disciplinary team to include GPs, Advanced Clinical Practitioners (ACPs) and nurses, specifically trained in the delivery of accident and urgent care for adults and children.

The new single ED will be fully equipped and staffed to deliver high quality emergency medical and surgical care 24 hours a day, seven days a week, 365 days a year. Patients who are acutely ill with potential life- or limb-threatening injuries and require immediate diagnosis and treatment will be taken directly to the ED accessed only via transfer from a UCC or ambulance. The ED will also serve as a Trauma Unit and will be co-located with a single Critical Care Unit. Ambulatory Emergency Care (Same Day Emergency Care) will be available 12 hours a day, 365 days a year.

A new Critical Care Unit will bring together all the Acute Trust adult critical care capacity, with level 1, 2 and 3 patients being managed in the same unit. This unit will support the consolidation of emergency activity and high risk elective inpatient procedures onto one site.

There has been considerable focus on potential changes to women and children's services. High risk women and children's services need to be based on the emergency site. This is the clear view of the experts both locally and nationally including the West Midlands (WM) Clinical Senate. This means that in-patient Obstetrics and Paediatrics will be co-located with ED and Critical Care. Most women and children will continue to receive the majority of their care and treatment in the same place as they do now under either option being considered. The services which will remain in their current location include:

- Midwife-led unit and postnatal care
- Maternity outpatients including antenatal appointments and scanning
- Gynaecology outpatient appointments

- Early Pregnancy Assessment Service (EPAS)
- Antenatal Day Assessment
- Children’s outpatient appointments
- Neonatal outpatient appointments.

### 3.3.3 Improved Outcomes

The CCGs believe that the proposals set out in this document will result in a number of measurable improved outcomes for patients:

- Improved clinical effectiveness through patients being cared for by the right clinician with access to senior decision-makers and enhanced ambulatory emergency care with fewer unnecessary admissions
- Improved experience of care through well-designed, appropriate capacity and physical settings promoting more healing for patients and improved patient experience through improved privacy and dignity
- Separation of emergency and planned care resulting in fewer delays and cancellations
- Better support for people with long term conditions and for people living independently through early access to a consultant opinion, fewer admissions and reduced length of stay and less decompensation in frail older people
- Equitable access to services through patients waiting less time in A&E, waiting less time for operations and avoiding cancellations and with the potential for repatriation of some services back into Shropshire and Telford & Wrekin.

### 3.3.4 Developing and Evaluating the Options

Having listened to people’s views, clinicians initially considered more than 40 potential ideas on how we could change the hospital services. A robust process was carried out, which included a series of meetings, a feasibility study and shortlisting panel. During this process, these 40 ideas were narrowed down to four options.



Figure 3.2 – Options development timeline

In September 2016, an Options Appraisal workshop took place with representatives from over 50 organisations across Shropshire, Telford & Wrekin and mid Wales. The panel looked at the non-financial impact that each of the four options would have on accessibility, quality, workforce and deliverability. As a result, two options (Option 1 and Option 2) received the highest scores on all four criteria. A financial appraisal of the four options was then carried out, followed by an overall economic analysis of both financial and non-financial appraisals. This found that Option 1 would provide the best value for money over the long term.

This process identified a preferred option; the Emergency Care site (with the Women and Children's Unit) at Shrewsbury with Planned Care based at Telford. This preferred option was chosen because having the Emergency Care site at the Royal Shrewsbury Hospital would mean:

- It can continue to be a Trauma Unit
- Fewer people would have to travel further for emergency care
- It would better meet the future needs of our older population, especially in Shropshire and mid Wales
- It offers the best value for money over the long term.

After challenges by Telford & Wrekin Council on the process and a recommendation from the Gateway Review in December 2016, an independent review of the options appraisal process was commissioned by the Programme. The resulting report by KPMG did not identify any material issues that would have resulted in a change to the preferred option and the process was deemed robust. This was supported by the Programme Board in its recommendations to the Joint Committee of Shropshire and Telford & Wrekin CCGs in August 2017, which then consequently voted unanimously to proceed to consultation with the two options, including identifying the preferred option. The details of the process for both the non-financial and financial appraisals are set out in section 11 of the PCBC.

### **3.3.5 Integrated Impact Assessments**

The Programme has demonstrated that the new model of acute care will improve services and outcomes for all patients whilst also tackling the service and workforce challenges facing the Trust. Integrated Impact Assessments (IIAs) carried out in 2016 and 2017 have concluded that in terms of overall health impacts, in either option under consideration, the main changes are expected to sustainably improve the effectiveness, safety and patient experience of clinical care provided to the whole population. These projected positive overall health impacts achievable under both options are the most significant of all the impacts assessed. It was, however recognised in this work that several groups will experience a combination of positive and negative effects arising from the projected impacts.

Some of these groups, for example the very young and the older population, may be disproportionately most likely to use the affected services, and would therefore benefit the most from the projected positive health impacts. Equally, some may be disproportionately affected by the longer projected journey times from certain localities. Developing plans for mitigation of the impacts identified pre-consultation in 2016 and 2017 has formed a key part of the work of the programme over the last 12 months. It has also shaped the consultation

plan in terms of continuing to engage with several groups who may be disproportionately affected by the changes proposed. The full IIAs can be found on the [Future Fit website](#).

### **3.3.6 IIA Steering Group**

A summary of the recommendations made was developed in January 2018 as a result of the impact assessment work undertaken.

In order to progress the actions, a Steering Group was established within the governance structure of the Future Fit Programme to oversee the work. Terms of Reference were developed by the group whose membership included clinicians, patients and public health leads for both councils. An independent Chair was appointed to support the process.

The group's focus was primarily to take into account any risks or adverse impacts from the impact assessments to date, to recommend priorities and ensure that mitigating actions were being developed by the appropriate group within the Future Fit Programme or wider STP Programme and ensure that the work was progressing to the agreed timescales. This also included ensuring the Programme met the requirements of any equalities duties within the mitigation plans. Therefore, the ongoing work of the Equality Impact Assessment was also monitored through this group.

Finally, where there were interdependencies identified with other key programmes and enabling workstreams, for example the work of the Local Maternity System in reducing risk factors in pregnancy and the ongoing midwife-led services review, these were monitored through reports into the Steering Group.

A document setting out "Expectations from the Programme Board" was developed and approved that clearly articulated the priority areas for mitigation post-PCBC. Table 3.1 below sets out these priorities. Regular updates and any escalation on all relevant priorities for mitigation were reported to the Programme Board and/or through the IIA Steering Group.

Mitigation	Purpose	Timescales
Travel and Transport Activity and Mitigation Plan	To address how, at the implementation stage, any adverse impacts may be mitigated for public transport To provide modelling on emergency and non- emergency transport and any potential financial consequences	1. Monthly updates to IIA Steering Group and Programme Board 2. Update to September 2018 Programme Board 3. Draft report October 2018 Programme Board 4. Final Travel and Transport Activity and Mitigation plan December 2018
Quality Impact Assessment Report	To ensure that the key service changes proposed in the options have had a service level Quality and Equality Impact Assessment pre-decision-making and that Boards are assured impacts are sufficiently mitigated	1. Monthly updates to IIA 2. Schedule approved by Clinical Strategy Group October 2018 3. Prioritised services to Programme Board by November 2018 4. Completed by December 2018
LMS Interdependencies	To set out interdependencies of transformation plans and how they contribute to mitigating impacts identified in the W&C IIA	1. Report to IIA Group July 2018 2. Report to Programme Board September 2018
Equality Impact Assessment and Mitigation Plan	To set out consultation findings in relation to the impacts on the nine protected characteristics plus the additional agreed four characteristics of rurality, speakers of Welsh as a first language, deprivation and carers and address how any disproportionate or differential impacts could be mitigated	1. Monthly updates to IIA and Programme Board 2. Phase 1 report July 2018 Programme Board 3. Phase 2 report September 2018 4. Phase 3 Final report November 2018
Workforce Transformation and Impact Mitigation	To assure on key workforce impacts identified in PCBC and delivery of key milestones of the Workforce Transformation Plan including the move towards delivering more services in the community	1. Updates to IIA Group July 2018 2. Report to Programme Board September 2018 3. Final report November 2018
Out of Hospital (OOH) Programme Interdependencies	To set out the OOH care vision interdependencies with the acute model and how the OOH care will support a move to delivering more services in the community and how it will be implemented together with detailed activity timescales and costs	1. Public narrative and case studies by August 2018 2. Monthly report to IIA 3. Draft report to Programme Board November 2018 4. Final report December 2018
Revised financial affordability plans	To set out post consultation and mitigation discussions, any revised financial plan. To assure on affordability	1. Draft paper for November 2018 CCG Board meeting 2. Draft DMBC content

Table 3.1 "Expectations from the Programme Board" the priority areas for mitigation



### **3.3.7 Equality Impact Assessment**

Whilst the assessments carried out in 2016 and later in 2017 for Women and Children's Services did look at a number of groups that are defined as having one or more protected characteristics under the Equality Act 2010, a full, refreshed Equality Impact Assessment (EIA) was developed in 2018. This took account of the recommendations from the original impact assessments, particularly those that set out potential disproportionate impacts on certain groups within the nine protected characteristics.

The EIA work examines if particular protected characteristic groups or other vulnerable groups, are likely to experience any disproportionate impacts from the proposals – either negatively or positively. Our assessment work paid particular attention to equality legislation and to showing how the Programme is considering the needs and views representative of the nine protected characteristics under the Equality Act 2010 and the Public Sector Equality Duty 2011.

Four additional groups that we have made particular efforts to engage with during the consultation were also identified:

- People living in rural areas
- People living in areas of deprivation
- Carers
- People whose first language is not English, particularly Welsh speakers

The findings of this report and draft recommendations and conclusions can be found summarised in more detail in section 7 and the report in full as Appendix 1.

### **3.4 The Pre-Consultation Business Case**

The Future Fit Programme in collaboration with its sponsor organisations and stakeholders developed the Pre-consultation Business Case. It set out the proposals for changing the configuration of acute hospital services for the populations of Shropshire, Telford & Wrekin and parts of Powys that will both improve the quality and safety of care for the whole population and increase the system sustainability for the next generation.

It provided assurance to the governance boards and NHSE that the system had thoroughly considered a range of requirements prior to deciding to move to public consultation on proposed service changes. These requirements included:

- Setting out the case for change and proposed model of care
- Evidence to support the model
- The facilities and workforce transformation required
- How the community model would support the acute reconfiguration including the activity and capacity modelling assumptions
- The options appraisal process and how we got to the preferred option
- Finance and affordability analysis and a plan to support financial balance
- A description of the public engagement that has occurred in helping to reach the proposals
- Governance and decision-making arrangements

- Assurance processes

In order to proceed to public consultation on proposed service reconfiguration the Future Fit Programme also needed to ensure it had met the original Department of Health (DH) four tests and the supplementary requirement which was introduced in April 2017 around demonstrating that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it.

NHS England, the Programme Board and the Joint Committee believed that the Programme had met these tests sufficiently in the PCBC to proceed to consultation.

Section 13 of this DMBC reconsiders these national criteria when considering the outcome of the consultation process and determining the final recommendations to make to the Joint Committee of Shropshire and Telford and Wrekin CCGs.

Within the PCBC a number of additional recommendations for further work pre final decision-making were set out, that were either recommendations from the NHSE Assurance Process and/or actions agreed by the Joint Committee of Shropshire and Telford & Wrekin CCGs. These are also reflected in the Consultation Document and are set out below:

- further develop the model of care in the community
- look at mitigation plans to lessen the impact for women and children and older people, their families and carers, particularly around travel
- understand more how the Urgent Care Centre at the Planned Care site will be staffed by skilled professionals to deliver the high level of care required for children
- understand the effect of the proposed changes on the demand for both emergency and non-emergency ambulance and patient transport
- consider new ways of working in the future, including new staff roles
- further test affordability, specifically around the availability and source of capital
- more detail on proposals for any repatriation of patient services including any relevant QIAs.

Table 3.2 below summarises these actions and where the further information can be found within this DMBC:



Reference	Action/Mitigation requirement	Timeline	Lead	Action progress update
CCG SOC/PCBC approvals 2016/17	<b>Workforce</b> - testing of workforce models through clinical design group (CDG) pre-implementation.	OBC	SaTH/SSP	Updates received from Chair of STP Workforce Group at Programme Board and IIA meetings on the progress against recruitment into new roles. Included in this DMBC as a narrative in section 10.3.
CCG SOC/PCBC approvals 2016/2017	<b>Repatriation</b> - Clarification on any proposed repatriation including QIAs.	Pre DMBC	SaTH/SSP	QIAs to be completed where appropriate. Currently no assumptions around repatriation of new services. QIAs in Appendix 17.
CCG SOC/PCBC approvals 2016/17	<b>Out-of-Hospital Care</b> - potential impact on primary care and community services in activity shifts; changes in financial flows.	Pre DMBC	CCGs Exec leads	Forms part of the out-of-hospital care programmes now established by both CCGs. Significant work has taken place in each CCG. CCGs' Executive to assure their Boards of the plans. This DMBC has updated progress and any change in assumptions. See section 9.2.
CCG SOC/PCBC approvals 2016/17	<b>Affordability</b> – further testing, including the assumptions around investments and efficiency savings.	Pre DMBC	STP DoFs	Post consultation and the decision on any preferred option, assumptions to be tested from the PCBC and any material changes set out in DMBC see section 9.5.
Joint Committee PCBC approvals 2017	<b>Paediatric Cover</b> - appropriate paediatric cover in place at the urgent care centre on the planned care site.	Pre DMBC	SaTH SSP	Clarification on skills set out in this DMBC and includes a summary of a joint agreement by the task and finish group on the Planned Care site UCC and the assessment and treatment of adults and children with minor illness. In addition how the workforce model in the UCC will meet the Royal College of Paediatrics and Child Health guidance (June 2018) Section 10.2
Joint Committee PCBC approvals 2017	<b>Travel and Accommodation</b> - mitigation is put in place for travel and accommodation needs for women and children using the emergency care site and for older people particularly using the planned care site.	Pre DMBC	STP	<i>Like for like</i> accommodation included within specifications and costs for paediatrics facility. Travel and Transport Group established to develop Mitigation Action Plan and included in this DMBC in section 9.1.
Joint Committee PCBC approvals 2017	<b>Ambulance Services</b> : balanced ambulance services to be in place.	Pre DMBC	STP	Ambulance modelling for emergency and non-emergency activity completed by ORH, summarised in section 9.1.1 and Appendix 9.
Joint Committee PCBC approvals 2017	<b>Workforce Solutions</b> - the local NHS needs to be innovative with developing workforce solutions and new roles.	Pre DMBC	SaTH	5 year Workforce Plan produced and progress made on recruitment to new roles set out. See section 10.3. Progress on developing the wider system workforce solutions will emerge from the out-of-hospital care plans.

Table 3.2 Recommendations from the NHSE Assurance Process and/or actions agreed by the Joint Committee

### 3.5 Independent Expert Advice and Assurance

#### 3.5.1 West Midlands Clinical Senate

The West Midlands Clinical Senate Review took place in October 2016. It made a series of 18 recommendations relevant to all options and supported the case for change and the clinical model:

*“The Panel was of the view that a clear and compelling case for change was made, based on sound evidence presented to it on current performance, improvements seen in other regions by reconfiguration of services with multi-site Trusts, the potential long-term benefits, and alignment with national NHS strategy.”*

The panel acknowledged that the decisions the health economy are trying to make are difficult:

*“We were made aware of the differing current and future demographics pulling maternity and paediatrics toward PRH where it is has recently been built, but more elderly around Shrewsbury pulls in the opposite direction. Moving the trauma unit and therefore other acute and time-dependent services from Shrewsbury might disadvantage residents of Powys but advantage residents of Telford.*

*Decisions are difficult and trade-offs inevitable but the time has come to make them. After all, both sites will get considerable and needed capital investment.”*

The WM Clinical Senate also supported the co-location of Obstetrics and Paediatrics with the Emergency Centre.

#### 3.5.2 North Midlands and North Wales Trauma Network

Future Fit was discussed at the request of the Programme at the North West Midlands and North Wales Trauma Network’s Governance Meeting In November 2016. The view of the Network was that the preferred site for the Trauma Unit should be Shrewsbury. This reflected its geographical location and an increased risk for the group of patients from Powys if it was sited at Telford. Wherever the unit is sited the Network emphasised that it would need to comply with the National Standards for Trauma Units. Shrewsbury is already accredited. Telford would have to undergo a formal accreditation process to become a Trauma Unit.

#### 3.5.3 NHS Transformation Unit

In light of an internal clinical review of the serious concerns around the safety and sustainability of a stand-alone Women and Children’s Unit remote from the Emergency Centre site, an external review was commissioned by the CCGs. Both the report from the NHS Transformation Unit and the Senate Report concluded the same, that this option was not clinically deliverable and should therefore not be taken forward into formal public consultation as a deliverable option.

#### 3.5.4 KPMG Review

The Joint Committee of Shropshire and Telford & Wrekin CCGs initially met on 12<sup>th</sup> December 2016 to receive recommendations on a preferred option. The recommendations did not achieve a majority vote with a split vote reflective of the differing position of the two CCGs. As a result of this position, together with the recommendations from the Gateway Review, agreement was reached to carry out an independent review of the process, scoring and methodology of the options appraisal. KPMG was selected to provide an independent

review of the Options Appraisal. In undertaking this review, KPMG compared written evidence to best practice guidance produced by both NHS England and NHS Wales.

KPMG was provided with three objectives:

- Review of Shortlisting Process Methodology
- Review of the Design of the Evaluation for Shortlisted Options
- Review Enactment of the Evaluation for Shortlisted Options

Some minor points were noted under each objective where improvement could have been made in retrospect; however the Independent Review of the Options Appraisal Process did not identify any issues to the process that would have materially changed the outcome of the preferred option. It concluded that the process for determining a preferred option was robust in its design and enacted in line with what was agreed by the Programme and its sponsors.

### **3.5.5 Learning from Others**

Throughout the options development phase and more recently as the clinical implementation of the model has developed, the Programme has continued to learn from other health systems. The development of the optimum service delivery model has been supported by the experience of acute providers elsewhere in the country, including Mid Essex, Southend, Basildon Hospital and Poole and Dorset NHS Trusts.

### **3.5.6 Northumbria Healthcare**

Of particular attention was the model developed in Northumbria. In 2015, Northumbria Healthcare NHS Foundation Trust opened England's first purpose-built dedicated specialist emergency care hospital, transforming urgent and emergency care services across Northumberland and North Tyneside. A&E departments were reconfigured at three other district general hospitals to Urgent Care Centres (UCCs) that are led by highly experienced emergency nurse practitioners. SaTH clinicians and other stakeholders have visited the Northumbria site. There are many similarities between the clinical model in relation to the emergency centre and the UCCs.

The Future Fit Programme Board considered whether having a single separate emergency centre and retaining the two DGH hospitals would address the challenges facing hospital services in Shropshire and a report was commissioned by the acute Trust.

There are key differences in the services that Northumbria Healthcare NHS Foundation Trust and SaTH provide. The Royal Shrewsbury and Princess Royal hospitals currently provide more services, including urology, nephrology, oncology and haematology. Adopting the exact same model as Northumbria would result in SaTH not delivering these services, meaning patients would have to travel out of county to access those services in other hospital trusts. In addition the proposed model for the RSH and PRH includes 24/7 Urgent Care Centres on both sites unlike the Northumbria model where urgent care is available only for certain hours.

The report found that adopting the Northumbria model would cost around £400-500 million, not including infrastructure costs (e.g. roads) and the cost of land. This is significantly higher than the £312 million allocated to the programme from the Department of Health and Social Care (DHSC), and significant backlog of maintenance work would remain at the two hospitals due to less investment at the existing sites.

The report was published in July 2018 (Appendix 14) and found that whilst establishing a similar single specialist emergency centre on one of the two existing sites is within the Future Fit model, adopting the Northumbria model would not be feasible and would create

substantial risk for SaTH due to a number of factors including workforce, and would result in some services being delivered outside of the county.

### **3.5.7 Alignment with best practice guidance**

Research has been undertaken to understand improvements, recommendations and evidence from elsewhere, specifically around Urgent and Emergency, Ambulatory and Planned Care. Use of clinical best practice, benchmarking and a review of national guidance on emergency clinical pathways and workforce has been undertaken to inform the proposed model of care, including:

- All pathways being redesigned in consideration of NICE guidance and best practice.
- Urgent Treatment Centres – Principles and Standards, NHS England 2017
- Emergency Department Care - Best Practice Guidelines. The Royal College of Emergency Medicine 2017;
- Transforming urgent and emergency care services in England, NHS England, 2015;
- Directory of Procedures, Fifth Edition, British Association of Day Surgery, 2016;
- Directory of Ambulatory Emergency Care for Adults, Version 6, NHS Elect, 2018;
- Care of Critically Ill and Critically Injured Children –Quality Standards, v5.1, Paediatric Intensive Care Society / West Midlands Quality Review Service, December 2015;
- Core Standards for Intensive Care Unit. The Faculty of Intensive Care Medicine / The Intensive Care Society 2013;
- Good practice guide: Focus on improving patient flow, July 2017
- Guide to reducing long hospital stays, June 2018
- Guidelines for the Provision of Intensive Care Services. The Faculty of Intensive Care Medicine / The Intensive Care Society, Edition 1.1, 2016
- Care of the critically ill woman in childbirth; enhanced maternal care. The Royal College of Anaesthetists, 2018;
- Operational productivity and performance in English NHS acute hospitals: Unwarranted variations, Final Report, Lord Carter 2016;
- Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21;
- The repeatable room's initiative established as part of the NHS P21+ programme.

### **3.5.8 NHSE Assurance Process**

A local touchpoint meeting with NHSE took place on 30th August 2017 led by the Director of Commissioning Operations (North Midlands) and the Regional Head of Strategy and Planning. This meeting followed a previous Strategic Sense Check Stage 1 Assurance meeting held some considerable time ago, back in May 2014.

Post the Joint Committee Meeting on 10<sup>th</sup> August 2017 where the unanimous decision was made to support the preferred option and to proceed to consultation, the NHSE touchpoint meeting took place. This was in advance of the formal NHSE Stage 2 Assurance Panel which would finally approve whether the programme was able to proceed to this next stage.

The purpose of this meeting was to review progress and to determine the level of assurance/approval required in the formal Stage 2 assurance process. Specifically:

- Exploring the case for change and level of consensus for change
- Ensuring that potential risks are identified and mitigated; and that options are feasible
- Ensuring that high-level capital cost and revenue affordability implications are being properly considered

- Confirming that assessment against the ‘four tests’ is ongoing (defined in section 13.2) and other best practice tests are being applied proportionally
- Understanding how the proposals can support a reduction in admissions and importantly how the proposals will improve key constitutional performance measures

A significant document submission by the Programme formed part of this process, including the PCBC and supporting appendices together with draft consultation documents and consultation plans. Following a presentation to a panel that included both NHSE and NHSI colleagues, a follow up letter highlighted a number of areas requiring further consideration and/or work but confirmed the Programme was ready for the Stage 2 Regional Assurance Panel.

After further evidence submissions, the formal Regional Assurance Panel then took place on 19th October 2017. A number of issues were raised requiring further clarification and submissions.

The final report from this NHSE assurance process was received following a final clarification meeting in December 2017, which set out a small number of outstanding issues that would be required to be addressed post-consultation. Therefore approval to proceed to public consultation was supported by NHSE subject to receiving assurance from NHSI that the funding would be made available.

Table 3.3 below summarises the outstanding issues requiring further action from the final report of the Regional Panel. This has been incorporated into the priority action plan that also incorporates other priority actions as set out by the Governing Bodies as part of approving the final version of the PCBC in November 2017. Progress against all these action points and any relevant mitigation plans can be found in section 10 of this report. Benefits realisation of service change is addressed in section 11.

Issue	Deadline for completion	Action progress update
<b>Trauma Mitigation Plan - Detailed plans to mitigate potential negative impacts of the final proposal in relation to trauma patients should be agreed and included in DMBC.</b>	Pre-DMBC	Specialised Commissioning who lead on commissioning major trauma, critical care and neonates submitted a letter of support. Several potential mitigations for further exploration were listed in the PCBC, were option 2 to be implemented. Clinical engagement with ambulance service on-going through SSP process.
<b>Benefits Realisation - Detail on expectation of improvements in performance the proposals will drive and the key underpinning milestones to achieve such improvements.</b>	OBC	Captured in Future Fit PCBC. Updated detail set out in DMBC and OBC.  Further and final development during FBC compilation. Updated benefits tracker received from SaTH and incorporated.
<b>Engagement with Specialised Commissioning - Ensure robust engagement with Specialised Commissioning on Neonates, Cancer and Trauma.</b>	Pre-DMBC	Regular contact with Specialised Commissioning is in place and input will form part of the decision-making process. Letter of support for DMBC to be included in NHSE checkpoint.
<b>Ambulance services- Impact on ambulance services requires modelling.</b>	Pre-DMBC	Travel and Transport modelling completed by ORH for emergency and non-emergency transport and will be included within the DMBC.

Table 3.3: - NHSE Action/Mitigation requirements



NHSE also advised that there would be a need to finally assure the decision-making business case. The process of assurance was to be agreed at a later stage post consultation and pre decision-making meeting of the Joint Committee of Shropshire and Telford and Wrekin CCGs.

### **3.6 Capital Investment**

The PCBC set out the capital cost estimates for both options 1 and 2 and the approach followed best practice and the guidance in the NHS Capital Investment Manual (ref PCBC). The Trust has received confirmation from NHSI that capital funding up to £312m has been allocated to support the reconfiguration of services across the two hospital sites.

Access to the capital funding is subject to the outcome of public consultation, the Joint Committee of Shropshire and Telford & Wrekin CCGs decision-making process, and submission by the Trust of SOC, OBC and FBC, as required by HM Treasury.

Within the PCBC it was assumed that the estate reconfiguration would be for the most part funded using a Public Dividend Capital (PDC) route. For PDC funding, the Trust would propose to procure the construction work using the Department of Health's ProCure22 (P22) procurement route, which is the default option for NHS construction projects.

In line with NHSI capital funding approval requirements, it has been requested that the Programme continues to consider private finance options. The Trust is in early discussion with the Community Health Partnerships, a subsidiary of the Department for Health, to establish whether the proposed 'Regional Health Infrastructure Company (RHIC)' vehicle could be appropriate for elements of the capital programme. This will be explored in further detail through the Outline Business Case, once the funding route has received HM Treasury approval.

### **3.7 Decision to proceed to consultation**

The Programme Board made recommendations to the Joint Committee of Shropshire and Telford & Wrekin CCGs in August 2017 and the Committee unanimously supported moving towards consultation on a preferred option, Option 1, together with Option 2. The PCBC was approved by both CCG Boards in November 2017 following the NHSE assurance process as outlined above. Approval to proceed to public consultation was given by both CCG Boards in April 2018 once the availability of capital funding was announced.

## 4.0 The Consultation Process

### 4.1 Introduction

The Future Fit public consultation, led by Shropshire and Telford & Wrekin Clinical Commissioning Groups (CCGs), ran for 15 weeks from 30<sup>th</sup> May to 11<sup>th</sup> September 2018. It asked people from Shropshire, Telford & Wrekin and mid Wales for their views on the future of hospital services provided by the Royal Shrewsbury Hospital in Shrewsbury and the Princess Royal Hospital in Telford.

The consultation focused on the CCGs' proposed new model of hospital care which would involve one hospital providing Emergency Care services (including women and children's inpatient services) and the other hospital providing Planned Care services. Under this proposal, both hospitals would have an Urgent Care Centre open 24-hours a day, seven days a week.

The consultation asked for people's views on this proposed model of hospital care and the two options by which it could be delivered:

**Option 1:** The Royal Shrewsbury Hospital becomes an Emergency Care site and the Princess Royal Hospital becomes a Planned Care site

**Option 2:** The Princess Royal Hospital becomes an Emergency Care site and the Royal Shrewsbury Hospital becomes a Planned Care site

To support the consultation, a consultation document was produced which was available on the Future Fit website and distributed widely throughout the 15 weeks. This document outlined the following:

- The reasons why local hospital services need to change
- The CCGs' preferred option (Option 1) and the reasons for this decision
- Detail on what services would be provided at both hospitals, what services would be provided on the Emergency Care site and the Planned Care site
- Information on what the proposed changes would mean for patients and their families
- Information on how doctors, nurses and other staff and patients have been involved
- Background information on the Future Fit programme and how the CCGs arrived at the options they are asking for people's views on
- Information and ideas around improving travel and transport and out-of-hospital care.

A survey was also developed which featured both inside the consultation documents and online on the Future Fit website. People were asked to take part in the consultation by completing the survey, writing or emailing their views or attending a meeting or event.

Independent consultation specialists, Participate Limited, were commissioned to provide an independent report of the findings based on the feedback from the formal consultation. In developing this report, Participate undertook the following activity:

- Analysed 18,742 completed surveys
- Reviewed letter and email correspondence
- Reviewed feedback received at a range of stakeholder meetings
- Developed a coding framework based on the responses received, to extract key themes from the consultation



- Interpreted the findings of this analysis to produce a single report. The full report can be found as Appendix 8.

## **4.2 The Consultation Process**

During the 15-week consultation period a series of face-to-face engagement events across Shropshire, Telford and Wrekin and mid Wales took place.

### **4.2.1 Consultation materials**

The following range of communication materials to support the consultation process was produced, which were all available on our website and in paper format:

- Full consultation document with a pull-out survey, including equality monitoring
- Summary consultation document with a pull-out survey, including equality monitoring
- Easy Read consultation document
- Word versions of the full and summary consultation documents and survey
- Large print versions of the full and summary consultation documents and survey
- Poster and flyer
- Welsh versions of all materials

Following a request received during the early stages of the consultation, a screen reader version of the online survey was developed.

#### 4.2.2 Communications activities

A range of communication activities supported the consultation, including:

##### **NHS Future Fit website:**

The NHS Future Fit website acted as a consultation 'hub', hosting the consultation materials and survey, details of upcoming events, informative videos, news items and frequently asked questions.



Figure 4.1 – The Future Fit website

There were more than 24,000 visitors to the Future Fit website during the consultation period and more than 8,000 people completed the consultation survey online.

##### **Social media:**

Social media was used throughout the consultation to promote the consultation and to explain the proposals. NHS Future Fit accounts were created for Twitter and Facebook. A suite of social media materials – including images and short video clips – was created and a social media schedule was developed to ensure consistent, continued activity across the social channels.

**Surgeon to answer Future Fit questions over Twitter**

Health | Published: Jan 4, 2018



Hi my name is [@MarkCheetham](#). I'm a surgeon [@sathNHS](#) and I'm hosting our Twitter Chat tonight between 7 and 8pm.



Figure 4.2 – Social media communications

Social media was mainly used as a ‘broadcast’ communications channel that directed people to the website and to the programme of events to ask questions or to find out more about the proposals. For real-time engagement with the public, the Future Fit Twitter page hosted five ‘Twitter chats’ with SaTH clinicians throughout the consultation period, allowing anyone to pose questions to the clinicians and receive prompt answers.

Paid-for Facebook promotions were used in the second half of the consultation period to raise awareness of the consultation and to drive people to the Future Fit website. This paid-for activity targeted the geographical area served by the two hospitals generally, as well as seldom-heard groups within the area. The paid-for activity provided a reach of more than 40,000 people and drove more than 500 people to the Future Fit website.

**Media relations:**

The Future Fit communications and engagement team worked closely with local journalists to create opportunities for promoting the consultation and explaining the

proposals across online, print and broadcast outlets covering Shropshire, Telford & Wrekin and mid Wales.

Media relations activities included regular press releases, interviews with spokespeople from the two CCGs, SaTH and other organisations, panel interviews and features.

The communications team hosted reporters from BBC Radio Shropshire and the Shropshire Star at all 13 public exhibition events, facilitating interviews with key clinical and corporate spokespeople and responding to concerns raised by event attendees and local people to improve understanding of the proposals and to address misinformation.

The communications and engagement team also provided a press office function, responding to media enquiries and dealing with reactive media relations as required.

To supplement the earned media coverage, an advertising campaign was commissioned to raise awareness of the consultation and the programme of events and to signpost people to the Future Fit website. The campaign consisted of a total of eight days of 'page takeovers' on the Shropshire Star website, half-page adverts in all local editions of the Shropshire Star<sup>2</sup> on three occasions and one advert in the Express & Star.

While the direct impact of the print advertisements is difficult to measure, web analytics show that the online Shropshire Star advertising drove an average of 71.5 users per day to the Future Fit website: a total of 572 users across the campaign. Of these, 470 were new visitors to the site.

## Have your say on Future Fit as consultation launches

By Lisa O'Brien | Telford | Health | Published: May 29, 2018

The future of Shropshire's hospital services will be placed in the hands of the public tomorrow when a 14-week consultation on Future Fit finally launches.



<sup>2</sup> Shropshire Star, Telford Journal, Shrewsbury Chronicle, Newport Advertiser, Market Drayton Advertiser, Bridgnorth Journal, Oswestry & Border Chronicle, South Shropshire Journal





Figure 4.3 Media coverage

#### 4.2.3 Engagement activities

Over 850 people attended 12 drop-in public exhibition events which took place at key locations across Shropshire, Telford and Wrekin and mid Wales. These 'marketplace' style events provided an opportunity for people to find out more about the consultation, meet our doctors, nurses and other healthcare staff, ask questions and have their say. At each event, videos played on a loop, featuring senior decision-makers and many clinicians, explaining the changes the CCGs were proposing. The Programme team captured feedback at the events and encouraged people to fill out our survey. (An additional public panel event was also held, making 13 formal public events in total).

More than 3,100 people attended one of the 74 pop-up displays that took place at high footfall and targeted venues across Shropshire, Telford & Wrekin and mid Wales. Venues included shopping centres, supermarkets, sports and leisure facilities, community centres and libraries. These events provided people with the opportunity to find out more about the proposed changes by picking up the consultation documents and survey and find out about their nearest public exhibition event.

32 engagement events took place in medical practices and community hospitals including attending patient participation group (PPG) and patient forum meetings and setting up information stands, providing information to over 850 patients, visitors and staff.

28 council meetings were attended to provide updates and answer questions from councillors, partners and members of the public with 691 attendees.

#### 4.2.4 Staff Engagement

The Programme team worked closely with local NHS and local authority communications and engagement colleagues to promote the consultation to staff through issuing regular toolkits. Each toolkit included:

- Latest press release that had been issued to the media
- Article for website/intranet

- Dates and information on upcoming events
- Tweets and images for social media
- Links to the Future Fit website and consultation materials

Communications colleagues also received hard copies of all consultation materials to distribute in staff areas across their buildings.

Staff at both Shropshire and Telford & Wrekin CCGs were also invited to attend a monthly face-to-face briefing where they could find out updates on the consultation and ask questions.

Prior to the start of the public consultation, the Programme team attended a Local Medical Committee (LMC) meeting which was attended by GPs from across Shropshire and Telford and Wrekin to update them on the upcoming consultation and provide the opportunity for them to ask questions.

At the start of the consultation, all 55 GP surgeries across Shropshire and Telford & Wrekin were sent a pack of Future Fit consultation materials, along with an electronic pack which included a FF presentation for their digital screens and electronic versions of the materials/resources.

Throughout the consultation, GPs and practice managers were sent Future Fit updates as part of the CCGs' regular newsletters.

In the year leading up to the consultation and throughout the consultation, the SSP team at The Shrewsbury and Telford Hospital NHS Trust continued to carry out regular face-to-face engagement with their staff through meetings, briefings and alternate weekly road shows at the Princess Royal and Royal Shrewsbury hospitals. Throughout the consultation period, they also attended a wide range of meetings to engage with clinical and administrative staff and provide the opportunity for people to ask questions.

The Future Fit communications and engagement team visited neighbouring NHS organisations to engage with their staff and patients. This included holding information stands at Ludlow and Whitchurch Community Hospitals (Shropshire Community Health NHS Trust) and the Redwoods Centre and Severn Fields Medical Village (Midlands Partnership NHS Foundation Trust). They also visited The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust to talk to NHS staff, answer questions and give out consultation materials.

The Powys Teaching Health Board engagement and communications team provided information to their own colleagues during the consultation via announcements, email updates, drop-in sessions and provision of consultation literature.

### **4.3 Joint Health Overview and Scrutiny Committee**

The local authorities in Shropshire and Telford & Wrekin established a Joint Health Overview and Scrutiny Committee (JHOSC) which meets at least quarterly. The Joint HOSC is formed of members of the two local authorities, with public representation and with delegated powers of oversight and scrutiny of the local health economy. Under the terms of reference for the Joint HOSC, each local authority has retained the independent right to refer proposals to the Secretary of State.

Throughout the last four years, the Future Fit Programme has been in regular dialogue with the Joint HOSC and responded to a number of lines of enquiry posed of the Programme by the Committee members. The Joint HOSC understands and has been supportive of the

proposed model of care and complementary about the process of public and staff engagement and communications the programme has undertaken. Both Joint HOSC chairs were observer members of the Non-Financial Appraisal in 2016 and are observers on the Programme Board.

The JHOSC received the draft PCBC and consultation documents at its meetings in September and November 2017. It requested further clarification on workforce, finance and the acute and community modelling in the PCBC and the consultation documents. The Programme responded to this feedback through further detail provided in the relevant sections of the PCBC and consultation documents and through a number of meetings prior to proceeding to consultation in May 2018.

The Accountable Officers of the CCGs and the Programme consultation team attended two formal meetings with the Joint HOSC during the consultation period, on 30<sup>th</sup> July and 15<sup>th</sup> August. An update was also given at the 19<sup>th</sup> September meeting after the consultation closed on 11<sup>th</sup> September 2018.

A further meeting took place on 3<sup>rd</sup> December to receive the consultation findings report and a number of other documents that set out mitigation plans. A number of clarification points were raised and additional information requested prior to the next meeting. However the conclusion by the Joint HOSC Chair was that Future Fit had been “....a good example of consultation.”

An additional meeting was convened on 17<sup>th</sup> December to receive the JHOSC formal response to the findings. Formal written feedback on the consultation was received from the Joint HOSC on the agreed and publicised date of 3<sup>rd</sup> January 2019.

#### **4.4 Powys Community Health Council CHC**

The Future Fit Programme has undertaken thorough engagement with Powys CHC in its role to scrutinise the process from the outset. Over the last few years, the Future Fit Programme team has been in regular dialogue with Powys CHC and Powys Teaching Health Board and therefore has provided regular updates, prior to, during and post-consultation.

The Programme team attended a meeting of Powys CHC on 4<sup>th</sup> December 2018 to present the consultation findings and discuss next steps. The Powys CH Executive Committee delegated its final decision-making authority to its Montgomeryshire Local Committee which met on 8<sup>th</sup> January 2019. At this meeting, the Local Committee Chief Officer presented a briefing paper, taking votes on each section relating to Welsh law and guidance. Formal feedback was received from Powys CHC on 9<sup>th</sup> January 2019. This feedback includes the outcomes of the eight votes taken at the meeting in relation to:

- 1/ Consultation - s.27: The Community Health Councils (Constitution, Membership and Procedures) (Wales) (Amendments) Regulations 2015
- 2/ Impact - s.40: Guidance for Engagement and Consultation on Changes to Health Services
- 3/ Consideration of comments received, including any observations by Powys CHC - s.41: Guidance for Engagement and Consultation on Changes to Health Services
- 4/ The Consultation proposal - s.42: Guidance for Engagement and Consultation on Changes to Health Services

#### **4.5 Consultation Assurance**



An assurance report on the consultation process has been submitted to the Future Fit Assurance Workstream for its consideration. This report sets out the NHS legal and policy context for significant service change in relation to public consultation and engagement, and the strategies, governance and subsequent activities that have been undertaken to ensure a robust process for the Future Fit consultation in line with this context. It can be found as Appendix 19 to the DMBC.

## 5.0 The Consultation Findings

The CCGs commissioned Participate Limited to provide independent analysis of all consultation responses.

The data sections within the full report set out the analysis and feedback from each dialogue method including the survey data, meeting notes and letters/emails received:

- An analysis from 18,742 surveys
- Coding of 203 letters/emails from the public and other stakeholders
- Themes to have emerged from the consultation meetings and focus groups with seldom heard groups.

The full report can be found in Appendix 8.

### 5.1 Survey Response Rate

As part of demographic profile data collected on respondents, the first half of the postcode was collected. Responses were then segmented into Shropshire, Telford & Wrekin, Shropshire/Powys border and Powys.

The overall response rate was very high, with over 3% of the population affected by the proposed changes responding to the consultation.

51% of the 18,742 surveys received (combination of online and hard copy) were from the Telford & Wrekin (T&W) area. A contributing factor could be that Telford & Wrekin Council undertook a household drop of the hard copy survey, together with its own campaign material supporting Option 2. This meant that 5,979 out of the 10,168 hard copy surveys returned were received from the Telford & Wrekin area.

To ensure there would be no undue locality bias in the survey findings, the responses were cross-tabulated by all localities. The split by other localities is as follows:

- 19% of all surveys were received from the Shropshire area
- 8% from the Wales/Shropshire border (where the first half of the postcode could either place the respondent in Wales or Shropshire)
- 8% from the Powys area
- 9% not stated
- 5% out of area

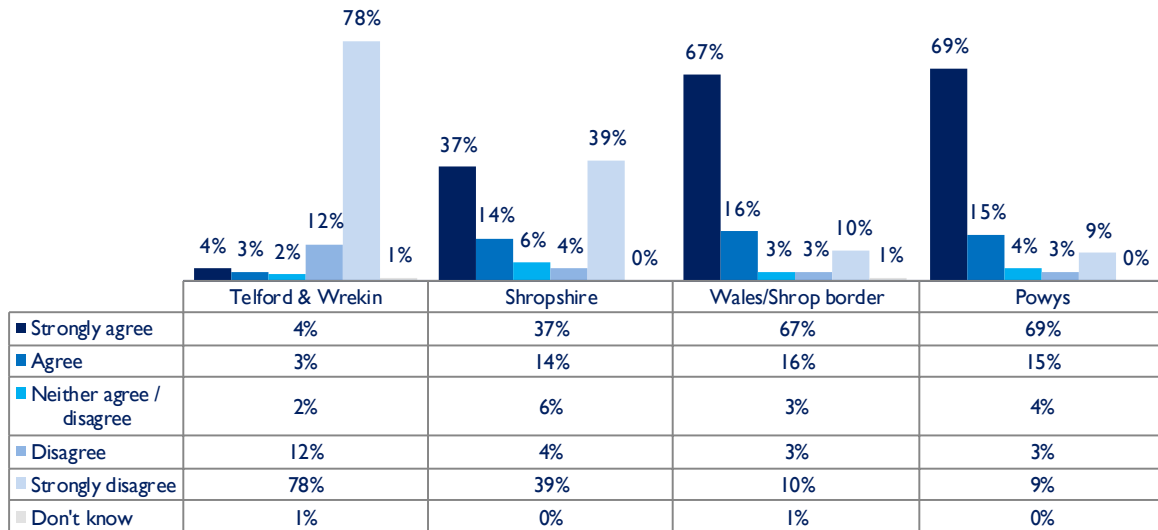
When looking at survey responses relative to overall population, the T&W % response rate was high, as was the response rate from Powys with both at around 5% of their populations responding; Shropshire was much lower, which may reflect the feelings from the public meetings that they were more comfortable with the proposals, particularly to the west of the county. The high response rate from T&W reflects the general view that they are less comfortable with the preferred option but it also supports the hypothesis that the household drop may have had an effect on the response rates in this area. Equally, the high response rate from Powys residents reflects the general view that they are less comfortable with Option 2.

The demographic profiling of responses was broadly representative of the local population across the surveys and the protected characteristic focus groups and meetings. There was slight underrepresentation in males and younger people (16-26 years old).

### 5.2 Survey Data Feedback

Whilst over half (65%) of all respondents either strongly disagreed or disagreed that Option 1 would meet their needs (50% of all responses to this question are from T&W area), this varied considerably across the different areas. In T&W, 90% disagreed with this option. Respondents from the Wales/Shropshire border and the mid Wales areas showed the highest level of agreement at 83% and 84% respectively.

**Q2a. To what extent do you agree that Option 1 would meet your needs or the needs of the people you care for, or those of the group or organisation you represent? By locality**



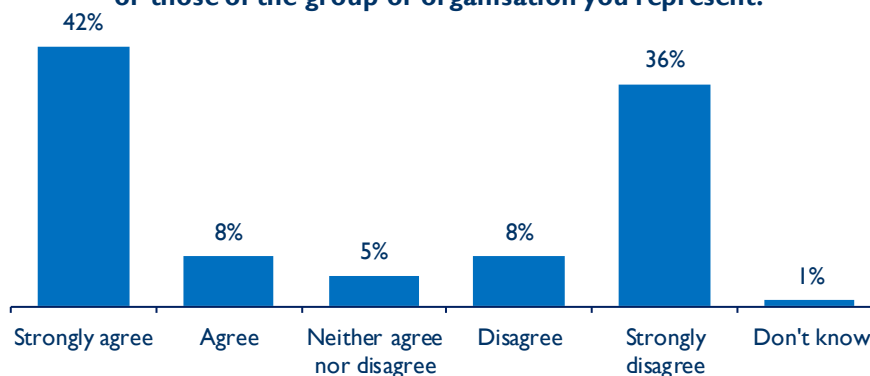
Source: Participate 2018 Bases: Telford & Wrekin: 9,150; Shropshire: 3,505; Borders: 1,594; Powys: 1,454

Figure 5.1 – Survey feedback re Option 1 by locality

By undertaking further cross-tabulation, levels of agreement with Option 1 are shown to be higher amongst those respondents in rural areas (53%) compared with only 15% in other more urban locations.

In examining the overall responses to the question to what extent does Option 2 meet their needs, 50% strongly agreed/ agreed with this statement. 44% strongly disagreed/disagreed with this option meeting their needs.

**Q3a. To what extent do you agree that Option 2 would meet your needs or the needs of the people you care for, or those of the group or organisation you represent?**

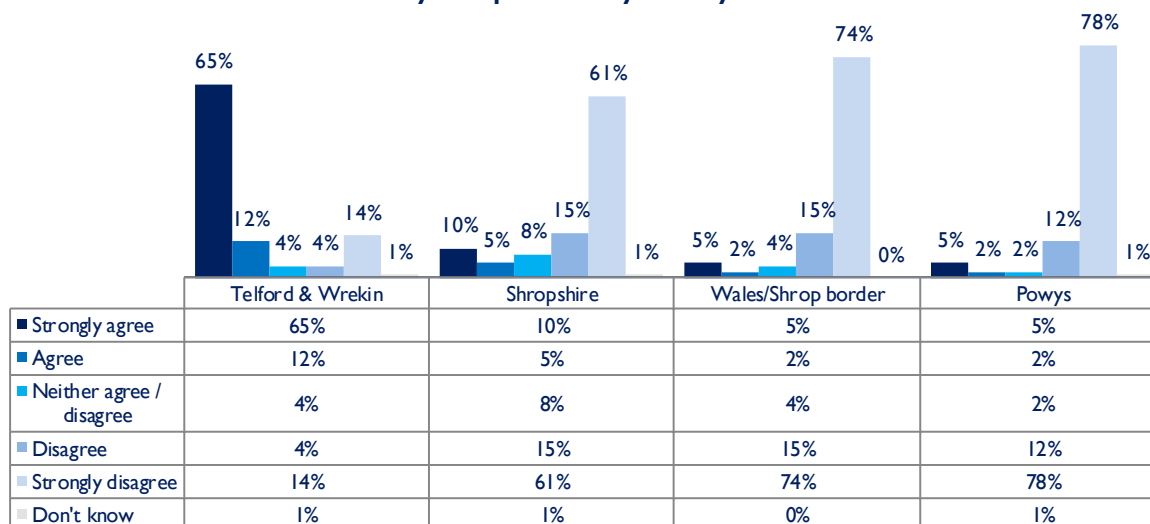


Source: Participate 2018 Base: 18,258 (all respondents)

Figure 5.2 – Overall survey feedback re Option 2

Again, as with the Option 1 question, responses to whether Option 2 would meet your needs varied considerably across the different areas, with 77% in T&W strongly agreeing/agreeing. Shropshire, Wales/Shropshire border and Powys all strongly disagreed (76%, 89% and 90% respectively).

**Q3a. To what extent do you agree that Option 2 would meet your needs or the needs of the people you care for, or those of the group or organisation you represent? By locality**



Source: Participate 2018 Bases: Telford & Wrekin: 9,403; Shropshire: 3,435; Borders: 1,551; Powys: 1,402

Figure 5.3 – Survey feedback re Option 2 by locality

Levels of disagreement with Option 2 were higher in rural areas (63%) compared with 30% in more urban areas.

In summary:

- It is important to note that the primary aim of consultation is not to undertake a referendum on proposed services changes, but to obtain views from the public and key stakeholders and gain an understanding of the impacts, both positive and negative, that the proposed changes may have.
- It is not unexpected that the levels of agreement or disagreement for either option varied by area, with T&W preference for Option 2 and Shropshire, Shropshire/Powys border and Powys preference for Option 1. This reflects a particular focus on the location of emergency care and the W&C Unit during the consultation. This is explored in the thematic analysis in section 5.3.
- The survey response rates are weighted towards T&W and this has influenced the overall % agreement or disagreement to the options. The household drop of material by T&W Council may have influenced response rates.

- Some Shropshire residents currently look to PRH as being their nearest local hospital. A significant number of Shropshire responses disagree with Option 1 (43%) with 51% strongly agreeing/agreeing. This more split response rate in Shropshire between levels of agreement and disagreement is examined further in the thematic analysis in section 6. This could be based on a focus of concerns around both emergency and planned care, given that under either option Shropshire residents will have to travel longer distances for at least some services.
- It is clear that overall levels of agreement with Option 1 and disagreement with Option 2 were considerably higher for more rural areas.

### **5.3 Overall Themes**

In line with the views identified during both pre-consultation engagement and the consultation process itself, the analysis identifies some local differences, particularly around the proposals relating to any move of women and children's inpatient services from PRH and the location of the Emergency Centre.

The overall themes reported to have emerged throughout all dialogue methods are outlined within the summary of findings in the Participate Report. However, the most commonly raised themes are highlighted below. With the exception of the theme around the move of the women and children's inpatient services away from Telford in Option 1, they are generic issues raised as rationales for or against either option across all areas of the population:

- Extended travel times for accessing Emergency Care
- Public transport links and travel times generally
- Increased pressure on ambulance services
- Concerns around the move of W&C unit and wasted investment
- Pressure on the workforce of any moves
- Meeting differing population needs i.e. two A&Es are needed
- A new centralised hospital would be a better solution
- Confusion around what services will be on each site, in particular in urgent care
- General lack of understanding on financial issues: clarity of funding; affordability; finance driven decision

Some of these themes are further developed in section 6 of this document; Addressing Common Themes and also in section 9 where key mitigations are considered.

### **5.4 Feedback from Key Stakeholders**

During the 15-week Future Fit consultation, the CCGs received formal feedback from 38 stakeholders. These responses and some key themes are set out in detail in the separate report as Appendix 10, Summary of Key Stakeholder Responses.

This was a separate analysis by the Future Fit team intended to enhance the summary report done by Participate. Key themes were identified:

Finance	Care closer to home
Mental health services	Women & children's
Patient safety	Stroke services
Population need	Consultation process
Rurality	Equalities
Workforce	Impact on other providers
Travel and transport	Alternative proposals
Emergency care	No change
Planned care	Urgent care

Figure 5.4 – Key themes used to analyse key stakeholder responses

Many of the themes mirrored those raised by the public. The report provides a detailed summary of all themes and a summary of the response from each stakeholder.

In addition to those concerns raised by the public, many stakeholder responses again related to travel and transport for both emergency and planned care. A summary of other key headlines from stakeholders were:

- The critical interdependencies of acute and community services and the potential for an enhanced community offer
- The importance of telehealth as an enabler
- That rurality is poorly understood
- The concerns around reduced staffing levels in the new configuration
- The need to carefully consider impact on other providers
- The reference to the Trauma Network view of location of the EC site
- A challenge around the consultation process and Gunning Principles

Below is a list of the key stakeholder organisation responses that were received, whether they stated a preference for either Option 1 or Option 2 and a summary of their main comments:

### **Councils**

**T&W Council supports Option 2.** Queries raised were in relation to: equalities evidence indicating differential need for their population; alternative providers' availability; public transport needs and travel times; impact on recruitment of hospital staff; impact on older people and women and children; level and source of investment in capital.

**Shropshire County Council stated no preference.** The following comments were made: Rural communities will experience longer journeys under either option; focus needs to be safe and effective services; focus on care closer to home.

**Powys County Council supports Option 1;** quality is at the centre of the decision; concerns around travel time to Telford for planned care; outreach services needed; need culturally appropriate developments; welcomed return of W&C unit to RSH (under Option 1).



### Healthwatch

**Healthwatch T&W support for Option 2.** Projected population growth and younger population in Telford; ED should be co-located with W&C Centre at PRH; concerns over staffing numbers; care in the community vital.

**Healthwatch Shropshire stated no preference;** travel and transport and accessing both emergency and planned care; people prefer Option 1 or 2 depending on their location and personal circumstances; welcomes a decision as early as possible.

### Other providers

All providers who responded offered support for Option 1:

**Midlands Partnership NHS Foundation Trust:** Link with Redwood Centre and RAID service; transfer of people detained under MHA; importance of community services supporting acute services.

**The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust:** taking account of orthopaedic trauma surgical rotas; opportunity to transform provision of MSK.

**The Royal Wolverhampton NHS Trust:** Recognises need to consolidate; wish to engage in discussions around any potential flow impacts and understand ambulance modelling.

**Wye Valley NHS Trust:** No further comment.

**Welsh Ambulance Services NHS Trust:** Understanding impact on capacity for emergency and non-emergency transport; extended travel times in Option 2; community resilience focus; impact on patient flow; repatriation protocols.

**Powys Teaching Health Board:** Consideration of other consultations in Wales; emergency care must be at RSH; travel times a concern in emergency and planned care; consultant outreach; digital solutions; improved appointment scheduling; concerns about equalities impact under Option 2.

**Hywel Dda University Health Board:** Strengthen clinical networks; removes unnecessary travel; Option 2 impact on Bronglais; concern around consultant outreach cover.

### Post consultation stakeholder feedback

West Midlands Ambulance Service NHS Foundation Trust provided a letter to summarise its position on 16th January 2019. The letter confirmed that WMAS supports the findings of the ORH Ambulance Modelling Report and are assured that, under either option, the CCGs would commission the right level of service provision to maintain patient safety and standards of care.

### Scrutiny

Both Powys Community Health Council (CHC) and the Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin Councils provided formal feedback in January 2019 after receiving the findings from the consultation.

### **The Joint HOSC**

Due to conflicting views, members were unable to agree on an overall response to the consultation. However, they did acknowledge the CCGs' participation and support in helping them to provide scrutiny to the Future Fit Programme, the high response rate and the effort to engage with seldom heard groups. They raised issues around stroke services, ambulance modelling, travel and transport mitigations and community services.

The Joint HOSC will continue to be regularly updated following the decision on the Future Fit proposals and throughout the implementation phase.

### **Powys CHC**

On 4<sup>th</sup> December 2018, the Powys CHC Executive Committee delegated decision-making authority to the Montgomeryshire Local Committee. Members of the Montgomeryshire Local Committee met on 8<sup>th</sup> January 2019 and unanimously voted in favour of Option 1. The corresponding formal written response from Powys CHC was received on 9<sup>th</sup> January confirming its position.

### **5.5 Travel and Transport Themes**

By far the most common concern related to different aspects of travel and transport. Travelling times and distance were frequently used as arguments against both proposed options, both for emergency journeys and journeys to access Planned Care. Poor public transport, prohibitive costs and difficulties with cross-border travel were also raised.

Travel difficulties for vulnerable groups were highlighted, especially in relation to older people, those in rural areas, and people with specific conditions that can make travelling more challenging, e.g. people with dementia, autism/learning disabilities, mental health issues/anxiety.

There is also a strong view that the parking provision is inadequate at both hospital sites in terms of the availability and cost.

The Travel and Transport Group, established in May 2018, has developed a mitigation plan to address some of these issues. More detail can be found in section 9.

The analysis of the responses through the Participate Consultation Findings Report has also identified specific themes relating to Emergency Care, Planned Care, Urgent Care, Women and Children's Services and Stroke Services.

### **5.6 Emergency Care/Urgent Care**

- Confusion in the distinction between urgent and emergency care
- Perceived increase in risk in extended journey times in emergency care
- Clarification of urgent care
- Concerns around demography and population growth

### **5.7 Planned Care**

- Clarification of what is meant by planned care
- Public transport concerns particularly for older people
- Need for community care closer to home
- Concerns related to barriers to accessing care for some groups with a protected characteristic

### **5.8 Women and Children's**

- Perceived wasted resource of W&C Unit
- Perception that the Telford & Wrekin demographic is more likely to need these services

### **5.9 Stroke**

- Concerns around the extended travel time in emergencies
- Concerns around current standards of stroke care even after it has been centralised

These are identified in more detail in the report findings (See Appendix 8). Some are also further developed in section 6 of this document.

### **5.10 Cross-cutting Stakeholder Themes**

In addition a number of cross-cutting themes were identified through the in-depth analysis of the stakeholder responses (Appendix 10) and also the other individual responses received by the Programme Team (Appendix 15). Many are similar to those from the survey responses:

- Travel and Transport
- Out-of-Hospital Care model
- Clinical safety concerns
- Impact on other providers
- Information technology
- Rurality
- Deprivation
- Workforce
- Process and Gunning principles
- Finance and Affordability - related to a lack of clarity around how options would be funded and concerns around the cost of borrowing.

A number of these themes are considered in more detail in Section 6 of this DMBC.

### **5.11 Campaigns**

#### **Shropshire, Telford & Wrekin Defend our NHS**

Prior to and during the consultation, there were some high profile local campaigns around the proposed changes; one led by Shropshire, Telford & Wrekin Defend our NHS, generally rejected both options and wanted to retain the current configuration by more resources being allocated to the NHS.

#### **Telford & Wrekin Council**

A second was led by T&W Council around keeping services at PRH pre-consultation and then supporting Option 2 during consultation. This campaign was also resourced by the Council in the form of a household drop of survey forms and campaign materials during the consultation, advocating support for Option 2. It is believed this has contributed to the high number of Freepost hard copy responses compared to other similar consultations and the disproportionate number of responses from T&W postcodes.

Full responses from these organisations and other key stakeholder respondents can be found in Appendix 10. Approval to share these responses in part or in full was obtained from respondents.

## 6.0 Consideration of Common Themes

This section further considers a number of the common themes emerging from the consultation both from the public and stakeholders. In considering a response to each theme, it reflects on previous relevant work carried out by the Programme team over the past five years, draws on more recent developing mitigation plans that are set out in more detail in section 9 of this DMBC and also reflects on the local and national criteria that have been consistently used for evaluating options throughout:

### Local Criteria

- Accessibility
- Quality: Time critical journeys, Safety, Effectiveness, Patient experience
- Workforce
- Deliverability
- Financial affordability

### National Tests

- Strong public and patient involvement
- Consistency with current and prospective need for patient choice
- Clear clinical evidence base
- Support from clinical commissioners
- Bed/capacity requirements

It is worth restating that the PCBC sets out a number of key benefits that will be realised through reconfiguration of acute services and the CCGs need to remain focused on these when considering any other alternative proposals heard during the consultation compared to those set out in the clinical model and preferred option:

- Safer, high quality and sustainable services
- Very best care, right place, right time
- Better facilities and environment
- Two vibrant hospitals
- Planned care separation from emergencies with fewer cancellations
- Reduced waiting times
- Attracting the very best staff to work at our hospitals
- Right level of highly skilled nurses and doctors.

In considering the themes identified in response to the consultation, there are no new suggestions that weren't evident at the pre-consultation phase. The comprehensive FAQs that were developed over the period of the Programme respond to questions raised at different events, or individual letters received. These can be found on the Future Fit website: [www.nhsfuturefit.org/faqs](http://www.nhsfuturefit.org/faqs).

Many of these themes are re-explored below. A number of specific quotes from individual surveys or other responses have also been used to illustrate the theme.

**Extended travel times will result in unsafe services in emergencies and worse outcomes. We need two A&Es.**

*"I live in a rural community in mid Wales, I believe that having the emergency care department in Telford would put lives at risk especially when considering the slow response times of the emergency services in our area".*

*"Living in Newport, I am concerned that in a life threatening situation, I shall be a long way from Shrewsbury. It might be quicker to use Stafford hospital - has that been considered for patients so far away?"*

*Longer travelling times to out of hours emergency putting lives at risk and putting greater pressures on the ambulance services.*

Some people under either option will have to travel further than they do now for emergency care. The current level of staffing at times means that there are no senior decision-makers at both the emergency departments 24/7. There are a high number of temporary agency staff, both doctors and nurses which means that there are risks to the quality and safety of care now.

Future Fit has been clinically-led since its inception and the model has the support of local clinicians and the WM Clinical Senate. Ambulance services also state that subject to the right capacity being in place they can provide safe transfer of patients in emergencies. Currently some patients are already taken out of county for example for major trauma, for coronary angioplasty and when children need specialised surgery or critical care. Outcomes are improved by going to major centres such as Stoke or Alder Hey and Birmingham Children's Hospitals. The public accept that this is the right thing to do to get the best care and the best outcomes and the evidence base for improved outcomes is clear. The concern around having to travel 17 miles further to PRH or RSH, whilst completely understandable, is not evidence-based.

Ambulance services are equipped, both in equipment and skills, to deal with longer distance journeys keeping the patient safe and stable. West Midlands Ambulance Service is a paramedic-led service with over 90% of its ambulances now having a paramedic on board.

A new study published in August 2018 from the University of Sheffield (Closing five Emergency Departments in England between 2009 and 2011: the closED controlled interrupted time-series analysis <https://www.sheffield.ac.uk/news/nr/emergency-department-closures-doesn-not-lead-to-more-deaths-1.797201>) has also found no statistically reliable evidence that the reorganisation of emergency care is associated with an increase in population mortality. However, there was some evidence to suggest that, on average across the five sites, there was a small increase in an indicator of the 'risk of death' for specific emergency conditions when compared with the five control areas studied. The populations of interest were in the resident catchment areas of five EDs that closed between 2009 and 2011 (in Newark, Hemel Hempstead, Bishop Auckland, Hartlepool and Rochdale) and five control areas.

The report concluded that any negative effects caused by increased journey time to the ED can be offset by other factors; for example, if other new services are introduced and care

becomes more effective than it used to be, or if the care received at the now nearest hospital is more effective than that provided at the hospital where the ED closed.

### *Can't we keep what we have got?*

*"Just leave it as it is."*

*"I think both the hospitals should be left alone as they are both equally important to all the areas of Shropshire".*

After the non-financial appraisal evaluation in 2016, the Future Fit Programme Board unanimously agreed that doing nothing could not be an option. This was because it was considered neither safe nor sustainable to continue as we are now. This decision was also unanimously supported by the Joint Committee of Shropshire and Telford & Wrekin CCGs in December 2016 and again in August 2017.

### *Travel and Transport Concerns*

*"I can travel to Shrewsbury on public transport, bus or train from Newtown."*

*"Travel becomes an issue as we get older particularly and driving a worry. Plans could be more easily made ahead to make the journey necessary to the Princess Royal Hospital at Telford."*

*"It would make accessing the accident and emergency facility much more difficult due to the very poor public transport to the RSH in Shrewsbury. Shrewsbury is the wrong place as the growing population is in East Shropshire in Telford."*

*"Travelling to Telford for planned care + visiting patients when there is no public transport will be impossible. A park and ride system between Shrewsbury and PRH must be provided."*

*"Transport - rural buses are few and far between and need 2-3 changes to get to either Telford or Shrewsbury for planned care etc. Taxis too expensive especially if on benefits."*

*"I currently live and work in S'bury and have no preference as to the hospital I attend for any treatment as although RSH is on my doorstep, PRH is also only a short journey away."*

*"I don't drive - but if they could put on a special bus service between the two hospitals it would work."*

The most frequently articulated concern in responses from both the public and stakeholders were around travel and transport and longer journey times, particularly for those using public transport. Travelling to either site is already an issue for some people, especially given the rural nature of our county. The Travel and Transport Group has developed a draft mitigation plan for consideration in the decision-making process. Section 9 summarises the mitigation themes and Appendices 3 and 4 contain the Travel and Transport Report and Draft Mitigation Plan in full.



**Why has Trauma influenced the decision? What about the Trauma Network in Wales?**

*“.....It would provide a high quality trauma unit in our area and attract appropriately skilled staff. Living in Telford, I may have further to travel. I accept this.”*

*“Maintaining a trauma centre at Shrewsbury is essential.”*

*“I believe your preferred option has been made very clear by consultants who want to keep their jobs at Shrewsbury trauma. You could move trauma - no excuses.”*

It is clear that one of the reasons why the CCGs have identified the Royal Shrewsbury Hospital as the preferred option for the Emergency Care site is so that it can continue to be a Trauma Unit (TU). The role of a TU in each region is to accept and manage, at any time, arrival of patients from the following two groups:

- Those considered to have injuries not requiring expertise of a Major Trauma Centre
- Those critically injured for whom direct transfer to a Major Trauma Centre could adversely affect outcome (with subsequent plans to transfer).

We know that a TU could be the primary receiver of seriously injured patients and is responsible for resuscitating and caring for patients who require optimisation if they are too unstable and unable to cope with a 45 minute transfer to a Major Trauma Centre.

The North West Midlands and North Wales Trauma Network co-ordinates trauma care services across our region and it is their view that a TU should be at the Royal Shrewsbury Hospital. This is because of its location and access for patients in the west of the region, mainly residents of mid Wales. The Network has advised that, whilst we could apply to move the TU (subject to meeting the standards and reaccreditation requirements) if the TU was at Telford, there would be an increased risk for the group of patients from Powys as their transfer times to a Trauma Unit would be significantly increased.

This view was also supported by the West Midlands Clinical Senate and Professor Sir Keith Porter (Professor of Traumatology). In any development of trauma networks in Wales, North Powys will continue to form part of and rely on the North West Midlands and North Wales Trauma Network for its patients' care.

Below is wording taken from the West Midlands Clinical Senate's Stage 2 Clinical Assurance Review Panel Final Report:

**KEY FINDING:** *The panel received evidence that from the perspective of patients with major life-threatening and life-changing trauma, the regional lead for major trauma in conjunction with the provider of adult major trauma services in Stoke have expressed a preference for option C1 (now known as Option 1). This has been driven by a number of factors but predominantly its geographical position - a significant number of patients, particularly out to the west in Wales whose care will be compromised by an additional journey time.*

**RECOMMENDATION:** *The Future Fit Programme Board should make a decision on their preferred option (Option 1).*

### Community care

*"Any reduction in hospital beds/staffing/services must occur AFTER increased community services are in place. Unlikely with total austerity cuts."*

*"I am pleased that related services will be concentrated in a single hospital because I believe that will significantly improve our experiences of all types of healthcare. However, for a document called "have your say on improving hospital services" with no mention of vibrant community hospitals is unhelpful to people living in the west."*

*"This is a questionnaire about emergency care only and its location. No consideration of care in the community, bed blocking, community hospitals for community care for those who don't need emergency care....."*

There were a number of negative comments around Future Fit being 'too limited' in not including community services. Stakeholders stated that acute and community services are 'critically interdependent' and care in the community is 'vital to reducing the demand of acute services'. Many people want to see more services available in community such as outreach clinics in community hospitals.

The Programme acknowledges the interdependency and in particular how the assumptions around admission avoidance will be delivered over the next five years. Progress has been made in the past 12 months in developing Neighbourhood Work in Telford & Wrekin and in developments in Care Closer to Home for Shropshire. This is described in section 9.2 of the DMBC along with the Powys Teaching Health Board vision for integrated health and care set out within its Integrated Medium Term Plan.

### Finance and cost cutting

*"I think it seems sensible to pool resources to the two different sites - makes economic sense."*

*"It is a pity that both sites cannot run as they are now, but in this day and age and finances being as they are the decision that has been made is acceptable."*

*"Claims of continued "investment" and continued cuts to staff and services don't add up....."*

There are mixed comments around the finances and affordability of the proposed model and the two options and some related to the whole reconfiguration being solely finance driven. Both options do provide a similar revenue saving to the Trust and to the system and therefore contribute to the system deficit reduction plan. Workforce efficiencies relate to removal of duplication, reduction in high cost agency and bank staff, improved estate and facilities and general efficiencies in the new models of working, including those relating to improved technology, are assumed to result in a saving of £14.5m. Affordability of both options is set out in the PCBC. In determining the preferred option, a cost benefit analysis was undertaken and shows that over the long term Option 1 is the most cost-effective.

The Case for Change is clear and is primarily driven by workforce and clinical sustainability. However, it does recognise that both clinical and financial sustainability are essential.

### There will be increased pressure on ambulance services

*"Longer travelling times to out of hours emergency putting lives at risk and putting greater pressures on the ambulance services."*

This was acknowledged by the CCGs and by NHSE as a potential impact of reconfiguration. The impact on the ambulance services for emergency and non-emergency patient transport (NEPT) has now been modelled. This is set out in section 9.1 of the DMBC.

### Concerns around the move of W&C Unit

*"The mother and baby care unit needs to serve the young and increasing population of Telford. It cost a fortune to build, is superb- so why change it? No waste please!"*

*"Option 1 does not make economic sense and to close the newly built women and children's centre at Telford would be a wicked waste of public money."*

*"I am a mum of four, my youngest has cystic fibrosis and has to be admitted to hospital up to four times a year for up to two weeks at a time. If we lost women and children services it would have a major impact on me as it would mean further to travel and make it near on impossible to stay with her as I have to take and pick up my other children".*

Understandably T&W residents have concerns around the move of the W&C inpatient facility in the preferred option. The public cannot understand the rationale given it was moved there only in 2014. The argument of clinical co-dependencies and the need to have the consultant-led obstetric unit and paediatric inpatients alongside the emergency centre has not always been understood. The significant number of W&C services remaining on both sites has also failed to mitigate concerns. The length of stay for children is often only 1-2 days and a commitment to provide like-for-like accommodation for families has been made in any move. The move of W&C in 2014 was a real cause for concern for many around safe care and that there would be poorer outcomes for children. This has not been the case and should the move be reversed, the benefits of consolidation of services for children will be maintained particularly for those children across the whole county who have on-going long term needs.

The Local Maternity Systems (LMS) Programme is focusing on reducing risk factors in pregnancy and examining an enhanced community hub model for antenatal and postnatal care and will contribute to improving access to services locally.

### There will be pressure on the workforce from any move

*"It looks like it will be a better more efficient service especially if clinicians get their way not politicians."*

*".....The plan to reduce nurse numbers by some 300 will leave gaps to be covered by community nursing, which in 2018 is itself being cut by £4.8 million. The proposal will categorically not meet the current needs of Shropshire, Telford, or Powys communities."*

*"Each hospital is the same distance from where I live but the need is to attract the right consultants to deal with Shropshire patients so I understand and am in complete agreement that one needs to be higher level."*

The drivers for change are primarily based on workforce challenges; challenges in recruitment and retention of staff because of a poor staff experience and workforce shortages both local and national. The reconfiguration addresses these issues and the decision to proceed to consultation has resulted in success in recruitment including a further three ED consultants. Recruitment into new extended roles has also been successful. These

positive impacts and improved working environments will mitigate some of the uncertainty of some staff needing to relocate. Many staff also already work across two sites.

### **The options do not meet differing population needs**

*"Living in rural Powys we are already at a disadvantage travel wise to any hospital. RSH would be a preferred option for emergency care."*

*"..... We do not have regular bus services and I feel that this would add extra stress of possibly not getting to appointments on time. If you are able to travel by car, parking is another problem."*

*"1. Travel would be an issue from Telford - no car & disabled. 2. My impression is that older/vulnerable persons would be restricted to accessible care. 3. Distance in an emergency is crucial."*

*"Firstly as I am disabled if my elderly husband or I had accident/trauma we would not be able to get to Shrewsbury hospital. With my husband's heart condition the difference in travelling to Shrewsbury could be the difference between life and death."*

*"Shrewsbury is my preferred option as I have a severely disabled daughter who is also epileptic and personally need it as close to Welshpool for her needs."*

Over half a million people across Shropshire, Telford & Wrekin and mid Wales use our two hospitals. This covers a very large geographical area of approximately 2,500 square miles. Shropshire, Telford & Wrekin and mid Wales are three very different areas with different populations and therefore different health needs. There is also huge variation in where our communities live, ranging from areas of densely populated housing to sparsely populated rural villages. However, there are concerns around whether there has been due consideration of access to services issues in relation to population need, including the projected population growth, the numbers of women of child-bearing age and older people, rural areas and areas with higher levels of deprivation. The Equality Impact Assessment (Appendix 1) sets out where there is potential for a disproportionate or differential impacts on certain groups whether that be for carers, people living in areas of deprivation, rural communities, BAME communities, age-related or other protected characteristics groups. It must be emphasised that both options will improve the quality and safety of services for the population as a whole and for those who are most likely to use services and therefore the positive impact will be more significant. Equally though where there is a potential negative impact around access to services and mitigations need to be considered. Travel and Transport Mitigation Plans and Equality Impact Mitigation Plans are appended to the DMBC.

### **Telford is a growing population and there has to be an A&E there**

*"I don't fully understand the difference between emergency care + urgent care. I can't see how the population of Telford which is so much higher than Shrewsbury, can function without an A&E dept."*

*"How do you justify using PRH as planned care site when we have thousands more people moving into new builds? It doesn't make any sense at all."*

The proposed model of hospital care takes into account the expected changes in our population over the coming years and how the best care can be provided for all. Having the Emergency Care site at Shrewsbury would mean fewer people would have to travel further for emergency care. More people would be disadvantaged under Option 2 (if the Emergency

Care site was based at Telford) as they would have to travel further to access emergency services. This includes communities across Oswestry, South Shropshire and mid Wales.

We also have an older population, especially in Shropshire and mid Wales. The majority of our older population live in these areas and these numbers are growing at a faster rate than across Telford & Wrekin. Population projections estimate that by 2036, people aged 70 and over will account for 25% of the population of Shropshire and 29% in mid Wales, compared to 18% in Telford & Wrekin. This has been another factor in identifying the preferred option of having the Emergency Care site at Shrewsbury.

### ***There is confusion around what services will be on each site, in particular in urgent care***

*"I don't fully understand the difference between emergency care and urgent care."*

Whilst in the consultation document and in pre-consultation engagement activity there was a focus on describing the difference between urgent and emergency care, it has failed to get the message across clearly to a significant number of people. Around six out of every 10 people who currently attend our A&Es do not actually need emergency care but need urgent care; and in the future, these people would be treated at one of the 24-hour urgent care centres at either the Princess Royal Hospital or the Royal Shrewsbury Hospital; in other words, they would be going to the same hospital as they do now for their urgent care. Around four out of 10 people who attend our A&Es do need emergency care as they have a potential life- or limb-threatening illness or injury. In the future, all of these people would need to be seen at our new Emergency Care site.

### ***Why can't we have the Northumbria Model?***

*"I think the model developed in Northumbria is possible to adapt and implement here in Shropshire. I would urge you not to reject the Northumbria model out of hand and think very carefully about the opportunity to have to build a safe, efficient, effective and affordable **integrated care system** here in the County of Shropshire".*

*"I know that the Northumbria model of healthcare has been touted as a plausible way forward and that you have dismissed it in a rather cavalier manner"*

An integrated care system is the ambition of the health and care system in Shropshire and Telford & Wrekin. However, SaTH recently commissioned a report to provide a more detailed comparison of hospital services in Northumbria with our proposed model of hospital care. Having a dedicated emergency care hospital similar to Northumbria is the solution and our clinicians have visited Northumbria and taken the best of this model into their thinking. But, there are key differences; if we adopted a clinical model exactly the same as in Northumbria and have a new emergency centre whilst retaining the two existing DGH models, then it would mean some services would have to be delivered outside of the county. The services that SaTH provides, which Northumbria doesn't, include urology, nephrology, oncology and haematology and 24 hours a day, seven days a week urgent care centres.



Adopting the Northumbria model would also have a huge impact on workforce. We are already struggling to provide staff to cover two hospitals so it would be even more difficult to staff three sites. We have also looked at adopting the Northumbria model and keeping all the hospital services that we currently provide in Shropshire. This is estimated to cost around £400-500m before we include infrastructure costs (such as roads) and the cost of the land. This is much higher than the £312 million we have been allocated from the Department of Health and Social Care. Appendix 14 provides the Northumbria Comparator Report.

### ***A new centralised hospital would be a better solution***

*"Unrealistic to have 2 emergency centres. A large single unit is more attractive to potential staff, emergency specialists in particular."*

*"It is regrettable that a single site hospital is not part of the consultation at this stage. Split site working is never a good idea."*

*"Preferred option would be to use common sense and build new super hospital midway between Shrewsbury and Telford as should have been done in first place."*

Due to the large geography of the area our hospitals serve, it would not be possible to have one hospital in the middle that offered *all services* for all patients across Shropshire, Telford & Wrekin and mid Wales. We would still have to provide some services locally. As part of our robust appraisal process, we carefully considered four options through a feasibility study in 2014, all of which would involve building a third hospital site which had an emergency department. A full cost analysis was carried out and as a result of this, it was decided that all four options would be unaffordable. In addition, the Trust is finding it increasingly difficult to staff just two hospitals so it would not be feasible to staff a third hospital. Having listened to the views of our communities, keeping two vibrant hospitals in Shrewsbury and Telford was one of the key messages that came through.

### ***Other Alternative proposals***

*"Please reconsider a different model that involves a central hub (I'd have all inpatient beds there, not just emergency ones), Day Care and outpatients at RSH and PRH, and rehab and diagnostics at the community hospitals. If you can't do that, then please go back to the Northumberland model."*

*"Is a twin site DGH hospital system totally out of the question"?*

*"It is also reasonable to ask why the CCGs have not asked the public about creating one DGH on an existing hospital site."*

In addition to the Northumbria model and a new single site, during consultation there were a number of other alternative models referred to by individuals in their responses.

The viability of smaller hospitals in other parts of the country was the focus of one response referencing Yeovil and Dorset and other examples of smaller sustainable hospitals. The importance of A&E based telehealth services supporting smaller units was included and has been introduced by SaTH. Whilst learning from other models is important, maintaining two emergency departments is not sustainable for this system and doing nothing is not viable. The clinical model of a single emergency centre has been unanimously supported by both CCGs.



At the long listing stage in 2015, a number of alternative options were considered which included moving everything to either the RSH or the PRH. Both were excluded from the shortlist as they were neither affordable nor met the expectations of the public to keep as many services as possible locally and retain two vibrant hospitals.

Finally, to conclude this section, there has also been a consistent message from the public and some stakeholders that the Future Fit Programme has taken an inordinate amount of time and resource and that the CCGs should now “just get on with it” and conclude their decision-making.

The different elements of the decision-making process, including conscientious consideration of these consultation findings are now set out in the following sections of the DMBC:

Section 7: Impact Assessments including Equality Impact Assessment

Section 8: Conscientious Consideration Process

Section 9: Addressing Key Mitigations

Section 10: Addressing Other Issues Raised by the CCG Boards and/or NHSE

Section 11 Benefits Realisation Approach

Section 12: Implementation Governance

Section 13: Analysis of Proposals and Recommendation Formation

Section 14: Decision-making

Section 15: Recommendations

Section 16: Conclusions and Next Steps

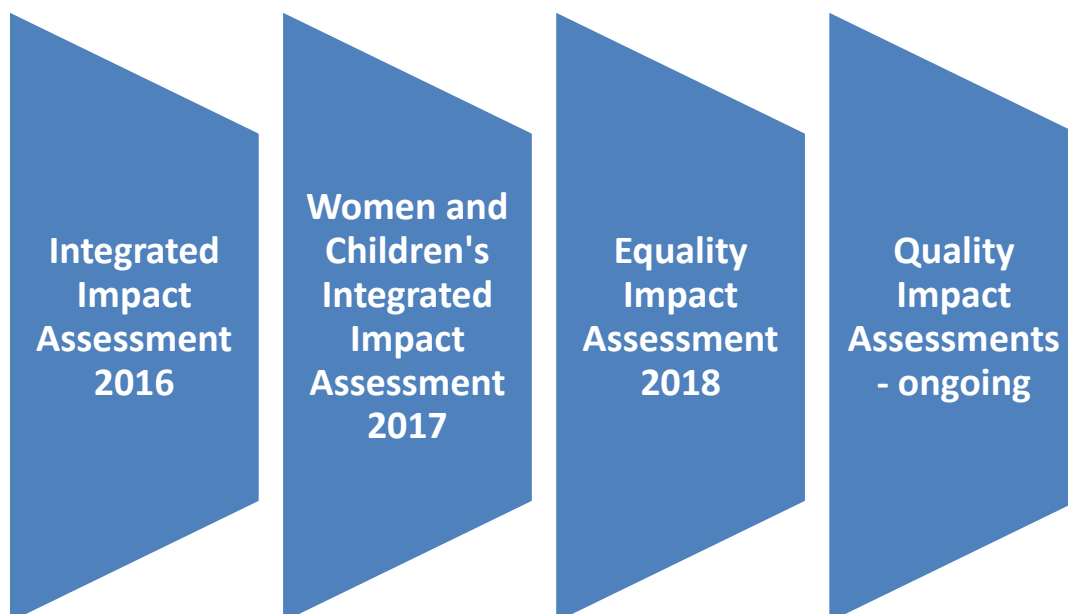
## 7.0 Integrated Impact Assessments

Throughout the Future Fit programme there has continued to be a focus on developing our understanding of the impacts that any proposed changes might have on the population as a whole and in particular considering where there may be a potential for disproportionate or differential impacts on certain groups.

The purpose of any impact assessment is not to determine the decision about which option should be selected; rather they act to assist decision-makers by giving them better information on how best they can promote and protect the well-being of the local communities that they serve.

The programme has, over the last two years throughout all the impact assessments it has carried out, used national evidence, Public Health data, Census data, travel times and distances to hospitals, and public and staff views to identify issues. These impact assessments have identified the issues common to the whole population as well as specific protected characteristic groups.

The diagram below sets out the different elements of the Impact Assessment work that has been progressed since 2016:



*Figure 7.1 – Progress of impact assessment work*

Each of these full reports can be found either as appendices to this DMBC or as part of the comprehensive document library on the Future Fit website for those produced before the Pre-Consultation Business Case (PCBC) approval in 2017.

### 7.1 *Integrated Impact Assessment 2016*

In support of the decision-making process, the Programme commissioned an integrated impact assessment report (IIA) on acute services: Future Fit Integrated Impact Assessment November 2016. The scope of the report and summary of the key findings are detailed below. The full IIA can be found on the Future Fit website.

The aim of this IIA was to conduct a robust, independent assessment of the potential impacts and equality effects of the proposed options at that time, which included option B (Option 2) and option C1 (Option 1). The IIA included economic, environmental, health and equalities impact assessments. A three-stage process was undertaken to: scope potential impacts, assess key impacts and, assess equality impacts including those on people identified as having a protected characteristic under The Equality Act (2010).

The IIA assessed potential impacts for different localities in addition to the area as a whole and for specific equality groups. The scope was restricted to assessing the impacts of the changes to acute hospital care. The IIA adopted a 25 year forward view, assessing the impact of the changes over a 25 year timescale.

The report concluded that in terms of overall health impacts, in either option, (B or C1) the main changes are expected to sustainably improve the effectiveness, safety and patient experience of clinical care provided to the affected populations.

Section 13 of the PCBC sets out the summary findings more fully, which included observations on extended travel times to accessing urgent and emergency care and planned care for certain localities.

In examining data on utilisation of acute services, three age groups were identified as potentially more sensitive to changes in local acute hospital services than others: pre-school age children, young adults (particularly men) and older people. A wider evidence base also suggested that disability is associated with higher levels of need for emergency services – particularly mental health and learning disabilities.

No evidence was identified to indicate that pregnant women and mothers of new born babies have disproportionate or differential needs in relation to acute hospital services. However, it was noted that one key point of difference between the options concerns young children, women and the pregnancy/maternity group, who may experience a negative equality effect under Option 1 arising from the relocation of care for women and children from Princess Royal Hospital (PRH) to the Royal Shrewsbury Hospital (RSH). This related to those living in Telford & Wrekin or in the eastern parts of Shropshire.

This IIA also provided some high level recommendations about how any negative impacts and effects could be mitigated and positive impacts and effects maximised. Those relating to women and children's services were then also reconsidered in the Women and Children's IIA carried out in 2017.

## **7.2 Women and Children's Impact Assessment 2017**

This complemented the IIA described above and focused specifically on women and children's services. Both documents were considered together when drawing conclusions about any relative impact analysis relating to our populations.

The aim of this additional analysis was to conduct a robust assessment of the potential health, access, economic, social and environmental impacts and equality effects of the proposed changes to women and children's services. The full report can be found on the Future Fit website.

Detailed evidence on the health characteristics and locality profiles of different groups of women and children were included in the report ([Annex 3 of the W&C IIA report](#)). It included

detailed locality profiles of population characteristics, a description of utilisation rates of services within the scope of this IIA and average travel times in car and on public transport.

Activity at any of the Shrewsbury and Telford Hospital (SaTH) sites during 2015/16 was used as proxy measures of need by lower super output area and these were included as maps. Relative rankings of utilisation using crude population rates together with actual numbers in 2015/16 were provided by locality. Both were important in considering relative impact. The extract below summarises these by patient groups:

For paediatric admissions, the Wrekin is the locality with highest population ranking and for actual activity it is Hadley Castle.

For birth inpatient spells, Lakeside South has the highest population ranking with the highest actual number of births from Shrewsbury and Atcham.

For neonatal admissions, Powys has the highest population ranking with the highest actual number of admissions for neonates from Shrewsbury and Atcham.

For gynaecology day rates, the Wrekin has the highest population ranking with the highest actual number of gynaecology day cases from Shrewsbury & Atcham.

Key recommendations for mitigation and enhancement came out of the Women and Children's IIA work and built on the previous IIA findings. Priority areas for further mitigation included:

- Reducing unnecessary journeys and transfers
- Safer care pathway agreements for children
- Reducing risk factors before, during and after pregnancy.

Other areas for further investigation were also identified:

- Work to enhance the availability of urgent services in remote locations;
- Additional data and information requirements to better understand patient experience;
- A strong public awareness campaign surrounding the correct service patients should access in the case of a medical emergency, potentially targeting the population as a whole, with emphasis on the current and future services across the sites;
- Build on existing and planned public health interventions and consider a more proactive/aggressive system-wide approach to prevention, bridging deprivation and other equalities gaps which would more effectively and appropriately support the reconfiguration and improve outcomes for women and children;
- Continued engagement with the West Midlands and Welsh ambulance services on the proposed model and on ambulance response times across Shropshire, Telford & Wrekin and Powys.

### **7.3 Developing IIA Mitigation Plans**

Following the Joint Committee decision-making process in August 2017, recommendations from both IIAs were drawn together in a draft mitigation plan. In early 2018, both IIAs were considered by the Programme Board pre-consultation and a number of priority areas and a structure for progressing mitigation work were agreed:

- Service-level Quality Impact Assessments for all clinical areas to be progressed
- Local Maternity Systems and Maternity Review
- Travel and Transport Group
- Impact on Paediatrics, Planned Care and Trauma

- Equality and Diversity/seldom heard groups and nine protected characteristics
- System-wide Workforce Transformation Plan
- Telford & Wrekin Neighbourhoods and Shropshire Care Closer to Home out-of-hospital programmes
- Public awareness of the model

These priorities and work on these were overseen by the IIA Steering Group which reported progress to the Programme Board. An independent chair was nominated to support the work.

The IIA mitigation plan was developed by the Steering Group (Appendix 16). All these themes are developed in section 9 when considering addressing common themes from the consultation and any mitigation.

#### **7.4 Equality Impact Assessment**

An Equality Impact Assessment (EIA) refresh was conducted pre-consultation in April 2018. The full report can be found in Appendix 1. Many of the findings had already been recognised in the previous two IIAs carried out in 2016 and 2017.

The Programme recognises that some protected characteristic groups may face additional difficulties in accessing the reconfigured services. However, it is also worth noting that the reconfiguration of services for some protected characteristic groups will, in fact, improve their access to these services as specialist sites are relocated more locally to them.

Additionally, reconfiguration will ensure that when our sickest patients do use these services, better access to senior clinicians will mean they will get the right diagnosis, start the right treatment quicker and get better faster, meaning their clinical outcomes will improve.

The public consultation process provided a public forum for people to share their experiences of accessing health services. It is hoped therefore that this process has in itself promoted better relations between people possessing protected characteristics and those that do not by raising awareness of the range of challenges each section of society may experience. Local voluntary organisations were commissioned to support the consultation process (PAVO – Powys Association of Voluntary Organisations, Impact Counselling and Psychotherapy in Telford, and Shropshire Rural Communities Charity - RCC). The Programme continues to engage with these and voluntary sector organisations working with the nine protected characteristics in the next phase of developing the Outline Business Case, so they can help ensure the needs of all members of the public are given due consideration.

The consultation process involved detailed mapping and engagement with seldom heard groups across Shropshire, Telford & Wrekin and mid Wales. A flexible approach was taken to encourage a broad range of views and this included attending existing meetings and events, organisation of focus groups, individual meetings and the circulation of consultation information and materials. Overall, 222 meetings were attended with seldom heard groups and consultation information circulated to a further 49 seldom heard groups.

The analysis and evidence presented in the full EIA have highlighted a number of potential impacts that people with protected characteristics may experience in accessing the health services under consideration within the reconfiguration proposals. Table 7.1 below summarises these potential impacts.

The disproportionate impacts identified mainly relate to increased travel and transport and costs. The level of potential positive, negative or neutral impact is linked to where people

live, particularly if they live in a rural or a deprived area and also if they belong to more than one of the protected characteristic groups.

Service	Option 1	Option 2
Emergency care	Positive impact: larger number of older and younger people in Shropshire and Powys. Negative impact: smaller number of older people, BAME groups and people living in deprived areas of Telford and Wrekin. Possible disproportionate impact on LGBT groups, gypsies and travellers and people with a disability depending on where they live.	Negative impact: larger number of older and younger people in Shropshire and Powys. Positive impact: smaller number of older people, BAME groups and people living in deprived areas of Telford and Wrekin. Possible disproportionate impact on LGBT groups, gypsies and travellers and people with a disability depending on where they live.
Consultant- led maternity	Positive impact: larger number of women of childbearing age/pregnant women in Shropshire and Powys. Negative impact: smaller number of women of childbearing age/pregnant women in Telford and Wrekin, particularly BAME women, pregnant teenagers and women living in deprived areas. Possible disproportionate impact on older women, lesbian and bisexual women and women with a disability depending on where they live.	No change in impact for women of childbearing age and pregnant women across all areas.
Paediatrics	Positive impact: larger number of babies, children and young people in Shropshire and Powys. Negative impact: smaller number of babies, children and young people in Telford and Wrekin, particularly if they are from a BAME group, have a disability and/or live in a deprived area.	No change in impact for babies, children and young people and their families across all areas.
Planned care	Negative impact: larger number of older people in Shropshire and Powys, particularly people who live in a rural and/or deprived area and who don't drive or have relatives living nearby. Positive impact: smaller number of older people in Telford and Wrekin. Possible disproportionate impact on LGBT people and people with a long term condition depending on where they live.	Positive impact: larger number of older people in Shropshire and Powys. Negative impact: smaller number of older people in Telford and Wrekin, particularly if they are from a BAME group and/or live in a deprived area. Possible disproportionate impact on LGBT people and people with a long term condition depending on where they live.

*Table 7.1 - Summary of potential disproportionate impacts of the proposed reconfiguration on people with protected characteristics*

Central to the Equality Impact Assessment is the consideration of actions to mitigate adverse impacts.

Consideration has been given as to whether separate or combined actions are necessary to lessen any negative impact on any relevant group and better promote equality of opportunity. A draft set of recommendations has been included in the EIA and these were considered by the Programme Board in their conscientious consideration phase.

#### **7.4.1 Recommendations from the EIA**



The Future Fit Programme has reached stage three of its Equality Impact Assessment, the post-consultation pre-decision stage. In examining this evidence and analysis and the detailed findings from the consultation response, the Future Fit Programme Board, through its conscientious consideration, will need to consider any necessary and relevant mitigation plans to address impacts or issues raised for protected characteristic groups and for the wider population, prior to making any final recommendations to the Joint Committee of Shropshire and Telford & Wrekin CCGs. The suggested initial mitigations are described below, and these will need to be worked through together with any further issues and mitigations once a decision about the way forward has been made. This will be the focus of stage four of the Equality Impact Assessment process.

For this reason, any issues and mitigations described at this stage must be considered preliminary, not exhaustive. The Programme has also shared the content of the draft EIA with the Directors of Public Health from Shropshire and Telford & Wrekin Councils and Powys Teaching Health Board and sought their input to inform the final EIA Report.

It is recommended that mitigation plans will need to include but not be limited to:

### **Engagement and Communications**

1. Developing an effective communications and engagement strategy, looking to address continued confusion from the public including those with a protected characteristic, regarding the differences between emergency care, urgent care and planned care. This could include the use of various tools such as online video, telling stories of services now and the proposed changes, emphasising that there will be urgent care on both sites where the majority of people will be able to go, as now. Advertising and materials should be in different languages and formats where appropriate.
2. Developing a strong public awareness campaign about the correct service to access in the case of an urgent or emergency medical need. Consider different tools and languages/formats to reach the widest possible audience and people belonging to a protected characteristic group. Target in particular those groups most likely to access A&E services, for example, young men, parents of young children, older people and new migrants.

### **Travel and Transport**

3. Incorporating findings into the work of the Travel and Transport Group and the potential impacts for access and travel on protected characteristic groups as set out in the EIA into the Travel and Transport Mitigation Plan. As the impact is likely to be greatest on people living in an area of deprivation or a rural area, older people and young people, people with a disability and homeless people, particular attention should be paid to the needs of these groups. This should include a review of appointment times by the Acute Trust and how these could be adjusted to take increased travel times and costs into account, particularly for groups who are more likely to travel by public transport. This includes people living in deprived areas, older people and younger people and people who are likely to have to travel further, for example, people living in rural areas.

### Out-of-Hospital Care

4. Considering how the out-of-hospital care strategies for Shropshire, Telford & Wrekin and Powys might mitigate some impacts in looking at avoiding the need for hospital admission, the need to travel to hospital for appointments and for any other opportunities for enhancing local services for some groups. Particular consideration needs to be given to groups who are more likely to travel by public transport, such as people living in deprived areas, older people and younger people and people who are likely to have to travel further, for example, people living in rural areas. Example developments under consideration include telemedicine.

### Women and Children's Services

5. Addressing the areas of mitigation in the Women and Children's Integrated Impact Assessment in 2017 that were set out in three broad areas to address the anticipated impacts relating to a consolidation of women's and children's services, including:

- i. Reducing unnecessary journeys and transfers for young children.
- ii. Safe care pathway agreements for children.
- iii. Reducing risk factors before, during and after pregnancy (particularly for young women, BAME women and women living in deprived areas.) This will include the work within the Local Maternity Systems (LMS) Programme.

6. Ensuring the ongoing review of midwife-led services considers findings and analysis in the EIA and that this feeds into developing the model of care for midwife-led services and in particular in the design, location and scope of community hubs under consideration.

7. Ensuring the provision of appropriate accommodation for parents/carers whose child is an inpatient to mitigate the impact of longer journey times and increased costs.

Post final decision-making and in the next phase of the reconfiguration programme the CCGs, the acute Trust and the wider STP partners should:

### Public Health

8. Continue to work collaboratively to build on existing and planned public health interventions and have a more proactive system-wide approach to prevention, bridging deprivation and other health equalities gaps.

### Patient and Public Involvement

9. Continue to work collaboratively with the voluntary sector, community groups, Healthwatch and patient reference groups to carry out more detailed assessments of potential impacts in future phases of the development, including the design phase and through to implementation.

10. Continue to improve the volume and diversity of patient views and increase future opportunities for ongoing engagement and establishing long term relationships with the protected characteristic groups as a result of the links developed through the Future Fit consultation.

### Addressing Language Barriers

11. Continue to consider an inclusive approach to language barriers through fair access to information, services and premises supported by embedding equality and inclusion compliance for all sections of our local community.
12. Consider the translation, interpretation and other services available to people whose first language isn't English in delivering any newly configured service to ensure that it is effective and that speakers of other languages are not negatively impacted when they access services.

### Data availability

13. Noting the limited hospital service activity data breakdown available, consider how the collection and analysis of data and information can be improved to better understand patient flows and experience of the people belonging to a protected characteristic group.

### Ongoing Engagement

14. Continue to share the EIA report and the outcomes of the consultation with the groups that the Programme has engaged with in developing the EIA and particularly the voluntary sector and others representing seldom heard groups to ensure that they are aware of how their feedback is utilised in the decision-making process.

Each of the recommendations 1-7 are further developed as mitigation plans in section 9 and section 10.

### 7.5 Quality Impact Assessments (QIAs)

The Trust has been tasked by the Future Fit IIA Steering Group to ensure that it has a system in place for developing Quality Impact Assessments for any relevant operational change pre-implementation and that they feed into the STP Clinical Strategy Group where appropriate. The process for developing and approving operational QIAs exists within the SSP. Figure 7.2 below sets out the governance structure.

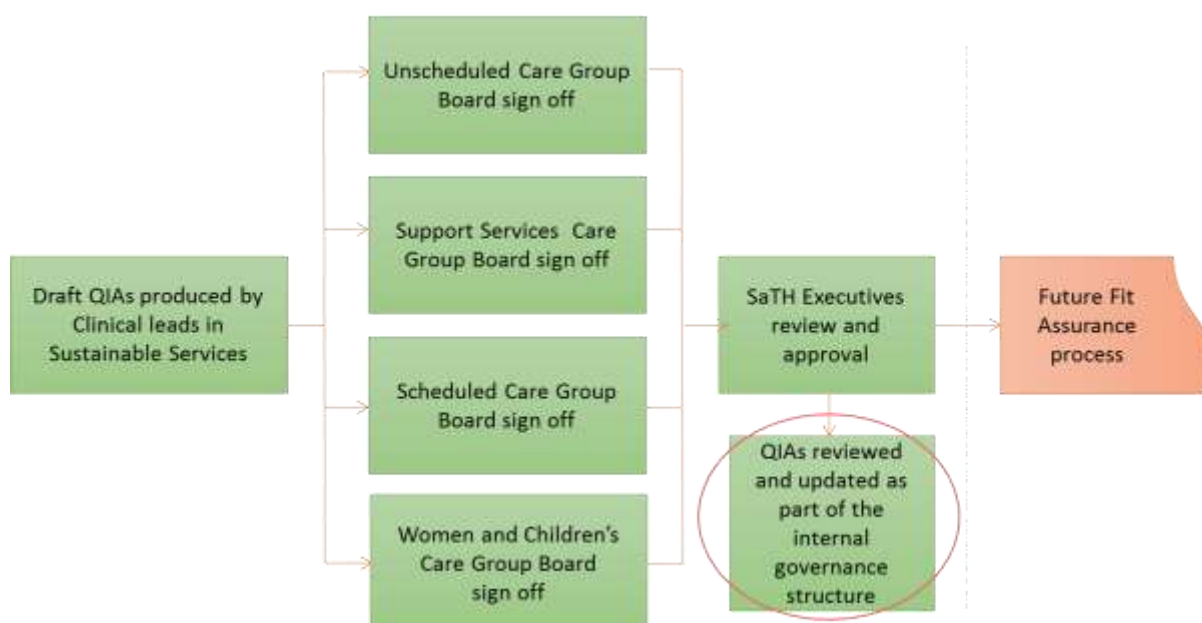


Figure 7.2 – Governance structure for development of Quality Impact Assessments for operational change

A number of QIAs have already been developed for key risks identified:

- Safe transfer of the deteriorating inpatient on the Planned Care site
- Safe transfer of walk-in patients on the Planned Care site (adult and child) where Emergency Care site care is required (across all specialties)
- Impact on patients from certain sections of our communities
- Recruitment and retention of the workforce
- Appropriate capacity within specialties and sites
- Pathway redesign
- Appropriately trained workforce across all disciplines
- Appropriate allocation of patients to site (scheduled and unscheduled)
- Maintaining safe operational delivery during construction phase
- Communication to enable patients to receive care on the right site first time.

Key mitigating actions have also been identified and are being progressed, for example:

- Robust pathway and service development with all stakeholders
- Robust communications and engagement with the public relating to the service offer on each site
- Extensive training programme to deliver skills and workforce where needed
- Full clinical engagement to identify essential skills, facilities, IT and equipment for the safe management of patients at each point of the patient's pathway.

A number of key QIAs developed by the Trust can be found as Appendix 17.

## **8.0 Conscientious Consideration of the Consultation Responses**

The Gunning Principles are a set of rules applicable to all public consultations that take place in the UK and are designed to make consultation fair to both consultor and consultee. Failure to follow the four Gunning principles may lead to a judicial review. The fourth principle states that the product of consultation must be conscientiously taken into account when finalising the decision.

The Accountable Officers and Chairs of the CCG Governing Bodies discussed this process, took legal advice and agreed an approach that ensured this principle is adhered to. They also agreed that the two CCG Boards would receive any additional information and analysis that they individually may require and that the Programme would be able to hold a Joint Committee of Shropshire and Telford & Wrekin CCGs by no later than February 2019.

### **8.1 The Approach**

The process was based on what others have used for similar consultation on service change and it was agreed that Participate Limited would facilitate Stages 1-3 in this process.

#### **Stage 1: Initial Analysis**

A full Consultation Findings Report was prepared by Participate Limited. The Programme Director and Future Fit Programme team provided an additional analysis of summaries and main themes from key stakeholders and other respondents. Original responses were themed using detailed spread sheets and consideration was given as to whether this theme had been addressed in previous work or required further investigation. Individual organisations and public bodies were written to seek permission to share the content of their responses in part or in full if required in the final report. This analysis was made available on request to Board members.

The Participate Consultation Findings Report and the Stakeholder Analysis Report can be found in Appendices 8 and 10.

#### **Stage 2: Joint CCG Board Workshop with Independent Facilitation**

A private meeting took place of the Joint CCG Boards on 14<sup>th</sup> November 2018. Attended by 16 members of Shropshire CCG and 10 members of Telford & Wrekin CCG, the purpose of the meeting was:

- to set out an approach for conscientious consideration and statutory responsibilities of Governing Bodies
- to receive in private initial draft consultation findings from Participate and the Future Fit Programme team
- to receive other material linked to key themes, for example Travel and Transport findings
- to consider other information or analysis that may be required by the governing bodies for decision-making, for example reports on outstanding actions or concerns raised at the Pre-Consultation Business Case stage
- to feed into the more detailed discussions to be undertaken at the Programme Board workshop on 22<sup>nd</sup> November

Facilitated by Jonathan Bradley, Director at Participate Limited, board members were taken through and asked to reflect on and consider the main findings from the survey responses, letters and emails received during the consultation. In conclusion, the following themes/ issues were agreed to be taken forward to the next stage of the conscientious consideration phase:

- Timescales
  - We need to be seen to pause and reflect on consultation
  - Timescale is crucial, we can't afford further delays
  - There is a balance between getting things right and any delays having a potentially worsening impact / risk to current services
  - We need to take enough time to adequately consider including validating other options e.g. Northumbria
  - Must get process right to avoid delays and judicial review
- Improving communication to the public
  - There's still an element of confusion about the model vs the options
  - We need to sell the benefits as part of a long term strategic plan
  - How the new model of care will provide improved quality of service needs to be communicated
- Community services
  - Need clarity around the community offer
- Travel and Transport
  - Need to see analysis and mitigations
- Impact Assessments
  - Are the IIAs still relevant and accurate from 2016/2017?
  - Need to see the full EIA
  - We need to see the net impact by population rather than percentage around planned care and urgent care
- Conscientious consideration of findings
  - We need to see the richness of the responses
  - Need a response from WMAS
  - Make sure nothing new, assure FF Programme Board by AOs seeing responses
  - We haven't seen anything today that materially changes what we have proposed, suggests robustness
  - Certain key stakeholder responses don't challenge the preferred option but do provide new information to be considered, e.g. response from Midlands Partnership NHS Foundation Trust in relation to the Redwoods Centre

### **Stage 3: Programme Board Event**



On 22<sup>nd</sup> November 2018, the Programme Board sponsors and stakeholder members met and discussed, at a whole-day event, the main findings from the consultation surveys, including stakeholder responses. They fully considered responses and counterarguments and through the Chairs and AOs considered feedback from the CCG Board event. All Programme Board organisations were well-represented and a number of invited guests, including SaTH clinicians and those representing seldom heard groups, were present, as were the Joint Chairs of the JHOSC.

Pre-read material included the Consultation Findings Report together with the draft EIA, the draft Travel and Transport mitigation plan and updates from the two CCGs and PTHB on out-of-hospital care strategies.

The morning session was focused on receiving the consultation findings and reflecting on whether there were any surprises, anything new emerging and where there was a need to examine further mitigating action. The afternoon was focused on receiving and discussing mitigation plans. This included:

- Travel and Transport Reports
- Impact on ambulance services
- Considering progress on out-of-hospital care strategies
- A clinical panel where acute clinicians, the ambulance service and GP lead for the MLU review responded to any safety or quality issues
- Equality Impact Assessment
- Workforce considerations
- Digital enablers

The output was a formal report from this event together with draft recommendations being incorporated into the DMBC for further consideration.

#### **Stage 4: Consideration of DMBC by CCG Boards and Programme Board**

Individual CCG Board meetings and the Programme Board meeting in December 2018 received the draft DMBC for comments. The DMBC was taken back to both CCG Boards and the Programme Board in January for any further comments and for approval to submit to the Joint Committee, subject to one further NHSE assurance meeting.

#### **8.2 Joint HOSC Response**

Findings were presented to the Joint HOSC on 3<sup>rd</sup> December 2018 and feedback was received at a meeting on 17<sup>th</sup> December 2018. The Joint HOSC formal response was received on 3<sup>rd</sup> January 2019.

#### **8.3 Powys CHC Response**

On 4<sup>th</sup> December 2018, the Powys CHC Executive Committee delegated decision-making authority to the Montgomeryshire Local Committee. Members of the Montgomeryshire Local Committee met on 8<sup>th</sup> January 2019 and unanimously voted in favour of Option 1. The corresponding formal written response from Powys CHC was received on 9<sup>th</sup> January confirming its position.

## 9.0 Addressing Key Mitigations

Through the conscientious consideration phase, the CCGs and Programme Board have heard and revisited a number of common themes raised during consultation by the public and stakeholders. Many are not new and reflect concerns expressed throughout the pre-consultation engagement and key decision-making phases over the last two years. A number align with themes raised as part of the NHSE assurance process and by the CCG Boards themselves at the PCBC approval stage. Others align with those emerging from the recommendations within the numerous impact assessments carried out.

Some of these issues were therefore already expressed as being key elements of the Programme's developing mitigation plans. At the Programme Board event on 22<sup>nd</sup> November 2018, in developing draft recommendations, consensus was gained on the key mitigations necessary before decision-making:

1. Travel and Transport Report and mitigations plan (Appendices 3 and 4)
2. Equality Impact Assessment recommendations and mitigation plan (Appendix 2). To be aligned with the previous recommendations from the Integrated Impact Assessments carried out in 2016 and 2017, with a particular focus on impacts on women and children.
3. Progress on out-of-hospital care strategies for both Shropshire and Telford & Wrekin CCGs to be described and to focus on co-dependencies in assuring the delivery of the acute model assumptions (appendices 11 and 12)
4. A clear description of the services on each site, particularly around service provision at the Urgent Care Centres
5. Clarifying affordability including the patient flow assumptions since the PCBC was approved. Noting that further refinement will be included within the OBC expected for approval in July 2019.

This section sets out a response on each of these and how the programme has progressed work to mitigate those themes identified.

### 9.1 *Travel and Transport*

Travel and transport to the Emergency and Planned Care sites has proved to be by far the most common concern raised during the consultation. There are already significant concerns about the adequacy of current public transport services, particularly to certain parts of Shropshire and Powys. The Integrated Impact Analyses (2016 and 2017) demonstrate that longer journey times of any reconfiguration of services will differentially impact on the different parts of the population served by the Trust.

Public transport is particularly an issue for the unwell, disabled and those from more deprived areas. There are also concerns for older people and their families, particularly as they are most likely to have to stay in hospital for long periods and their families would have longer to travel to visit them if they were located further away.

For children, there were similar concerns, although length of stay is often much shorter. Responses also refer to the high percentage of non-car owners in certain areas. There is also a concern about the reliance on public transport and getting to early morning appointments for surgery on the Planned Care site.

There are also fears that ambulance services will be under greater pressure under the proposals. There have been consistent concerns raised around ambulance response times. The move to a single emergency centre would increase average journey times for ambulances responding to calls and transporting patients to emergency care. The public has

expressed concerns about whether that additional journey time would impact on outcomes for patients in emergency situations.

Concerns around the impact upon service delivery and operational capacity for all ambulance services in emergency and non-emergency situations were raised at PCBC approval stage. These concerns continued to be raised during the consultation. Consequently the CCGs commissioned a piece of work described below to better understand this impact and to enable them to commission a service with sufficient capacity.

A Travel and Transport Group was established in early 2018 to address the issues which were identified in the early Integrated Impact Assessments completed in 2016 and 2017 and from pre-consultation engagement concerns raised by the public and stakeholders.

Mitigation plans have been under development in three specific areas:

- Ensuring that there is sufficient capacity available within the commissioned emergency and non-emergency transport ambulance services. The work of Operational Research in Health Ltd (ORH) in modelling the impact of the proposed reconfiguration has been included within this DMBC. (full report Appendix 9)
- Safe Transfer of Patients policies developed and led by SaTH to address the need to safely transfer patients from the Planned Care site to the Emergency Care site should they require more specialist care. The policies also covers patients who will be transferred from the Emergency Care site to the Planned Care site when they no longer require specialist care but need a further period of inpatient stay. (Appendix 6)
- A Travel and Transport Mitigation Plan has been developed to address the particular concerns around public transport and access. (Appendix 4)

### **9.1.1 Ambulance Impact Modelling**

In order to assess the impact that either of the proposed changes would have on the emergency, routine and air ambulance provision, there was a need to be able to model the different options being proposed.

ORH was selected to undertake the modelling work for the programme. ORH has, for many years, been working with ambulance services, amongst many other public bodies and commissioners both in the UK and abroad, to carry out work similar to that required by the Future Fit Programme Board.

To undertake this work, ORH collected data from the Office for National Statistics and engaged with the following providers:

- Shropshire Patient Transport Services - Falck
- West Midlands Ambulance Service (WMAS) – Emergency Services (EMS) and Air Ambulance
- Welsh Ambulance Services NHS Trust (WAST) – emergency medical services (EMS), Patient Transport Service (PTS) and the air ambulance services
- The Shrewsbury and Telford Hospital NHS Trust

The work was overseen by the Travel and Transport Group. Table 9.1 below is an extract from the report and sets out the impact on the two ambulance trusts in terms of additional vehicle hours:

	<b>Option 1 (RSH Emergency Care, PRH Planned Care)</b>	<b>Option 2 (PRH Emergency Care, RSH Planned Care)</b>
WMAS	144 vehicle hours	90 vehicle hours
WAS	0 vehicle hours	32 vehicle hours
<b>Total</b>	<b>144</b> vehicle hours	<b>122</b> vehicle hours

Table 9.1 - Impact of each option on each of the Emergency Service providers

WMAS is affected by Option 1 more than Option 2. WAST is unaffected by Option 1 but will be impacted by Option 2 where the Princess Royal Hospital provides emergency care, creating a longer travel time for patients from mid Wales.

However, overall the impact of implementing either option is very similar when looked at in terms of total emergency medical services into the county of Shropshire e.g. 144 hours where RSH provides emergency care or 122 hours where PRH provides emergency care.

Simulation models for each provider were used to identify the additional vehicle hours required to restore performance to the baseline position under each option. The requirements are summarised in Table 9.2 below:

Service		Option 1	Option 2
<b>Shropshire PTS (Falck)</b>		<b>136</b> additional stretcher vehicle hours per week	<b>136</b> additional stretcher vehicle hours per week
<b>WAST PTS</b>		No resource requirement	No resource requirement
<b>WMAS</b>	No change in time at hospital	<b>144</b> additional ambulance hours per week	<b>90</b> additional ambulance hours per week
	Time at hospital reduced to 30m at emergency site	<b>100</b> additional ambulance hours per week	<b>40</b> additional ambulance hours per week
<b>WAST EMS</b>		No resource requirement	<b>32</b> additional ambulance hours per week

Table 9.2 - Impact Summary: Restoring Performance to Baseline Position

The modelling indicates that both options are broadly similar in their additional resource requirements for non-emergency patient transport services. Although the local patient transport service, provided by Falck, for either option requires an additional 136 stretcher vehicle hours. Option 1 (RSH emergency care, PRH planned care) affects slightly more patients but still represents only 4.18% of all journeys undertaken by Falck.

Patients travelling from mid Wales are relatively few and the numbers affected are consequently low. Neither of the options produced sufficient evidence for more resource.

The model identified an impact on the emergency services provided by Welsh (WAS) and West Midlands (WMAS) although either option has a very similar requirement in additional resources.

WMAS state that whilst there may be longer journey times with the CCGs preferred option of Option 1, this would create an improved flow which would improve the turnaround times for ambulance crews and, as a result, improve performance standards.

The impacts on routine patient transport services (Falck) are well defined in the ORH report with either option requiring more stretcher resource(s) to be based at Atcham, although further work will be required on establishing the precise number of vehicles and their hours of working.

The EMS impact requires further discussion with stakeholders to determine how the additional resource hours can be created. The following are some examples:

- Additional resources. The overall impact equates to a single 24/7 resource.
- Conveyance rates. A discussion on whether WMAS and WAST have plans to reduce their conveyance rates through, for example, new clinical interventions provided by paramedics or more opportunities to signpost patients to more appropriate pathways. Whilst this may not reduce the impact on ambulance services due to job cycle times, it may reduce the impact on emergency departments.
- Handover times. Modelling by ORH has identified that reducing patient handover to the national accepted standard of 30 minutes (clinical and crew turnaround) could recover between 40 and 50 vehicle hours.

All of the above potentially requires system changes and therefore wider engagement. The full report Modelling Options for Change can be found in Appendix 9. This work will inform the discussions between the CCGs and the ambulance service providers on any implications for contracts.

The CCGs have currently made a prudent estimate of cost in their Long Term Financial Models (LTFMs) and will refine this as specifications are developed.

### **9.1.2 Safe Transfer of Patients**

SaTH currently does not have all services on both sites. As a consequence, there are already safe transfer policies in place which are agreed with ambulance service providers to enable the safe transfer of patients who present on the wrong site and need to be transferred either to the other site within the Trust or to another hospital outside of area to receive specialist care. Examples include surgical, paediatric, stroke and trauma patients.

The clinical model for post reconfiguration requires the development of robust pathways to ensure the safe transfer of patients in the following scenarios:

- Transfer to the Planned Care site post-admission to the Emergency Care site modelled at 72hrs post admission for appropriate patients. Clinical audit completed supported the modelling. Sub-specialty pathways development is ongoing
- Deteriorating patient on Planned Care site requiring transfer to the Emergency Care site
- Emergency patient walking into Urgent Care Centre on the Planned Care site
- Unstable elective patient during surgery
- Elective patient deterioration post-surgery from ward.

Draft pathways and policies have been developed with a further programme of work underway to test the assumptions. A programme of clinical audit is being developed with guidance and support from other Trusts to ensure that the modelling assumptions are robust. The management of these pathways and patients forms a large part of the Programme's QIAs.



The Trust has been collaborating with experts in clinical transfer policies and developing appropriate pathways post reconfiguration of services. These include representatives from WMAS and WAST, the Trauma Network and the air ambulance services.

This work will continue to develop a new service specification and Standard Operating Procedure (SOP) for the safe transfer of patients post reconfiguration of services. Any new policy will need to be in place before any relevant service changes are implemented. It assumes that the ambulance service will make the decision on the most appropriate site once a decision is made that the patient needs on-going treatment, whether that be the Emergency Care site or the Urgent Care Centre on the Planned Care site.

A small number of patients will present on the Planned Care site but will benefit from more complex care and these patients will be stabilised at their presenting UCC, have treatment commenced and be transferred to the Emergency Care site or the most appropriate specialist unit for their on-going care.

Current emergency patient pathways and protocols which involve an agreed hospital bypass process will continue, for example serious heart attacks and major trauma.

During initial optimisation and diagnosis at the UCC on the Planned Care site, consideration will be given as to whether the patient needs to be transferred. This is a clinical decision based on the benefits of transferring the patient. It will be made by the team assessing and optimising the patient with due regard and knowledge of the agreed patient pathways across the Trust. The decision will be facilitated by input at the presenting site and also by contact with the Emergency Care centre or other specialist unit to discuss the patient's suitability.

Prior to any transfer, a risk assessment will be undertaken to identify the level of anticipated risk and hence the competencies of the staff who will accompany the patient. (See draft protocol in Appendix 6).

### **9.1.3 Travel and Transport Mitigation Plan**

This Plan draws together travel and transport issues raised within the two Integrated Impact Assessments, the Transport Study undertaken by JMP for SaTH in September 2016, key issues identified from the members of the Travel and Transport Group and the key themes from the Consultation Findings Report submitted. The Full Report and Mitigation Plans can be found in Appendix 3 and Appendix 4.

A number of areas for mitigating action have been identified:

- Consider implications on proposed model through review of the Department of Transport's Inclusive Transport Strategy: achieving equal access for disabled people
- Ensure access to national funding is available to improve transport infrastructure and services in the county
- Review Shropshire Travel Plan 2011-2026 to incorporate impact of hospital reconfiguration
- Review Telford & Wrekin Travel Plan 2011-2026 to incorporate impact of hospital reconfiguration
- Review Powys Local Development Plan 2011-2026 to incorporate impact of hospital reconfiguration
- Shropshire and Telford & Wrekin integrated care programmes - deliver services closer to home resulting in fewer hospital admissions and need for travel
- Baseline review of all public transport providers across Shropshire, Telford & Wrekin and mid Wales to identify opportunities for improvements through a collaborative and



system-wide partnership approach where travel stakeholders are working together to map public transport availability and identify opportunities to improve services, reduce overlap and improve spread of availability

- Bus services travelling to the hospital and on site - improve the number of journeys to and from hospitals
- Concessionary travel - raising awareness of eligibility for concessionary travel
- Through-ticketing developed - seamless access across borders
- Train services - raise awareness of the current train links and review opportunities to improve
- Review of taxi service provision, including pricing and access
- Review provision of community transport services across Shropshire, Telford & Wrekin and Powys
- Increase the role of community transport services
- Widen the scope and role of community transport services
- Raise awareness of community transport availability for those who need it
- Review all non-emergency patient transport services to ensure fitness for purpose and opportunities to provide services to areas which lack services
- Review other potential transport options e.g. Fire Service vehicles
- Publicise widely the Help with Travel Costs Scheme
- Improve and reduce the need for parking facilities for patients and staff across both sites
- Develop Park and Ride facilities
- Improve signage and walking access to site
- Reduce unnecessary travel to hospitals
- Use of technology to reduce travel and travel costs

The proposed mitigations will be progressed through the Travel and Transport Group.

#### **9.1.4 Use of Technology**

A key enabling activity to help mitigate the need to travel to hospital will be the digital developments that will be progressed over the implementation period of Future Fit. In the future, technology will be utilised to:

- Prevent the need for hospital journeys as much as possible by making available virtual access to specialists from several locations remotely; and by identifying high risk individuals early, using data analysis and correlation from multiple sources.
- People will be able to access support for self-care and decision making using available technology. This will include access to relevant information and clinically approved apps to support decision making.

The Shropshire, Telford & Wrekin Local Digital Roadmap sets out the ambition to improve health and care for the population with an aim to provide an informed and seamless flow of care. The vision to make the right information available to the right people at the right time, in the right place to enable the best possible care, supports all local health and care partners to make decisions.

The roadmap will lead to easy collaboration between individuals and teams within and between organisations, making technology an enabler and not an obstacle. The journey to get there requires support from all partner organisations to get to a common, high standard in three main areas over the next 3-5 years:

Year one onwards - **Infrastructure and Security** - making sure that all of the technology behind the scenes ensures that information is accessible at the point required, and is only seen by the appropriate individuals.

Year two onwards - **Data and Business Intelligence** - make sure that the appropriate teams have the right information to ensure care runs smoothly, with continuity between teams working with a shared care record, whether caring at home, in the community, or in hospital.

Year two onwards - **Digitally able staff and residents** - make sure that people are comfortable with using the tools and systems available to them, with training available to get them to the level required.

Outcomes should include:

- More information available to residents, utilising assistive technology and unobtrusive wearable devices where suitable, helping them to stay healthy at home, manage long term conditions better at home and reduce the need for trips to hospital as much as possible.
- Providing primary care and community clinicians with access to the same information as acute and specialist services where appropriate to enable a streamlined flow of joined up care.
- Utilising telehealth and multimedia conferencing to access expertise from multiple specialists from several locations remotely for some checks and consultations to reduce the need for long trips from rural areas.

Key milestones are set out in the Local Digital Roadmap for Shropshire, Telford & Wrekin.

## **9.2 Out of Hospital Care**

A recurring theme during pre-consultation engagement and in the consultation process was the lack of understanding of what services might be available in the community to support the acute model and to reduce the number of times people would have to travel to hospital. Some people also had concerns about the number of admissions the PCBC had assumed will not take place in future and how that might be delivered. Investment in community services and a wish to have more planned activity closer to home was a recurring theme, particularly relating to more rural communities and the use of existing community hospitals.

For the acute model of care described in the PCBC to work optimally and to achieve maximum benefit, the CCGs recognise that all health and social care sectors need to make a contribution to effective and integrated patient pathways, which both support reduction in demand on acute services and improve flow through acute services to discharge back into the community.

This section provides updates on the approaches currently being taken to ensure that the wider system capacity changes and impacts are delivered to support the acute reconfiguration activity and capacity assumptions since it was set out in the PCBC in November 2017. It describes the proposed community models at their current stage of development through the Neighbourhood and Care Closer to Home workstreams for each commissioner. More detailed reports can be found in appendices 11 and 12.

### **9.2.1 Shropshire CCG/local authority area**

A review of the provision of community-based services in the Shropshire CCG/local authority area in 2017 identified the need to make changes to the overall system that is required to better deliver services closer to home. The Community Services Review identified a case for change and the out-of-hospital programme was agreed to develop options for future delivery models of community services that are:

- Equitable, clinically and financially sustainable and consistent
- Fit for the future needs of the people of the Shropshire CCG/local authority area
- Functionally integrated with the rest of the county’s urgent care system as required by NHS England’s Next Steps on the NHS Five Year Forward View
- Able to deliver the activity assumptions set out in the Pre-consultation Business Case (PCBC) for Future Fit

Out-of-hospital care will become a much larger part of what we do across the Shropshire care economy. The PCBC sets out the work completed by Optimity (2017) and Deloitte (2016) which illustrated Shropshire’s over-dependency on inpatient resources secondary to inadequate, poorly commissioned community-based services. Optimity (2017) suggested that through moving secondary service utilisation by a five year age band will reduce emergency usage of secondary services by 385 cases per 5,000 head of population within the 65+ age band, equating to 4,586 admission avoidances.

Based upon the existing parameters in the Future Fit PCBC, the target admission avoidance for this age band is set at 2,689. The work produced to inform the target for the Frailty Intervention Team focused on the non-elective admissions of over 75 year olds during previous years. This methodology has been expanded to include patients aged 65+ and has now provided an admission avoidance target of circa 3,000.

Table 9.3 presents the potential admission avoidance:

Optimity admission avoidance figures against resources required to meet need			
Service	Admission Avoidability		
	Usually avoidable	Sometimes avoidable	Total
Hospital at Home	1093	48	1141
Hospital at Home or Crisis Response/Step up beds	1796	1215	3011
Hospital at Home or Crisis Response/Step up beds or Admission	0	464	464
Crisis Response/Step up beds	72	0	72
Crisis Response/Step up beds or admission	0	358	358
<b>Total</b>	<b>2963</b>	<b>2085</b>	<b>5048</b>

Table 9.3 - Optimity admission avoidance figures against resources required to meet need

There are three phases of the programme:

**Phase 1: Frailty Intervention Team (presently operational)** - A dedicated Frailty Intervention Team (FIT) based in the Emergency Department is responsible for early identification, treatment, risk assessment and planning for frail and long term condition patients.

**Phase 2: Case Management** - This model has two parts. The first is about our community-based NHS workforce working closely with GP practices across the area to get a clear understanding of how many people over the age of 65 have complex care needs. A crucial part of this process relates to categorising the people identified in terms of whether their need complexity is low, moderate or severe - a process known as “Risk Stratification”.

Once Risk Stratification is complete, those identified as being in severe need will be given the opportunity to work with a designated professional (also known as a “case manager”) who in turn will be responsible for a group of patients - also known as a “caseload”. The development of care plans and their delivery represents the second part of the Case

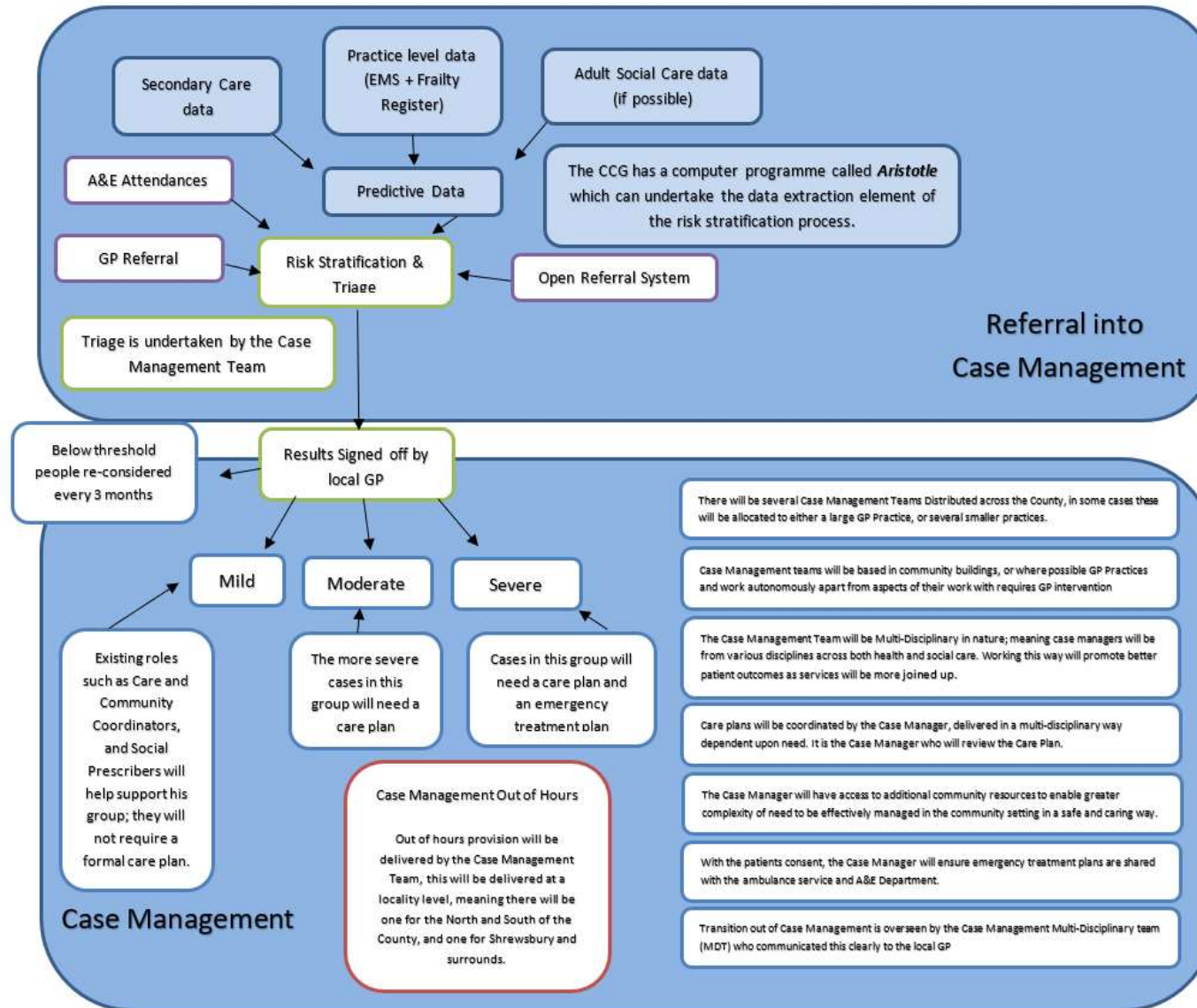
Management Model. Service specifications have been drafted and shared with providers and stakeholders for:

- Shropshire Care Closer to Home Community Model
- Risk Stratification
- Case Management
- Interdisciplinary Teams
- Intermediate Care

A series of design and engagement workshops took place between December 2017 and July 2018 involving a wide range of stakeholders across the health and social care economy including patients and public representatives, Shropshire CCG, Shropshire Council, SaTH, Shropshire Community Health NHS Trust, Midlands Partnership NHS Foundation Trust, GPs and primary care colleagues and the voluntary and care sector. This ensured fully collaborative co-design of the Case Management Model options as well as delivering thorough engagement.

The collaboratively designed Risk Stratification and Case Management Model was approved by the Shropshire CCG Clinical Commissioning Committee on 15<sup>th</sup> August 2018 and is shown in Figure 9.1 below:

Figure 9.1 - Shropshire Care Closer to Home Case Management Model





Additional resource is now focusing on progressing the Alliance Agreement Partnership needed to enable operationalisation of the model through developing more detailed service delivery and workforce models that underpin demonstrator pilot sites. Detailed service specifications are being developed for all aspects of Case Management to enable workforce planning.

### **Phase 3: Hospital at Home/Crisis Response/Rapid Response/DAART (Diagnostics, Assessment and Access to Rehabilitation and Treatment) and Step-Up Beds**

The third phase is made up of a number of high-level models:

The aim of Hospital at Home is to provide diagnostic testing and treatment interventions that are traditionally associated with care in a hospital setting either in people's own homes or from places close by. Just as is the case in the local general hospital, this model would be delivered by a multi-disciplinary team made up of a range of health professionals including GPs, Specialist Consultants, Social Workers, Community Nurses, District Nurses, Advanced Nurse Practitioners, Mental Health Nurses, Pharmacists, Physiotherapists, Occupational Therapists and Dieticians.

However, Hospital at Home is not a rapid-response model of care delivery. It functions in a planned fashion, working alongside the Case Management model to prevent health crises from happening. Design work on possible Hospital at Home models is currently underway. Feedback and critique on the options will be sought from public and patient representatives and stakeholders before a longlist of model options is produced.

A Rapid Response model will be developed in the same way. This service would deliver both diagnostic testing and treatment interventions similar to those available from the Hospital at Home model, but within a standardised two-hour response window. This team would be made up of senior clinical staff, for example Advanced Nurse Practitioners, who are capable of making clinical decisions and in most cases prescribing and administering medicines to manage acute health needs.

The modelling of Step-Up beds has been deferred awaiting the publications of the Joint Strategic Needs Assessment, essential in shaping a sustainable and fit-for-purpose service.

More detail on these developments in Shropshire can be found in Appendix 12.

#### **9.2.2 Telford & Wrekin**

In 2015, Telford & Wrekin CCG and Telford & Wrekin Council began work on a collaboration to design and deliver a programme called 'Neighbourhood Working' across the area. This programme was adopted as part of the Shropshire, Telford & Wrekin STP. Neighbourhood Working encompasses all elements of community-based developments including volunteering, development of community health services and joint-working between GP practices. The work includes a broad range of changes which aims to improve quality of life for the people living in Telford & Wrekin and, amongst other aspirations, will reduce admissions to hospitals. This will be achieved through primary prevention, strengthened community support and by taking a more proactive approach for patients with known illness.

In the summer of 2017, the CCG outlined its current position around Neighbourhood Working in the Pre-consultation Business Case (PCBC) which was produced to support the Future Fit acute reconfiguration.

More detail was presented to the Programme Board in November 2018 and can be found in Appendix 11: *Telford and Wrekin: The Community Solution Across Health and Social Care*. It provides an updated position on Neighbourhood Working and has been produced to provide assurance around any admission avoidance assumptions in the future and to inform



mitigation plans for avoiding unnecessary journeys to hospital and the impacts on some people of having to travel further for their care.

The Neighbourhood Working programme is a complex set of activities bringing together all aspects of community-centred approaches. There is no single model of care, rather this is a collection of approaches and services, each with their own description and all contributing to the achievement of the outcomes below:

- Communities will be connected and empowered
- People will stay healthy for longer
- Clinical outcomes will be optimised for patients
- Services will be available closer to home for patients
- People will feel support during times of crisis (both physical and mental health)
- People and their carers will be supported at the end of their lives

Over the last year, the CCG and local authority have had a continuous process to review and progress all aspects of Neighbourhood Working. The activities are now grouped into five workstreams:

- Prevention and Encouraging Health Lifestyles
- Community Resilience
- Direct Care in the Community
  - Integrated Teams
  - Rapid Response
  - Frailty Front Door
- Speciality Reviews
- Primary Care Networks

The multiple projects within Neighbourhood Working are cross-cutting and contribute to the same outcomes. In the PCBC, a set of planned activity reductions were outlined against each of the known projects. Table 9.4 below summarises the revised predicted activity and financial reductions associated with each project. There is also an indication of the investment needed to achieve the change. In addition to these reductions, as per the PCBC, the workstreams around healthy lifestyles and community resilience will help to reduce the impact of demographic growth. Therefore they are considered as part of employing a 'realistic' growth figure in projections for acute activity.

	18/19				19/20				20/21				21/22				Total Impact			
	Activity reduction	Financial reduction	Investment	Net	Activity reduction	Financial reduction	Investment	Net	Activity reduction	Financial reduction	Investment	Net	Activity reduction	Financial reduction	Investment	Net	Activity Reduction	Financial Reduction	Investment	Net Financial Reduction
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Activity reduction committed to in Pre Consultation Business Case	883	1668	1167	501	428	711	498	213	445	772	540	232	438	723	506	217	2194	3874	2711	1163
<b>Neighbourhood Schemes in Delivery or with a development plan</b>																				
Diabetes programme	27	52	23	29	24	46	0	46				0				0				
CVD programme (non elective)	95	180	0	180	89	65	46	19	89	65	46	19	89	65	46	19				
CVD programme (elective)					44	84	59	25	44	84	59	25	44	84	59	25				
Care Home Support Team		117		117	19	67		67	10	37		37	5	11		11				
Development of integrated teams*					243	462	220	242	243	462	220	242	243	462	220	242				
Frailty Front Door (before the front door)					91	237	166	71	91	237	166	71	91	237	166	71				
Frailty Front Door (at the front door)					205	534	320	214	69	178		178				0				
Respiratory	110	209	8	201																
<b>Total Schemes in Progress</b>	<b>232</b>	<b>558</b>	<b>31</b>	<b>527</b>	<b>715</b>	<b>1495</b>	<b>811</b>	<b>684</b>	<b>546</b>	<b>1063</b>	<b>491</b>	<b>572</b>	<b>472</b>	<b>859</b>	<b>491</b>	<b>368</b>	<b>1965</b>	<b>3975</b>	<b>1824</b>	<b>2151</b>
<b>Balance - Schemes in development</b>	<b>651</b>	<b>1110</b>	<b>1136</b>	<b>-26</b>	<b>-287</b>	<b>-784</b>	<b>-313</b>	<b>-471</b>	<b>-101</b>	<b>-291</b>	<b>49</b>	<b>-340</b>	<b>-34</b>	<b>-136</b>	<b>15</b>	<b>-151</b>	<b>229</b>			
<b>Examples of schemes in early development</b>																				
Urgent Care Under 75's Project									134	198	138	60	134	198	138	60	268	396	276	120
Respiratory Phase 2									41	59	0	59	41	59	0	59	82	118	0	118

*Table 9.4 - Revised predicted activity and financial reductions associated with neighbourhood workstreams*

In addition to a reduction in the number of admissions, projects may also contribute to a reduction in length of stay. In particular, the care home project has already been shown to reduce the length of stay for patients who are admitted from the six participating homes by two days. The Frailty Front Door will also reduce length of stay by supporting discharge planning from the point of admission.

In summary, Neighbourhood Working across Telford & Wrekin has progressed significantly over the past 18 months. Relationships have been established, a series of developments have begun, new teams have been introduced and plans have been created to increase the pace of change in community-based solutions. Figure 9.2 overleaf describes the work in the context of demand reduction on acute care based on a multifaceted approach which addresses ill health across a continuum with an emphasis on prevention.

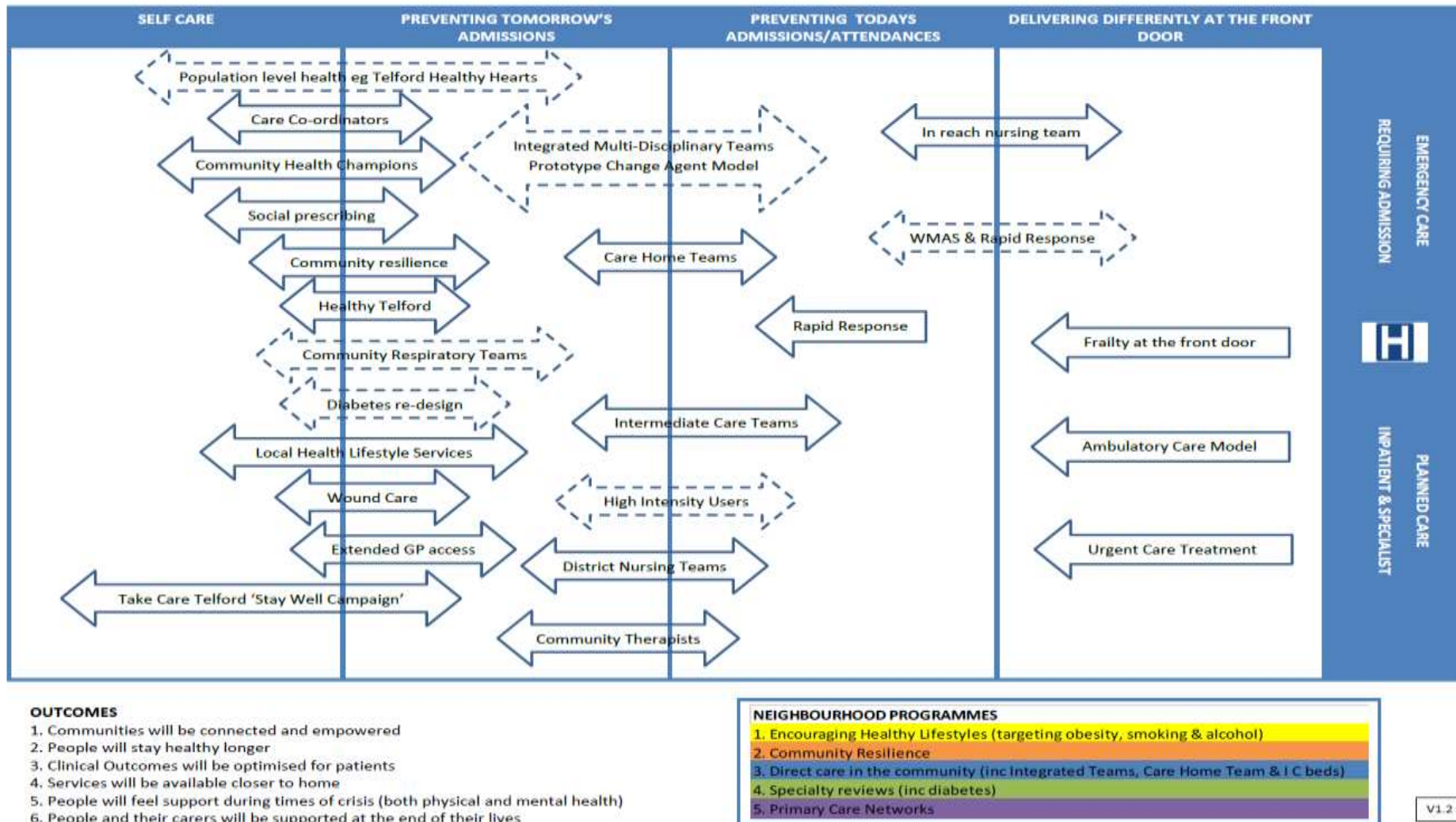


Figure 9.2 Neighbourhood Working across Telford and Wrekin progress in 18 months

### 9.2.3 North Powys

Powys Teaching Health Board (PTHB) has set out a long term vision for integrated health and care in the Health and Care Strategy for Powys, agreed jointly between PTHB and Powys County Council. The delivery priorities are set out in more detail in the Health Board's Integrated Medium Term Plan 2018/19 to 2020/21. The full Integrated Medium Term Plan is available from the [PTHB website](#).

Whilst activities that support urgent and unscheduled care, care co-ordination and out-of-hospital care are embedded throughout the PTHB's plans, key delivery priorities are included within Objective 4: Joined Up Care. Key areas for delivery include:

- Care Co-ordination Hub
- Virtual Ward
- Integrated Teams
- Reablement
- Improvements to the flow of patients in and out of care pathways
- Joined up approach for people with learning disabilities and children with disabilities

The plan aims to ensure that people in Powys experience the following outcomes:

- I have timely access to equitable services as locally as possible
- I am treated as an individual with dignity and respect
- My care and support are focused around what matters most to me
- I receive continuity of care which is safe and meets my needs
- I am safe and supported to live a fulfilled life
- I receive end of life care that respects what is important to me

PTHB and Powys County Council have been focussing on the development of two Integrated Team pilot sites in South Powys, in Ystradgynlais and Brecon, through 2017/18. Considerable achievements in the delivery of care have been gained through improved communication, co-ordination, knowledge and skills. It is recognised that there is great potential to deliver further improvements, and a qualitative review has recently been completed to assess the current pilots and support the next phases of development.

A Health and Care Co-ordination Hub was established in 2018. The prioritisation and coordination of repatriation from secondary care is complex. Powys patients are admitted to any one of the six other health boards in Wales or the two main NHS Trusts in England, including SaTH. The development of the Co-ordination Hub will ensure a more efficient way of managing the timely repatriation of Powys patients from other health board's acute hospital beds in Wales and England and manage flow in and out of community hospitals in collaboration with Powys County Council. It will increase the ability to ensure the length of stay in a DGH acute care bed for Powys patients is minimised, as patients who are admitted will be transferred to the most appropriate setting in a timely way as soon as they no longer need acute hospital care. This will support a 'home first' ethos and a 'discharge to assess' model of care.

By providing one single source of real time admission, transfer and discharge data that can be accessed and acted upon, a more effective method of prioritisation and allocation will be implemented.

Improving discharge planning processes also provides opportunities to release inpatient capacity and reduce length of stay. Key future improvements will involve a review of the district nursing specification, caseload activity, acuity and skills with the national programme

to provide enhanced care in the community, in line with the Chief Nursing Officer District Nursing Principles and a test of the Buurtzorg model in Powys. This will also include evaluation of in-reach schemes that support facilitated hospital discharge and investment in appropriate models.

Finally, the current reablement service is provided jointly between Powys County Council and PTHB through a Section 33 agreement and offers intensive support to help people who are recovering from an illness or injury to regain their maximum level of independence. A review of the joint reablement services will propose an improved model for Powys patients.

### **9.3 Description of services on each site and in particular Urgent Care**

One of the key actions set out from the recommendations of the Programme Board at the deliberative event in November 2018 was to more clearly describe the services that will be on each site, with particular clarity around the future urgent care model. This section attempts to do this although more work will be done by the acute Trust throughout the next stage that will include a communications and engagement strategy.

The Strategic Outline Case (SOC) sets out the proposed model of care and services on each site at a high level. Figure 9.3 below summarises this.

**Emergency Care Site**

**Emergency Department**

**Urgent Care Centre**

**Critical Care Unit**

**Ambulatory Assessment**

**Surgical Assessment**

(all surgical specialties including Gynaecology Assessment and Treatment Unit [GATU])

**Theatres**

**Medical wards**

(including Respiratory, Renal, Cardiology, Stroke, Care of the Older Person, Dermatology, Diabetes, Neurology, Oncology and Haematology)

**Surgical Wards**

(including emergency and complex surgery for Urology, Gynaecology, Colorectal, Head and Neck, Trauma and Orthopaedics, Gastroenterology, Upper GI, Vascular)

**Children's inpatient ward**

(including day case, oncology and haematology, medical and surgical)

**Children's assessment Unit**

**Maternity wards**

(including Early Pregnancy Assessment Services (EPAS) Antenatal, Postnatal, Delivery Suit, Midwife led unit)

**Neonatal Intensive Care Unit**

**Diagnostics**

(including Endoscopy, MRI, CT, x-ray, interventional radiology, Cardio-respiratory, ultra-sound scanning –including maternity, mammography)

**Renal Dialysis**

**Day Case Chemotherapy**

**Radiotherapy (RSH under both options)**

**Outpatients**

(specialties with in Obstetrics, Children's, Medicine, Surgical, Orthopaedics and Therapies)

**Pharmacy**

**Planned Care Site**

**Urgent Care Centre**

**Theatres**

**Surgical Wards**

**Day Surgery Unit**

(including planned surgery for Urology, Gynaecology, Colorectal, Head and Neck, Orthopaedics, Gastroenterology, Upper GI, Vascular, Breast)

**Medical wards**

(including Care of the Older person, Rehabilitation and End of Life Care)

**Midwife Led Unit (MLU)**

**Diagnostics**

(including Endoscopy, MRI, CT, x-ray Cardio-respiratory, ultra-sound scanning –including maternity, mammography)

**Renal Dialysis**

**Day Case Chemotherapy**

**Specialist Breast Services**

**Outpatients**

(specialties with in Obstetrics, Children's, Medicine, Surgical, Orthopaedics and Therapies)

**Pharmacy**



### 9.3.1 Urgent Care

The consultation documentation attempted to set out the differences between Urgent and Emergency Care and how the pathways would differ and/or remain the same in the newly configured services. The messages that the vast majority of patients - up to 80% - would be seen where they currently are now and that over 60% of patient presentations currently attending our A&E departments are categorised as Urgent Care rather than Emergency Care, were difficult to communicate within the context of the consultation.

It was clear from the consultation response findings that many people do not understand or cannot distinguish urgent from emergency care. The key message that requires continued emphasis is that the majority of patients that go to the current A&E departments now would carry on going to their nearest hospital to receive the urgent care they need. This service will be available 24/7 for those patients who have an injury or illness that is urgent and cannot be treated by their GP practice. (Urgent Treatment Centre principles and standards, NHSE, July 2017.)

In line with national NHSE principles, the UCC would be delivered by highly skilled Advanced Clinical Practitioners (ACPs) and GPs specifically trained in the delivery of urgent care for adults and children. For training purposes, junior doctors could rotate through the UCC on the Emergency Site. The skills and competencies of the UCC staff would therefore be consistent across both sites.

Where the Urgent Care Centre is co-located alongside the Emergency Department (ED) it would be accessed through a single front door, though patient flows would be managed separately from the ED (i.e. there would be a separate ambulance entrance for the ED).

Patients would access the service on both sites as a 'walk-in' or via ambulance if it is considered by paramedic staff to be clinically appropriate. There would be dedicated facilities for children to ensure that they wait and are treated away from adult areas.

In relation to the service offer of the Urgent Care Centre on the Planned Care site, the following clinical model has been agreed:

- Children who would normally be observed within primary care or at home, to determine whether they need further treatment or not, could be managed within the service on the Planned Care site if the team felt competent to do so.
- Children needing further assessment or treatment from the paediatric team however, would need to be transferred to the Emergency Care site where the Children's Assessment Unit and Children's Inpatient Service would be located. There would be a clinician trained in Advanced Paediatrics Life Support available for the stabilisation of the critically ill child who may present at the Planned Care site.
- Some adult patients would be seen and their treatment started through the urgent care service at the Planned Care site.
- An Ambulatory Care Service would be at the Emergency Care site. Some adult patients with Ambulatory Care sensitive conditions could be seen through the urgent care service at the Planned Care site in line with the skills and competencies of the team in place. Patients needing more detailed assessment or treatment or those needing admission would be transferred to the Emergency Care site.

- Mental health presentations could account for at least 20% of primary care attendances. The UCCs would have 24/7 direct access to the psychiatric liaison team and access to a mental health assessment room that would be compliant with the relevant Royal College of Psychiatrists' safety standards.

The UCC would carry out tests such as blood tests and non-complex x-rays and provide treatment. For example, they could look after those patients that have:

- Non-complex injuries from tumbles, falls or sport where there is reduced movement or pain from a single limb or joint. This will include patients who have undisplaced closed fractures of the distal part of single limbs/dislocation of fingers or toes.
- Cuts and scrapes that cannot be managed with a simple plaster, or where the edges of the cut are wide apart (usually greater than 3 inches and ¼ inch deep).
- Mild asthma in previously diagnosed asthmatics, such as breathing difficulties in the absence of airway complication where the patient can speak in short sentences.
- Ear, nose and throat problems, such as a persistent nose bleed, sore ear or throat which is rapidly getting worse and cannot wait for the GP.
- Foreign object stuck up nose or in ear that IS NOT obstructing the patient's airway.
- Scalds or burns that involve part of a single limb where the skin is red and painful.
- Bites and stings where there is more than expected swelling but there is no swelling in the mouth or tongue or difficulty breathing.

The staff in UCCs on both sites will work closely with the team at the Emergency Department and will ensure patients receive the care they need without delay. Where the ED is not co-located with the UCC service tele-links will support the patients' prompt diagnosis and treatment.

### **9.3.2 Emergency Care**

Patients who are acutely ill with potentially life- or limb-threatening injuries and require immediate diagnosis and treatment would be taken directly to the ED. Access to the ED would be gained only via transfer from an UCC or ambulance. The ED would also serve as a Trauma Unit and would be co-located with a single Critical Care Unit, providing care for level 1, 2 and 3 patients. There would be full and immediate access to Diagnostics (Radiology), Haematology, Clinical Biochemistry, Blood Transfusion and Pharmacy. Children and adults would be managed in separate areas within the ED. Within resuscitation, the facility would be designed to manage both the critically ill adult and child with provision for some division.

The Clinical Decision Unit (CDU) would be co-located alongside the ED providing dedicated clinical space for those patients who require further assessment and monitoring prior to a clinical decision being made.

The Ambulatory Emergency Care (AEC) Unit located adjacent to the ED would be operational for 12 hours per day providing Same Day Emergency Care (SDEC). The AEC would support unscheduled care activity for those patients who require admissions for no more than 12 hours (both planned and unplanned).

The AEC would also support a shift in activity flows for patients who currently stay between 13 and 72 hours through the successful implementation of best practice, for example the treatment of DVTs, outlined within the Ambulatory Care Directory (2017). Further work is

underway to look at the opportunities for a joint assessment facility for medical and surgical patients and would inform the planning as the clinical model develops further.

The Critical Care Unit on the Emergency Care site would bring together all the Acute Trust adult critical care capacity, with level 1, 2 and 3 patients being managed in the same unit. This unit would support the consolidation of emergency activity and high risk elective inpatient procedures onto one site.

Critical Care Outreach would support the wards on the Emergency Care site and the Planned Care site. The risk of patients requiring Critical Care Outreach on the Planned Care site would be minimised through the appropriate clinical streaming of patients and early identification of deteriorating patients.

For those patients who unexpectedly deteriorate on the Planned Care site, for example, post-surgery, the admitting consultant in conjunction with anaesthetic and Operating Department Practitioner (ODP) support would liaise with the consultant intensivist on the Emergency Care site to discuss the treatment plan, stabilisation and if appropriate, transfer.

### **9.3.3 Women and Children's Services**

The model for Women and Children's services would be based on the model developed and effectively implemented as part of the consolidation of services at PRH in 2014. Essential clinical adjacencies have been identified between maternity, neonatology and paediatrics, and between Women and Children's services, the ED and critical care.

High risk women and children's services would need to be based on the Emergency Care site. This is the clear view of the experts both locally and nationally. Most women and children would continue to receive the majority of their care and treatment in the same place as they do now. This includes:

- Midwife-led unit, including low-risk births and postnatal care
- Maternity outpatients including antenatal appointments and scanning
- Gynaecology outpatient appointments
- Early Pregnancy Assessment Service (EPAS)
- Antenatal Day Assessment
- Children's outpatient appointments
- Neonatal outpatient appointments

## 9.4 Addressing Equality Impacts

Table 9.5 summarises the impacts identified within the EIA for both options

Service	Option 1	Option 2
<b>Emergency care</b>	Positive impact: larger number of older and younger people in Shropshire and Powys. Negative impact: smaller number of older people. Negative impact: BAME groups and people living in deprived areas of Telford and Wrekin. Possible disproportionate impact on LGBT groups, gypsies and travellers and people with a disability depending on where they live.	Negative impact: larger number of older and younger people in Shropshire and Powys. Positive impact: smaller number of older people, BAME groups and people living in deprived areas of Telford and Wrekin. Possible disproportionate impact on LGBT groups, gypsies and travellers and people with a disability depending on where they live.
<b>Consultant- led maternity</b>	Positive impact: larger number of women of childbearing age/pregnant women in Shropshire and Powys. Negative impact: smaller number of women of childbearing age/pregnant women in Telford and Wrekin, particularly BAME women, pregnant teenagers and women living in deprived areas. Possible disproportionate impact on older women, lesbian and bisexual women and women with a disability depending on where they live.	No change in impact for women of childbearing age and pregnant women across all areas.
<b>Paediatrics</b>	Positive impact: larger number of babies, children and young people in Shropshire and Powys. Negative impact: smaller number of babies, children and young people in Telford and Wrekin, particularly if they are from a BAME group, have a disability and/or live in a deprived area.	No change in impact for babies, children and young people and their families across all areas.
<b>Planned care</b>	Negative impact: larger number of older people in Shropshire and Powys, particularly for people who live in a rural and/or deprived area and who don't drive or have relatives living nearby. Positive impact: smaller number of older people in Telford and Wrekin. Possible disproportionate impact on LGBT people and people with a long term condition depending on where they live.	Positive impact: larger number of older people in Shropshire and Powys. Negative impact: smaller number of older people in Telford and Wrekin, particularly if they are from a BAME group and/or live in a deprived area. Possible disproportionate impact on LGBT people and people with a long term condition depending on where they live.

Table 9.5 The impacts identified within the EIA

As described in section 7 of the DMBC recommendations have been made to develop mitigation plans. A draft Mitigation Plan can be found in Appendix 2.

### **9.5** *Review of Affordability*

Recommendation 4 of this DMBC notes the consensus of the Programme Board that the consultation has found no new viable alternative models for consideration or no new themes or key issues to address that were not evident prior to the consultation. On this basis no new financial modelling is required for this DMBC.

Affordability modelling provided for the PCBC continues to be reviewed to bring baseline assumptions up to date and to reflect more up to date assumptions as modelling for out-of-hospital care progresses.

Now that the ambulance activity modelling has been undertaken, we can estimate the financial impact that this will have. The CCGs have currently made a prudent estimate of cost in their Long Term Financial Models (LTFMs) and will refine this as specifications are developed.

Capital assumptions in the PCBC remain unchanged at this stage in the absence of any material proposed changes to the hospital models. These will be reviewed and updated if necessary as part of the Trust's work to develop its OBC.

Further detailed financial modelling will continue over the coming months in order to ensure that both Trust and CCG financial plans are fully aligned, in preparation for the OBC.

## 10.0 Addressing Other Issues Raised by the CCG Boards and/or NHSE

The issues raised as part of the NHSE Assurance process and by the CCG Boards and Joint Committee at the point of approval of the PCBC have all been captured in Table 10.1 below. Many of these have already been considered when addressing key themes within the consultation response in the relevant sections which are referenced in the table. Three need to be explored in this section of the DMBC. Specifically:

- Trauma
- Paediatric cover on the Planned Care site
- Workforce transformation plans

Reference	Action/Mitigation requirement	Deadline for completion	Action progress update
NHSE Assurance Oct/Nov 2017	<b>Trauma Mitigation Plan</b> - Detailed plans to mitigate potential negative impacts of the final proposal in relation to trauma patients should be agreed and included in this post consultation DMBC.	Pre- DMBC	Specialised Commissioning (as leads in commissioning major trauma, critical care and neonates) submitted their letter of support for consultation on both options. A number of potential mitigations for further exploration were listed in the PCBC, were option 2 to be implemented. Clinical engagement with ambulance services is ongoing through SSP process. Recent discussions with the Trauma Network and the ambulance services is described in 10.1 below
NHSE Assurance Oct/Nov 2017	<b>DMBC</b> NHSE to assure the decision-making business case.	Pre-decision-making meeting	Checkpoint on 20th December 2018.
NHSE Assurance Oct/Nov 2017	<b>Benefits Realisation</b> - Detail on the expectation of improvements in performance that the proposals will drive and the key underpinning milestones to achieve such improvements.	OBC	Captured in Future Fit PCBC. Updated detail set out in section 11 of this DMBC.  Further and final development during FBC compilation. Updated benefits tracker received from SaTH Oct 18.
NHSE Assurance Panel Oct/Nov 2017	<b>Engagement with Specialist Commissioning</b> - Ensure robust engagement with Specialist Commissioning on potential impacts on Neonates, Cancer and Trauma.	Pre- DMBC	Regular contact with Specialised Commissioning is in place and their input will form part of the decision-making process in relation to all 3 areas. SMT meeting in January to confirm no further information or assurance required should there be no material change to preferred option. Letter of support for DMBC included in NHSE checkpoint.
Reference	Action/Mitigation requirement	Deadline	Action progress update



		for completion	
<b>NHSE Assurance Panel Oct/Nov 2017</b>	<b>Ambulance services</b> - Impact on ambulance services requires modelling.	Pre- DMBC	Travel and Transport modelling completed by ORH and is included within this DMBC in section 9 and as Appendix 9.
<b>CCG SOC/PCBC approvals 2016/17</b>	<b>Workforce</b> - Further testing of workforce models detail through the Clinical Development Group pre-implementation.	OBC	Updates received from Chair of STP Workforce Group at Programme Board and IIA meetings on the progress against recruitment into new roles. Updated detail on the 5 year workforce plan and new roles implementation progress included in section 10.3 below.
<b>CCG SOC/PCBC approvals 2016/2017</b>	<b>Repatriation</b> - Clarification on any proposed repatriation including Quality Impact Assessments.	Pre DMBC	QIAs to be completed where appropriate. Currently no assumptions around repatriation of new services. QIAs found in section 7.5 and appendix 17.
<b>CCG SOC/PCBC approvals 2016/17</b>	<b>Out-of-Hospital Care</b> - potential impact on primary care and community services in activity shifts, and changes in financial flows.	Pre DMBC	Forms part of the Out-of-Hospital Care programmes now established by both CCGs. Significant work has taken place in each CCG. CCG Executive leads will need to assure their Boards of the plans. This DMBC has updated progress and any change in assumptions. Further information can be found in section 9.2.
<b>CCG SOC/PCBC approvals 2016/17</b>	<b>Affordability</b> needs further testing, including the assumptions around investments and efficiency savings.	Pre DMBC	Post consultation and the decision on any preferred option, assumptions to be tested if material changes proposed to the model set out in the PCBC and any material changes set out in this DMBC. No material changes.
<b>Joint Committee PCBC approvals 2017</b>	<b>Paediatric Cover</b> - appropriate paediatric cover in place at the urgent care centre on the Planned Care site.	Pre DMBC	Paediatric cover was set out in the PCBC. Clarification on skills will be further set out in this DMBC and will include: A summary of a joint agreement by Unscheduled Care Group Medical Director, Clinical Director Emergency Department, Consultant Paediatrician and GP leads from both CCGs on the Planned Care site UCC and the assessment and treatment of adults and children with minor illness. How the workforce model in the UCC will meet the Royal College of Paediatrics and Child Health guidance (June 2018). See section 10.2 below.
<b>Reference</b>	Action/Mitigation requirement	Deadline	Action progress update

		for completion	
<b>Joint Committee PCBC approvals 2017</b>	<b>Travel and Accommodation</b> - mitigation is put in place for travel and accommodation needs for women and children using the Emergency Care site and for older people particularly using the Planned Care site.	Pre DMBC	Assurances given around <i>like for like</i> accommodation requirements included within specifications and costs for paediatrics facility. Travel and Transport Group established to consider impacts and mitigations in relation to public transport. Taking account of consultation feedback, a high-level Mitigation Action Plan has been developed and is included in this DMBC. (Section 9.1 and Appendix 4)
<b>Joint Committee PCBC approvals 2017</b>	<b>Ambulance Services</b> - carefully balanced ambulance services need to be put in place.	Pre DMBC	Ambulance modelling for emergency and non-emergency activity completed by ORH, summarised in section 9 and included in this DMBC in Appendix 9.
<b>Joint Committee PCBC approvals 2017</b>	<b>Workforce Solutions</b> - the local NHS needs to be innovative with developing workforce solutions and new roles.	Pre DMBC	SaTH has produced a 5-year Workforce Plan and progress made on recruitment to new roles. This is set out in section 10.3 of this DMBC. Progress on developing the wider system workforce solutions will emerge from the out- of- hospital care plans for both CCGs and for the STP system as a whole and will need to be set out in the OBC and FBC prior to approval. Update in section 10.3.

Table 10.1 - Progress on issues raised as part of the NHSE Assurance process and by the CCG Boards and Joint Committee at the point of approval of the PCBC

### 10.1 Trauma Mitigation Plan

The ambulance services continue to meet with the SaTH SSP team to develop clinical pathways.

In developing the model over the last few years, ambulance providers have supported the view of the Trauma Network and the West Midlands Clinical Senate. They recognised that Shrewsbury would be the preferred location for a Trauma Unit, based on access and journey times, particularly for the patients who might need to divert to a Trauma Unit for optimisation and stabilisation and who are not within an hour of a major Trauma Centre. This was presented in the PCBC in 2017 together with mitigation highlighted to reduce the risks were the preferred site for trauma to be Telford. These were developments that were already being progressed by ambulance services or in place now outside of any Future Fit proposals:

- Increase in the use of air ambulance; review of dispatch protocols
- Extended flying time for night flights through more night approved landing sites
- Upskilling of workforce; enhanced availability of paramedics and pre-hospital care protocols; potential technology advancements over next 3-4 years in mobile diagnostics
- Increased access to trauma doctor and/or more critical care paramedics in transit
- Review location of strategically-placed land vehicles
- Conveyance to nearest alternative TU: Hereford, Worcester, Wrexham, Wolverhampton

A clinical meeting of the ambulance providers took place in November 2018 to consider any further mitigation plans. Representatives from SaTH, Welsh Ambulance Services NHS Trust, Welsh Air Ambulance, the Major Trauma Network Lead (Consultant in Emergency Paediatrics) and West Midlands Air Ambulance were present together with members of the Future Fit Team.

A number of points of consensus were made:

- The ambulance services could give assurance to the general public that quality of services will not be impacted by any proposed change.
- Option 1 remained the preferred option as stated by the WM Clinical Senate and Professor Sir Keith Porter.
- Option 2 would require a new application and would cause some destabilisation of the current Trauma Network hub.
- It was the opinion of the Trauma lead that there was no requirement for another Trauma Unit or second option considering the significant challenges already being faced in the area. Shrewsbury is well placed for patients from Wales to access the Trauma Centre at Stoke and for children at Birmingham Children's Hospital.
- Taking patients to the right place at the right time is what happens now and will continue to happen and needs to be better publicised.
- Any change must ensure processes are slick especially with the Trauma Network which works well because the right clinical teams and expertise are based in the right place.

- Patients need to be aware they are going to the best place for their treatment and there is a need to promote better that pathways are working well now as people already travel longer distances out-of-area for services.
- Roles within ambulance services need to be more clearly articulated so the public understand the well organised system in operation to get people to the right place and the right staff in ambulances.

A number of transformation plans discussed include a plan to provide 24 hours flying time in Wales (currently 12 hours); new helicopters can now go further, fly longer and carry more people; Advanced Practitioners being trained and will be available in ambulances, GP surgeries, and community settings; Stroke thrombectomy as a development.

### **10.2 Paediatric cover in the urgent care centre on the planned care site**

Discussions have been on-going over the last two years on the level of paediatric cover necessary for the safe management of children within the Urgent Care Centre on the Planned Care site. A Task and Finish Group was established with acute Trust clinicians, GPs and patient representation. In May 2017, there was a joint agreement by the Unscheduled Care Group Medical Director, the Clinical Director Emergency Department, Consultant Paediatricians and GP leads from both CCGs that at the UCC on the Planned Care site, the assessment and treatment of adults and children with minor illness would include:

- Children who would normally be observed within primary care or at home, to determine whether they need further treatment or not, could be managed within the Urgent Care service on the Planned Care site if the team feel competent to do so.
- Children needing further assessment or treatment from the paediatric team however, would need to be transferred to the Emergency Care site where the Children's Assessment Unit and Children's Inpatient Service would be located.

In addition, the workforce model in the UCC will meet the Royal College of Paediatrics and Child Health guidance (June 2018) in relation to:

- Standard 3: Staff receiving children in Urgent Care Centres have the appropriate paediatric competence to provide immediate assessment
- Standard 16: All children who are streamed away from an Emergency Care setting must be assessed by a clinician with paediatric competences and experience in paediatric initial assessment within pre-agreed parameters, including basic observations.
- In response to the critically ill child walk-in patient presenting at the Urgent Care Centre on the Planned Care site the following have been considered:
  - UCC team will have 24/7 Paediatric Assessment competence
  - Both GP and Advanced Clinical Practice (ACP) Nurse will possess paediatric life support and diagnostic skills
  - ACP paediatric module training essential
- With no Paediatrician on the Planned Care site, specialist advice will be from the on-call Consultant Paediatrician in and out-of-hours
- The recovering team would need to speak to the Paediatric team on the Emergency Care site whilst arranging blue light transfer to the Emergency Department
- Use of telehealth with live telemetry of patients' observations from UCC to Emergency Care site.

SaTH will continue to discuss pathways with the ambulance services prior to implementation to ensure children are transported to the most appropriate place in the future. Transfer

policies are in place currently for the safe transfer of children between sites. These can be found in appendix 7.

As part of the NHSE assurance process the Programme has received feedback from NHSE with regard to the importance of mapping and read-cross of the paediatric models of care in the EC and UCC model to the West Midlands Quality Review Service (WMQRS) recommendations/standards:

*As part of addressing the concerns raised at the Future Fit Joint Committee and PCBC approval stage, the Boards and NHSE wish to see mapping of the model for EC and UCC specification and pathways for paediatrics against the WMQRS standards. This would need to be completed prior to Outline Business Case sign off.*

### **10.3 Developing Workforce Solutions and New Roles**

Throughout the consultation, the public has struggled to accept the workforce challenge as presented and that the primary driver for change has been availability of workforce rather than just a cost-cutting issue. Consolidating services onto a single site, we know, will address the recruitment issues in our most challenged specialties. However this is only part of the solution. The workforce needs to transform. In order to deliver the clinical model proposed, the workforce will increasingly be:

- Treating higher acuity patients on the Emergency Care site as a matter of routine
- 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
- Up-skilled to take on extended roles
- Required to use new technology to deliver clinical care and non-clinical services
- Required to have more routine working new patterns of employment e.g. 24/7 on site presence, 7-day working and delivering routine services in the evening and at weekends.

The Trust workforce plan incorporates the guidance within the recent publication from the National Quality Board (July 2016) in 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time'. This ensures all opportunities to maximise the contribution of our multi-disciplinary teams and the number of care hours per patient per day have been considered.

The workforce transformation key drivers are:

- Activity and pathway driven changes in workforce e.g. acute intake on one site, strengthened elective provision, improved rota management and removal of duplication, reducing reliance on high cost temporary staffing
- Productivity driven reductions in workforce, leading to fewer Whole Time Equivalents (WTE) to deliver a given quantity of activity e.g. use of technology and improved processes
- Reduction in the cost per WTE of the future establishment e.g. ensuring that staff spend a greater proportion of their time conducting tasks appropriate to their grade through role redesign and the introduction of more junior roles



This will result in a planned reduction of 295 WTE. Workforce plans have assumed that workforce establishment in terms of WTE is reduced but also the average cost per WTE would be reduced (although this would be focused rather than universally applied).

The workforce change is detailed in table 10.2, which would be achieved through a combination of new roles and workforce change associated with new ways of working. New roles will bring the opportunity to develop and expand roles for existing staff whilst replacing roles that are increasingly difficult to fill due to workforce supply.

Staff Group	Summary Narrative	Current		Proposed		Comments
		Establishment (WTE)	Budget (£k)	Workforce change (WTE)	Financial Estimate (£k)	
Nurse Associates	Introduction of Nurse Associate	0	0.00	118.62	(2,762)	The Trust plans to reduce the number of registered nursing roles (currently reliant on agency) by 141 through the establishment of 118 Nurse Associate roles (identified as non-clinical) and efficiencies due to improved consolidation of services across the Care Groups.
Registered nursing change	Introduction of Nurse Associate	1564	73,627	(118.62)	4,385	
	Nursing efficiency			(21.20)	904.64	
	<b>Total</b>			<b>(141.11)</b>	<b>5,338</b>	
Allied Health Professionals	Therapies - SCHT buyback	472	21,770	(65.40)	2,671	A reduction in requirements due a change in the outpatient therapy model (developed as part of the community model). This change does not impact on the inpatient therapy service.
	CSS Other			(2.00)	73	
	<b>Total</b>			<b>(67.40)</b>	<b>2,744</b>	
Other Scientific, Therapeutic and Technical Staff	Perioperative Role	286	10,549	(16.00)	424	A reduction of 28 linked with the introduction of the new perioperative role within theatres to support the ODPs (16 posts), and improved site efficiencies within clinical support services (12 posts)
	Clinical support efficiency			(12.20)	281.27	
	<b>Total</b>			<b>(28.20)</b>	<b>706</b>	
Support to Clinical staff	Perioperative Role	1736	48,744	16.00	(373)	Through the removal of administration in running duplicated services across both sites, improved ways of working and IT it is assumed that there would be a reduction of 109 administration posts over a 5 year period (a combination of medical secretarial, general administration roles/dinical preparation). This results in an overall increase of 9 WTE.
	Operational transformation and IT			(64.00)	1,447	
	Med recs/Med secs			(61.15)	1,409.22	
	<b>Total</b>			<b>(109.15)</b>	<b>2,484</b>	
Non Clinical	Nursing efficiency	803	30,211	(32.00)	769	Reduction in 70 non clinical administration and management posts over a 5 year period associated with single site efficiencies, the introduction of an electronic patient record system (clinical preparation)
	Single Site Efficiencies			(38.30)	1,092.31	
	<b>Total</b>			<b>(70.30)</b>	<b>1,862</b>	
Consultant	Rota Efficiencies	259	39,598	4.89	(167)	Net 4.89 additional consultants at a cost of £711k, offset by the PA reduction of £545k associated with duplication of services across sites



Middle Grades	Rota Efficiencies	371	26,024	(15.00)	1,161	Change in middle grade rota requirements associated with removing duplicated rotas.
Junior Doctors				(33.82)	1,407	
ACPs	Introduction of ACP					Through the introduction of the ACP role, it is envisaged that reliance on junior doctor roles will reduce, to be replaced with ACPs. This is phased over a 5 year period due to training lead time (incorporated within the registered nurse numbers).
				46.50	(2,276)	
Grand Total				(294.97)	10,495	

Table 10.2 Proposed workforce changes

The Future Fit Programme has received a five year Workforce Plan from the Trust. The following assumptions will have an impact on staffing demand, which is reflected in that workforce planning:

- The changes in nursing and midwifery workforce numbers are reflective of a considered approach to building a sustainable nurse team. It is planned to introduce a new Nurse Associate role for all wards to ensure Registered Nurses are supported to deliver nursing care and reduce reliance on agency staff.
- The change in medical workforce, associated with removing the current duplication of medical rotas across the two acute hospitals e.g. acute intake on the emergency site, single critical care, elective provision centralised.
- There would be a reduction in deanery supply for doctors in training
- Increasing apprenticeships to meet demand of Apprentice Levy
- Productivity driven reductions in workforce, leading to fewer staff numbers to deliver a given quantity of activity e.g. use of technology and improved processes. For example:
  - Administration associated with running duplicated services across two hospital sites.
  - The introduction of electronic patient records is planned to deliver efficiency and release time for nursing staff to work clinically, and to release non-clinical staff associated with management and transportation of medical records.
  - Change in therapy model, to support delivery of some services in a non-acute setting.
  - Improved layout and patient flow associated with the capital reconfiguration programme will impact on staffing demand. For example, pneumatic tube systems.
  - Reduction in the WTE of the future establishment e.g. ensuring that staff spend a greater proportion of their time conducting tasks appropriate to their grade through role redesign and the introduction of more junior roles.

The workforce transformation programme has been benchmarked against national standards and Royal College guidance and is underpinned by:

- The intention to utilise Nurse Associates (NA) has now been strengthened following agreement and publication of NA standards and the move for the role to become a regulated workforce through Nursing Midwifery Council (NMC) in January 2019.

- Transformation assumption considers backfill costs to support 0.4 WTE learner time and Continuing Professional Education support. Designated funding would be required for backfill and a commitment to have dual entry (existing and external supply) to support the transition.
- The role of Physician Associate (PA) has been progressed and the Trust is now going to be working in partnership with Chester University to support placement delivery for new PA trainees.
- SaTH is committed to using the national Health Education England framework for Advanced Care Practitioner (ACP) training, recruited externally and identified those individuals who are maybe not 'ready now', but 'ready soon' with bespoke training to enable access to trainee positions. There is a need to consider the requirements for clinical supervisor time to support the introduction of this role.
- The critical care support worker role is due to commence as a pilot. Funding from HEE/LWAB (Local Workforce Action Board) to support this role is under consideration.
- The training and learning experience of staff is fundamental in ensuring the Trust continues to develop a high quality workforce. All workforce changes will align with Deanery guidance on training environment and rota requirements and innovations within workforce best practice and role developments will be used as a basis for the organisation's transformation journey.

Transitional arrangements associated with the workforce transformation are currently being developed and will be described in more detail within the OBC. The changes are being managed through a dedicated workforce steering group, which has representation from across each care group, reporting into the Sustainable Services Steering Group.

Figure 10.1 below provides an update on progress of the transformation programme for SaTH.

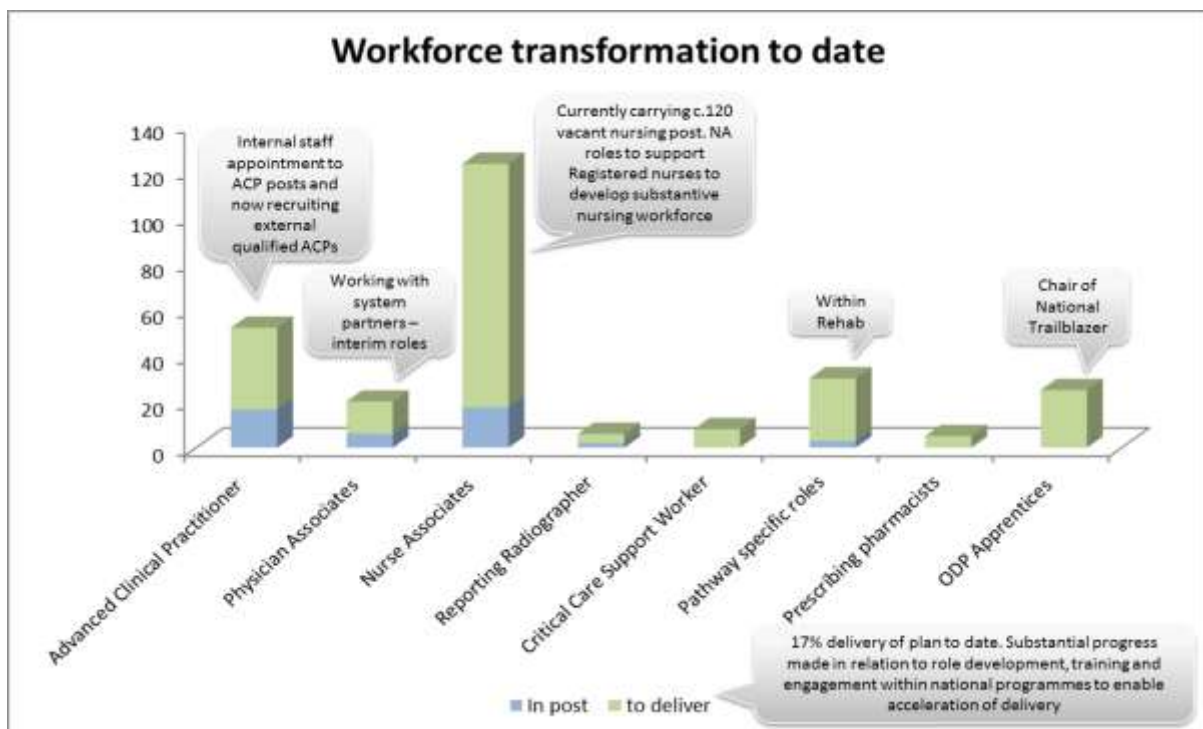


Figure 10.1 – SaTH workforce transformation to date

In addressing concerns around workforce reductions, in addition to this workforce transformation programme, there are inefficiencies within the workforce model that are a

direct consequence of the current clinical configuration of services, which would not be continued following the reconfiguration programme. They include:

- No requirement for Consultants to 'act down' into a middle grade post due to staff vacancies
- Reduced requirement for financial enhancements due to unattractive rotas
- Removal of premium agency costs associated with medical agency staff
- Rota efficiencies from duplicated services
- Reduction in travel expenses as a result of split site configuration of services

The wider STP focus on workforce transformation between acute and community care is perhaps less well developed. There is progress with specific developments including Rotational Apprentices; Wound Care Practitioners; Neighbourhoods Physician Associates and system-wide approaches to recruitment. However, progress needs to continue around improved system working using the Local Workforce Action Board (LWAB) as a forum.

## 11.0 Benefits Realisation of Service Change

The Programme Execution Plan (PEP), at the point the Programme was established in 2014, set out a number of benefits that will be realised through reconfiguration of acute services. The key benefits of the Future Fit Programme can be summarised as follows:

- The delivery of safe, high quality and sustainable urgent, emergency and critical care for all patients in response to their clinical need and delivery of the NHS Constitution standard for A&E;
- The delivery of safe, high quality and sustainable planned care and the delivery of the NHS Constitution standard for Referral to Treatment Time (RTT);
- Patients are seen and treated in the right environment for their need and by the right clinical teams and individuals in a kind, timely and efficient way;
- Improved patient flow through the acute care pathway and onto home or community/ primary care and support;
- Improved recruitment and retention of SaTH's workforce;
- Improved patient and visitor environments at both hospital sites that protect privacy and dignity and deliver a better user experience;
- Maximising the potential of IT to support an efficient, safe and networked approach to care delivery;
- Improved patient experience and outcomes through the delivery of services from buildings and in an environment that supports high quality care and effective patient flow;
- Delivery of key performance targets;
- Delivery of a sustainable financial position.

Central to the plans for the delivery of a revised clinical model are, of course, the improved outcomes for patients. In order to do this, the core element of the proposed clinical model is the plan that all patients are seen in the right place, at the right time by the right person. If the right place for the patient is the acute setting, then the services that patient accesses need to be suitable for their needs.

### 11.1 Benefits Realisation Plan

The purpose of a Benefits Realisation Plan (BRP) is to set out the nature, degree and timing of benefits that the Programme expects to deliver. As such it is a key tool of post project evaluation.

A draft BRP was initially developed in 2015 through the involvement of many stakeholders via Programme workstreams, patient focus groups and the Clinical Reference Group. It was further revised by the Programme Team taking account of:

- The key benefits sought from the Programme as described in the PEP
- The expected impact of the specific proposals under consideration
- Examples from comparable business cases in other reconfigurations; and
- Further input from Clinical Design, Finance and Workforce workstreams.

For the current stage of the Programme, detailed measures and timings are not required but the draft plan will need to form part of any OBC.

The Programme Board approved the current draft in April 2015 for further detailed development of measures and timescales and this has now been updated to reflect the current clinical model. It can be found in Appendix 21. It remains a draft and will be discussed with the acute Trust to ensure that the original benefits set out for the programme are included in the OBC.

Four local criteria for evaluating any options have been consistently used throughout the Future Fit Programme: Access, Quality, Workforce and Deliverability, with the latter also including a financial evaluation. The Trust has now developed its draft Benefits Realisation Plan for the proposed reconfiguration of services based on these four criteria and a series of outcome measures that they will further develop in the OBC.

These benefits have been developed with stakeholders from across the system and can be found in Table 11.1 below.

Criteria	Benefits	Implementation	Outcome Measure
<b>Access</b>	To deliver sustainable access to emergency care in line with 4 hour A&E target. To offer comprehensive access to all surgical and medical sub-specialties within the county. To provide a flexible range of services based on clinical need. Repatriation of appropriate clinical activity to within the county.	<ul style="list-style-type: none"> <li>▪ Consolidation of services</li> <li>▪ Same day admission</li> <li>▪ Protected elective bed base</li> <li>▪ Scheduling and theatre utilisation</li> <li>▪ Ambulatory care</li> <li>▪ 23 hour stay facility</li> <li>▪ Creation of centres of excellence e.g. Cardiology and Breast services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Increased activity levels</li> <li>▪ Increase in day surgery versus inpatient activity ratios</li> <li>▪ Reduction in out of county transfers</li> <li>▪ Speciality Centres of Excellence</li> <li>▪ Care closer to home where possible</li> </ul>
<b>Quality</b>	To continually improve clinical outcomes through a consolidated service To be able to provide an urgent response for emergency, surgery and critical care To deliver a service in line with national cancer and diagnostic standards.	<ul style="list-style-type: none"> <li>▪ Consolidated services increase volumes which improves outcomes</li> <li>▪ All patients managed through a standardised recovery system</li> <li>▪ Co-location of skills and expertise</li> </ul>	<ul style="list-style-type: none"> <li>▪ Improved standard mortality rate</li> <li>▪ Reduced length of stay</li> <li>▪ Reduction in readmission rates</li> <li>▪ Meet national diagnostic and cancer targets</li> </ul>
<b>Workforce</b>	To maintain expertise and skills with high levels of recruitment and retention in the county. Improved working environment attracting health professionals to county.	<ul style="list-style-type: none"> <li>▪ Out-of-hours theatre teams</li> <li>▪ Improving workforce recruitment and retention</li> <li>▪ Robust and shared teaching</li> </ul>	<ul style="list-style-type: none"> <li>▪ Levels of recruitment</li> <li>▪ Staff turnover</li> <li>▪ Access to training</li> <li>▪ Compliance with national staffing standards</li> </ul>
<b>Deliverability</b>	To deliver a sustainable 18 week RTT across the surgical sub-specialities Sustainable future for the Trust and services for the county	<ul style="list-style-type: none"> <li>▪ Sustainable financial position for the Trust</li> <li>▪ Estates maintenance backlog addressed</li> <li>▪ Modernisation of facilities</li> </ul>	<ul style="list-style-type: none"> <li>▪ Financial performance</li> <li>▪ Ability to generate internal capital for reinvestment</li> </ul>

Table 11.1 Benefits Realisation Plan

Whilst the key elements of the Benefits Realisation Plan for the Programme were set out in 2015, the measures have now been developed by the Trust into a draft strategic benefits tracker in terms of timescales for realisation over the next five years. In implementing any

recommendations approved by the Joint Committee of Shropshire and Telford & Wrekin CCGs, it will be important to agree and measure these benefits to our patients. The proposed benefits tracker (Table 11.2) provides a draft framework, which will require further development to ensure that all of the original benefits are incorporated.

Achieving the wider changes described in the STP Plan will also deliver improvements in access and quality, including patient safety, clinical effectiveness and patient experience, in particular, the developments set out in the CCGs' out-of-hospital care strategies. The final benefits realisation framework will therefore need to take account of measures within these interdependent programmes. The framework will require further refinement from key groups to reflect the final implementation decision made, including CCG Boards and the STP Clinical Steering Group.

The agreement of the more detailed benefits realisation framework will be undertaken by the proposed system Implementation Oversight Group (IOG) and be set out in the Full Business Case (FBC). Through the IOG a clear governance framework will be developed which will track progress and identify mitigating actions in response to benefits not being realised.



BENEFITS TRACKER			SOC	OBC	FBC	Build solution				
						Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
1.1	Reduction in workforce revenue	Target	0m	0m	0m	0m	0m	10m	12m	14.2m
		Actual								
1.2	Recruitment of new roles	Target	0%	0%	0%	0%	0%	75%	85%	99%
		Actual								
2.1	Delivery of Referral to Treatment (RTT)	Target	80%	80%	80%	80%	80%	95%	95%	95%
		Actual								
2.2	Implementation of Best Practice Tariff (BPT)	Target	0%	0%	0%	60%	80%	100%	100%	100%
		Actual								
2.3	Emergency and Planned Care sites modelled	Target	0%	0%	0%	60%	80%	100%	100%	100%
		Actual								
2.4	Bed occupancy	Target	97%	92%	92%	92%	92%	90%	88%	85%
		Actual								
2.5	Reduce op cancellations due to no bed	Target	0%	0%	0%	0%	0%	75%	85%	99%
		Actual								
2.6	Reduce readmission rates	Target	0%	0%	0%	0%	0%	75%	85%	99%
		Actual								
2.7	Care closer to home activity	Target	0%	0%	0%	0%	0%	75%	85%	99%
		Actual								

3.1	Reduction in high risk backlog	Target	0%	0%	0%	0%	0%	75%	85%	99%
		Actual								
4.2	Engagement with all SaTH teams	Target	60%	80%	100%	100%	100%	100%	100%	100%
		Actual								
5.1	Reduce notes storage requirement	Target	0%	5%	10%	20%	30%	40%	50%	60%
		Actual								

Table 11.2 - Draft Benefits Tracker for Acute Reconfiguration of Hospital Services

## 12.0 Implementation Governance

### 12.1 Future Fit Programme Board

The Future Fit Programme Board was established in 2013 following the Call to Action. As described in the current Programme Execution Plan (PEP), the key objectives of the programme are:

- To agree the best model of care for excellent and sustainable acute hospital services that meet the needs of the urban and rural communities in Shropshire, Telford and Wrekin and mid Wales;
- To prepare all business cases required to support any proposed service and capital infrastructure changes;
- To secure all necessary approvals for any proposed changes; and
- To implement all agreed changes.

The Programme Sponsors are the Boards of:

- Shropshire Clinical Commissioning Group
- Telford and Wrekin Clinical Commissioning Group
- The Shrewsbury and Telford Hospital NHS Trust
- Shropshire Community Health Trust
- Powys Teaching Health Board

The joint Programme Owners and Senior Responsible Officers (SROs) are David Evans, Chief Officer, Telford and Wrekin CCG and Dr Simon Freeman, Accountable Officer, Shropshire CCG.

It was agreed at the Fit Programme Board on 16<sup>th</sup> January 2019, that the board would meet at least once more time, planned for February 2019 ensure a detailed plan is in place to ensure a smooth and thorough handover of all ongoing activity, including actions within mitigations plans to an Implementation Oversight Group, under the governance of the Sustainability and Transformation Partnership (STP.) These arrangements are to be agreed at the next meeting of the System Leadership Group.

### 12.2 Role of the STP

In Spring 2019, the Future Fit Programme governance structure will therefore be in transition to a new STP governance structure as detailed in Figure 12.1.

Updated Version 4.0  
June 2018

Shropshire, Telford and Wrekin  
Sustainability & Transformation Programme Governance Structure

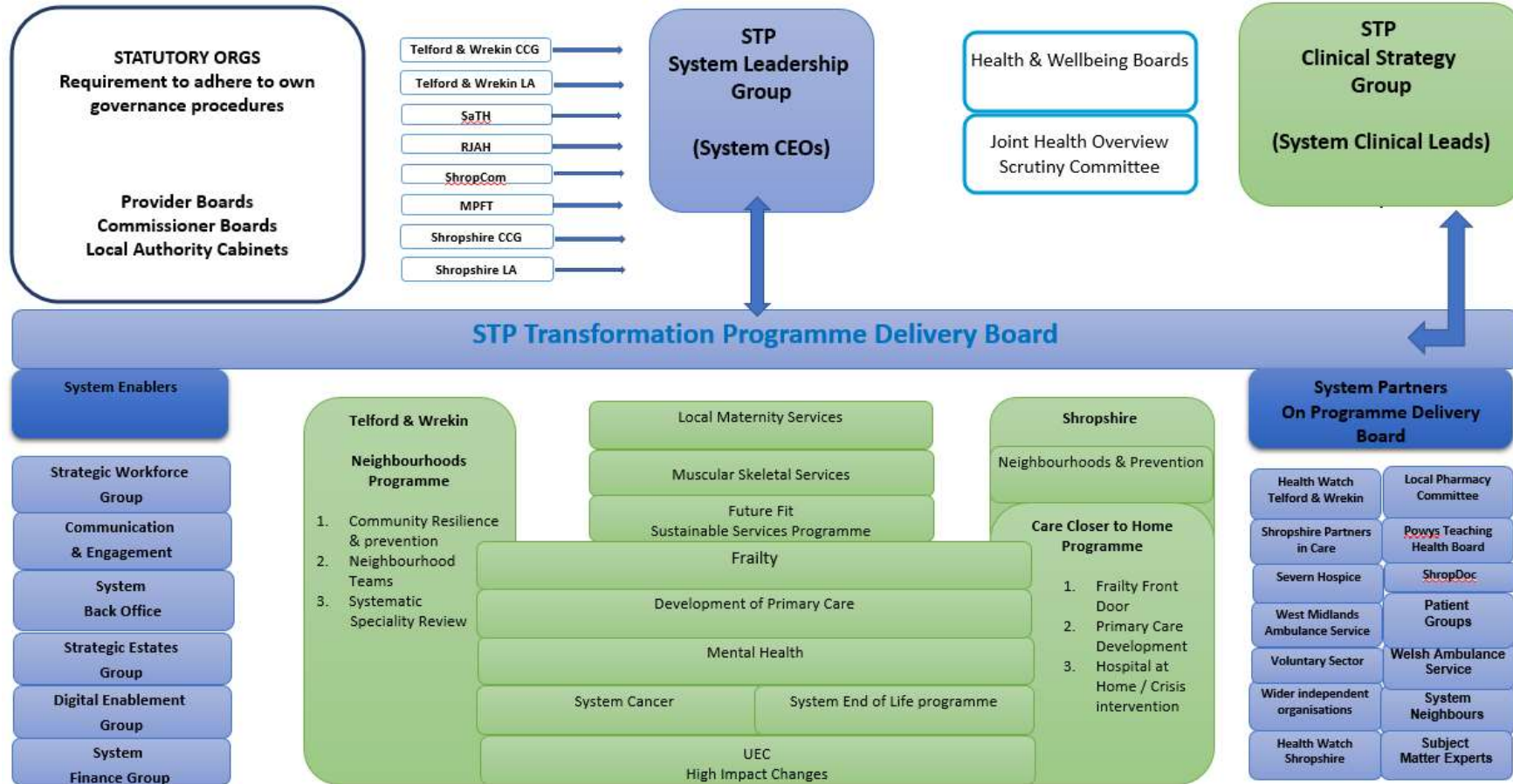


Figure 12.1: The Future Fit programme governance structure

### **12.3 Implementation Oversight Group**

The key purpose of IOG is to share actions being taken by the Trust to address and mitigate risks to ensure the implementation of the acute reconfiguration post the completion of the consultation decision-making process. The group will oversee operational and quality risks and provide stakeholders with a single forum to receive updates regarding the implementation and the ongoing interdependent workstream activity, including out-of-hospital care strategies.

The key objectives of the Implementation Oversight Group will be to:

- Receive detailed progress updates in relation to the implementation plans, gaining the required assurance from the Trust
- To ensure that there is a collective responsibility to determine whether the group is assured
- To ensure that the group is sighted on all communications and reporting between the Trust and any other statutory bodies on matters relating to the implementation
- To provide assurance to the Systems Leadership Group of the STP / Integrated Care System Shadow Board

The Terms of Reference for this Group are yet to be signed off and the Chair and membership is therefore yet to be confirmed.

### **12.4 Sustainable Services Programme**

As the provider of acute hospital services within Shropshire, Telford & Wrekin, the Shrewsbury and Telford NHS Hospital Trust (SaTH) established the acute Sustainable Services Programme (SSP) in 2016. This programme has worked closely alongside the Future Fit governance structure to ensure that the overarching programme objectives are delivered. The Trust has successfully managed the SSP programme to date, supporting the development of the clinical model, input into the options appraisal process and supporting the financial and economic analysis within the PCBC.

A Sustainable Services Programme Steering Group leads and coordinates the Trust's actions and deliverables in progressing the SSP. The Steering Group has a number of objectives:

- To support the Project Team, Clinical Leads, Operational and Corporate Leads in the delivery of their work plans
- To oversee and ensure the delivery of the required business cases (SOC, OBC, FBC) and their approval, focussing on clinical safety, workforce sustainability and affordability
- To support and ensure coordination between all working groups and work streams (within the programme and across the Trust/local health system) ensuring inter-dependencies are identified and maintained
- To receive workstream reports, monitor progress and ensure the delivery and performance of the construction programme and project as a whole
- To oversee and support on-going engagement and communication in relation to the SSP, both internally and externally
- To be responsible for addressing the ongoing questions and delivery of the assurance process including those from the Future Fit programme Board, Clinical Commissioning Groups and Joint Health Overview and Scrutiny Committee
- To work in partnership with the Clinical Commissioning Groups, Health Boards and Ambulance Trusts in the delivery of the SSP

The SSP completed a Strategic Outline Case (SOC) which was approved in 2016. This is currently being refreshed for submission to NHSI and reflects the content of the PCBC which was approved in November 2017. The Trust is managing the SSP process with an internal team, complemented by external advisors where appropriate. It has confirmed that adequate time, resource and expertise are being allocated to the project to ensure its successful delivery.

As the SSP moves into implementation stage, it is intended that the SSP will report progress into the IOG which sits within the STP governance arrangements. An internal governance structure for SSP is in place. This is set out below in Figure 12.2.

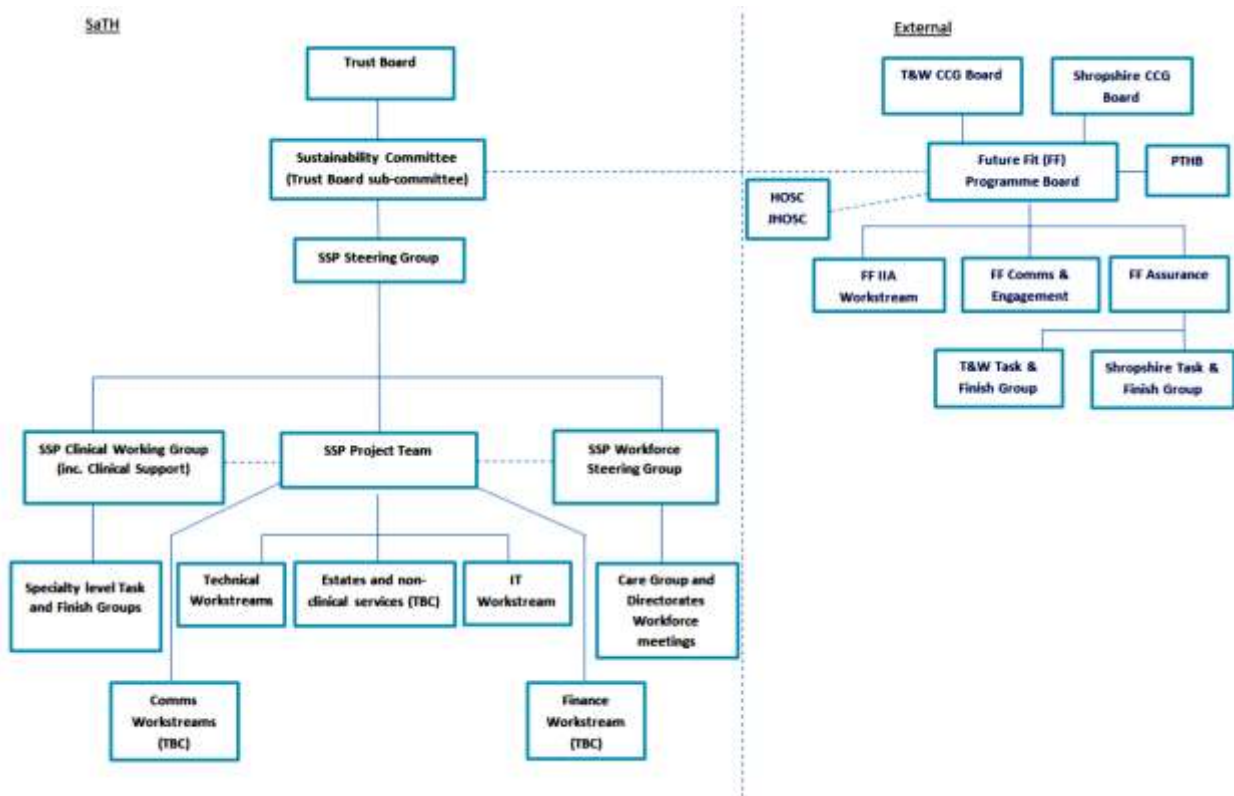


Figure 12.2 - Current SSP Governance arrangements November 2018

### 12.5 Implementation Timetable

These proposed dates take account of the necessary conscientious consideration of the consultation responses and the necessary assurance and approvals processes for NHSE.

Table 12.2 below sets out the indicative timeline from final decision-making to full implementation. This incorporates the necessary approvals processes for NHSI, Governing Bodies and HM Treasury.



Milestones	Date
Programme Team receives Consultation Finding Report from Participate Ltd	9 <sup>th</sup> November 2018
Joint CCG Board Workshop with independent facilitation	14 <sup>th</sup> November 2018
Powys LTHB receives Findings of Consultation Report	21 <sup>st</sup> November 2018
Extended Programme Board to receive Consultation Findings Report and Joint CCG Board Workshop report. Also to receive EIA, IIA mitigation priority plans including, Ambulance Modelling, Travel and Transport Report, Out of Hospital Care model and other NHSE assurance.	22 <sup>nd</sup> November 2018
Joint HOSC and Powys CHC receive Findings of Consultation Report	3 <sup>rd</sup> /4 <sup>th</sup> December 2018
Telford and Wrekin CCG Board receives first draft DMBC (Private session)	11 <sup>th</sup> December 2018
Shropshire CCG Board receives first draft DMBC (Private session)	12 <sup>th</sup> December 2018
JHOSC and CHC provide initial verbal feedback	17 <sup>th</sup> December 2018
NHSE Assurance check point	20 <sup>th</sup> December 2018
Joint HOSC formal feedback to public consultation received	3 <sup>rd</sup> January 2019
Telford and Wrekin CCG Board receives Final Draft DMBC (Private session)	8 <sup>th</sup> January 2019
Montgomeryshire Committee of Powys CHC receives presentation on findings from consultation	8 <sup>th</sup> January 2019
Montgomeryshire Committee of Powys CHC formal feedback received	9 <sup>th</sup> January 2019
Shropshire CCG receives Final Draft DMBC (Private session)	9 <sup>th</sup> January 2019
Future Fit Programme Board meets to approve documentation and agree recommendations to Joint Committee of CCGs	16 <sup>th</sup> January 2019
NHS England Assurance Meeting	22 <sup>nd</sup> January 2019
Joint Committee decision- making in public to receive and consider DMBC and recommendations from Programme Board	29 <sup>th</sup> January 2019

*Table 12.1 - Indicative Timeline for Future Fit Decision-making*

Milestone	Start date	Completion date
SaTH Trust Board approval of Strategic Outline Case (SOC)	-	February 2019
NHSI approval process for SOC	December 2018	June 2019
SaTH Trust Board approval of Outline Business Case (OBC)	-	June 2019
NHSI approval process for OBC	June 2019	December 2019
Development of Full Business Case (FBC)	February 2019	March 2020
Initial building and enabling works at PRH/ RSH (assumed date)	December 2019	December 2020
SaTH Trust Board approval of FBC	March 2020	April 2020
NHSI FBC approval period	April 2020	September 2020
New Build and Refurb Works - Phase 1 <ul style="list-style-type: none"> <li>Emergency Care site - construct new ED, critical care, wards, W&amp;C services</li> <li>Planned Care site - refurbish theatres and main entrance</li> </ul>	December 2020	December 2022
New Build and Refurb Works- Phase 2 <ul style="list-style-type: none"> <li>Refurbish theatres, refurbish vacated A&amp;E</li> <li>Construct new entrances</li> </ul>	September 2022	January 2025
New Build and Refurb Works- Phase 3 <ul style="list-style-type: none"> <li>Refurbishment of other areas e.g. outpatients, imaging, day case chemo</li> <li>Backlog</li> </ul>	January 2024	January 2025

Table 12.2 - Indicative Timeline to Implementation

## 13.0 Analysis of Proposals and Recommendation Formation

Any recommendations within this DMBC need to be tested against local criteria described in Table 13.1 (as defined in the PCBC and used in the non-financial appraisal of options) and the prescribed national tests for reconfiguration. This section considers these tests and brings together the consultation findings and other recent work completed since the PCBC approval to test whether there is any new information or evidence being presented or whether there is an alternative option requiring consideration. This framework is described below.

<b>Local Criteria</b>	
<b>Access</b>	<i>Is it materially inferior/superior in terms of promoting equity of access to acute hospital services?</i>
<b>Quality:</b>	<i>This domain covers the three quality domains of safety, effectiveness and patient experience and specifically travel times for patients with time-critical conditions</i>
<b>Time critical Journeys</b>	<i>Will it lessen or worsen the impact on time critical journeys to the Emergency Care site?</i>
<b>Safety</b>	<i>Does it improve/ worsen safety issues beyond the current option? Will it increase or reduce clinical risk?</i>
<b>Effectiveness</b>	<i>Will it make day-to-day operational delivery better or worse? Are effective and clear care pathways able to be implemented? Does it impact on removing duplication of services across two sites and addressing variation in working practices?</i>
<b>Patient Experience</b>	<i>Does it provide improved facilities and the physical disposition of services within each site? Does it deliver improved performance? Are pathways clear for patients? Is care responsive and in right place, at right time with right person?</i>
<b>Workforce</b>	<i>To what extent will it improve recruitment and retention and enable better use of the workforce? Does it deliver a sustainable workforce, particularly for those most challenged services? Would it be attractive/acceptable to staff?</i>
<b>Deliverability</b>	<i>Is it able to be delivered by the Trust? Is there evidence that it is practically infeasible or materially inferior in terms of deliverability to current options?</i>
<b>Financial Affordability</b>	<i>Can it be delivered within the financial envelope both capital and revenue? Is the proposal affordable to the Trust, to commissioners, to the system? Does it provide value for money?</i>

Table 13.1 - Local criteria against which recommendations within the DMBC must be tested

### 13.1 Local Criteria for Service Reconfiguration

In the pre-consultation phase, options development and evaluation have consistently been assessed against these five key criteria. This DMBC uses the same criteria against which to consider responses to the consultation findings and any new proposals in developing its recommendations.

Table 13.2 sets out the evidence that has been reviewed pre- and post- consultation to support decision-making and the development of recommendations to the Joint Committee of Shropshire and Telford & Wrekin CCGs. Where appropriate, appendices to this DMBC are referred to. References to other documents are in italics and can be found on the Future Fit website in full or as links to external websites.

Local Criteria	Pre-consultation evidence considered	Post consultation evidence considered
<b>Access</b>	Non-financial Appraisal September 2016: access impact for emergency, planned and Women & Children (car and public transport) <i>Integrated Impact Assessment 2016</i> <i>Integrated W&amp;C Impact Assessment 2017</i> IIA Steering Group <i>IIA Mitigation Priorities Plan</i>	Equality Impact Assessment 2018 (Appendix 1) EIA Mitigation Plan Response to Consultation Findings (Appendix 2) Travel and Transport Report (Appendix 3) Travel and Transport Mitigation Plan (Appendix 4)
<b>Quality:</b> <b>Time critical</b> <b>Journeys</b> <b>Safety</b> <b>Effectiveness</b> <b>Patient Experience</b>	<i>Non-financial Appraisal briefing pack</i> Compliance with Best practice guidance set out in PCBC <u>WM Clinical Senate Stage 2 and review of progress against recommendations</u> Professor Sir Keith Porter support for TU at RSH Trauma Network letter support for Option 1 Specialised Commissioning letter of support Ambulance service conveyance times Task and Finish Group UCCs Pre-consultation engagement report	UCC Draft specification (Appendix 5) <u>Urgent Treatment Principles and Standards NHSE 2017</u> SSP Review of alignment with best practice updated in DMBC section 3. Draft Transfer Policy (Appendix 6) PICU Time-critical Transfer Policy (Appendix 7) Response to Consultation Findings (Appendix 8) ORH Ambulance modelling data (Appendix 9) Ambulance services and Trauma Network meetings Response from other providers (Stakeholder Response Analysis Appendix 10) Outcome of Programme Board event Nov 2018 Engagement with seldom heard groups during consultation <i>Future Fit FAQs</i>
<b>Workforce</b>	<i>Non-financial Appraisal briefing pack</i> Future Fit Workforce workstream PCBC workforce plans	SSP Staff engagement programme STP Workforce workstream Updates on recruitment progress to Programme Board Work of the LWAB
<b>Deliverability</b>	<i>Non-financial Appraisal briefing pack</i> Letters of support SaTH, Letter of support PTHB Letter of support WMAS Draft OBC	Report on Neighbourhoods strategy in T&W (Appendix 11) Report for Shropshire Care Closer to Home (Appendix 12) PTHB Annual Plan Summary (Appendix 13) Provider responses to consultation Deliverability statement SaTH (TBA)
<b>Financial Affordability</b>	Financial appraisal of options <i>Financial Feasibility Study 2014</i> PCBC Financial and economic case NHSE stage 2 assurance process 2017	Review of financial plans within PCBC by STP Finance Group ORH ambulance modelling data Refresh of admission avoidance data Northumbria Comparator 2018 (Appendix 14) NHSE Assurance Process Dec 2018

Table 13.2 - Evidence against local criteria for service reconfiguration

### 13.2 National Tests for Service Reconfiguration

In 2010, the NHS set four key tests for service reconfiguration:

- Strong public and patient involvement
- Consistency with current and prospective need for patient choice
- Clear clinical evidence base
- Support from clinical commissioners

In 2017, a further test was added in relation to proposed bed closures. There are no planned bed closures in the proposed model for Future Fit. However, whilst the activity and bed model has incorporated demographic growth and there is an assumed growth in overall clinical capacity, there is an assumption that out-of-hospital care will result in a reduction of non-elective inpatient activity in the region of circa 5,000 episodes across the two CCGs by the end of the five year implementation period.

Table 13.3 describes the national tests for reconfiguration and outlines the evidence considered, both pre- and post-consultation, to support the formation of recommendations placed before the Joint Committee of Shropshire and Telford and Wrekin CCGs.

National Criteria	Pre-consultation evidence considered	Post consultation evidence considered
<b>Strong public and patient involvement</b>	Call to Action 2013 <i>Options Appraisal Report 2016</i> Patient Representation on Programme Board and work streams <i>Pre-consultation Engagement Report</i> <i>Consultation Plan</i> Consultation Methodology Engagement with CHC and JHOSC Stakeholder Reference Group	Seldom Heard Groups Engagement and EIA Report Participate Consultation Findings Report Stakeholder Responses Report Individual Responses Report (Appendix 15) Patient representation during conscientious consideration events with CCG Board and Programme Board Engagement with CHC and JHOSC
<b>Consistency with current and prospective need for patient choice</b>	Clinical Model set out in consultation: many services remaining on both sites; some services already exist on one site Out of county flows for specialist care will remain same as now 80% will continue to go to where they go now for urgent and emergency care	Strategies around care closer to home Development of clinical model for maternity community hubs Ambulance modelling assurance around capacity UCC both sites 24/7
<b>Clear clinical evidence base</b>	Clinical consensus for the model Alignment with best practice guidance <i>WM Clinical Senate Stage 2 Review</i> Trauma Network View <i>NHS Transformation Unit Review</i>	Clinical consensus for the model Programme Board event Nov 2018 SSP Review of alignment with best practice guidance (DMBC) UCC draft specification Urgent Treatment Centres Guidance 2017 Ongoing engagement with SSP, ambulance services and Trauma Network Engagement with Specialised Commissioning
<b>Support from clinical commissioners</b>	SOC and PCBC approval by CCGs Unanimous support for consulting on preferred option 1 and option 2 Caveats set out for further work	EIA and mitigation plan SSP QIAs (Appendix 17) Travel and Transport Plan Paediatrics cover in UCC ORH Ambulance Modelling

<b>Bed/capacity requirements</b>	Growth of 2.8% included Overall clinical spaces increase from 877 to 991 (PCBC) Assumptions around circa 5,000 avoided admissions over 5 years	Refresh of Neighbourhoods and Care Closer to Home strategies Admission avoidance assumptions retested in DMBC NHSE Assurance process
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*Table 13.3 - Evidence against national tests for service reconfiguration*

A review of the key themes and any alternative proposals contained within the public consultation responses was conducted against each of the criteria and tests described above. An overview of findings and further detail on the evidence and rationale considered for each of the recommendations can be found in section 14.



## 14.0 Decision-making

This DMBC is intended to support the Joint Committee of Shropshire and Telford and Wrekin CCGs in making decisions in line with its terms of reference. (Appendix 18)

### 14.1 Decision-making Process

The Joint Committee of Shropshire and Telford and Wrekin CCGs will take into account a range of information to enable a balanced approach to decision-making; no one source of information has priority over another. The information to be considered by the Joint Committee of Shropshire and Telford and Wrekin CCGs is contained within this DMBC and its associated appendices and includes:

- The Consultation Findings Report
- Summary of Stakeholder Responses and Individual Responses
- The views and outcomes from the Conscientious Consideration Events with CCG Boards on 14<sup>th</sup> November and with Future Fit Programme Board 22<sup>nd</sup> November
- The Equality Impact Assessment, its recommendations and supporting Mitigation Plan
- The Integrated Impact Assessments and their recommendations from 2016 and 2017
- The Travel and Transport Report and Mitigation Plan
- The outcome of the ORH Ambulance Modelling and implications for commissioning
- The specification for the UCC and in particular plans around paediatric care
- The supporting draft policies for the safe transfer of patients
- The Draft Quality Impact Assessments
- Updates from the T&W Neighbourhoods Programme
- Updates from Shropshire Care Closer to Home
- Updates from the Powys Annual Plan
- The Outcome of the *Northumbria Comparator Analysis*

In considering all of the above, the Joint Committee of Shropshire and Telford & Wrekin CCGs will have considered updates of progress against caveats set out by the CCG Boards and the Joint Committee, and actions requested by NHSE at the PCBC approval stage in 2017. These are set out in section 10 of this report as a summary.

### 14.2 Overarching Statements to Support Decision-making

Table 14.1 below considers whether the recommendations set out in section 15 have met the local criteria and national tests for service reconfiguration when considering each service area. Where mitigation is required it is referenced.

Definitions of each criteria or test can be found in sections 13.1 and 13.2 above.

Evidence considered pre-consultation and post-consultation that supports this rating is also referenced in these sections.

The table also refers to where mitigation plans have been developed.

Criteria	Emergency Care	Urgent Care	Complex planned care	Stroke	Non-complex planned care	Consultant led births	Paediatrics	Outpatients	Diagnostic tests
<b>Impact on health access inequalities</b>	Some impact see EIA mitigation	No change	No change	Some impact see EIA mitigation	Some impact see EIA mitigation	Some impact see EIA mitigation	Some impact see EIA mitigation	No change	No change
<b>Impact on all elements of Quality:</b>									
<b>Time critical journeys</b>	met	N/A	N/A	met	N/A	met	met	N/A	N/A
<b>Safety</b>	met	met	met	met	met	met	met	met	met
<b>Effectiveness</b>	met	met	met	met	met	met	met	met	met
<b>Patient experience</b>	met	met	met	met	Some impact see T&T mitigation	Some impact See LMS/T&T mitigation	Some impact see T&T mitigation	met	met
<b>Positive impact on workforce recruitment</b>	met	met	met	met	met	met	met	met	met
<b>Deliverability</b>	See mitigation out of hospital care	met	met	met	met	met	met	met	met
<b>Financial sustainability</b>	met	met	met	met	met	met	met	met	met
<b>Public and patient involvement</b>	met	met	met	met	met	met	met	met	met
<b>Consistent need for patient choice</b>	met	met	met	met	met	met	met	met	met
<b>Clear clinical evidence base</b>	met	met	met	met	met	met	met	met	met
<b>Support from clinical commissioners</b>	Subject to mitigation	met	met	Subject to mitigation	Subject to mitigation	Subject to mitigation	Subject to mitigation	met	met
<b>Bed capacity requirements</b>	met	N/A	met	met	met	met	met	N/A	N/A

## 15.0 Recommendations

As a result of conscientious consideration of the consultation responses and consideration of the mitigation and other actions developed since the approval of the PCBC, a series of six draft recommendations were agreed by consensus at the end of the Programme Board event on 22nd November 2018 subject to an agreed set of 5 mitigations that were to be developed within the DMBC. These were subsequently approved at the Programme Board on 20<sup>th</sup> December 2018 and are set out below for approval.

A seventh recommendation has been suggested by the SROs since the Programme Board event to ensure that post decision-making, governance arrangements are made clear to the CCGs and that there is robust arrangement for oversight of the development of the OBC and FBC which will be led by the Trust.

### **Recommendation 1: Consultation Process**

The CCG Joint Committee is asked to confirm that the Committee and its constituent Clinical Commissioning Groups have met their statutory duties and ensured that an effective and robust public consultation process has been undertaken and will be used to inform the decisions made. (See Appendix 8 Consultation Findings Report from Participate Ltd).

### **Recommendation 2: On-going Engagement**

The CCG Joint Committee is asked to support the need for the Clinical Commissioning Groups to continue to engage with and feedback to stakeholders the outcome of the consultation and the decision-making process, including those from seldom heard groups.

### **Recommendation 3: Principles of Consultation**

The CCG Joint Committee is asked to reaffirm the model underpinning the future provision of hospital services for Shropshire, Telford and Wrekin and mid Wales upon which the consultation process was based.

1. Our patients receive safer, high quality and sustainable hospital services by creating:
  - a. a separate emergency care site where specialist doctors treat the most serious cases
  - b. a single planned care site where patients would not have to wait as long and beds are protected for their operations
  - c. urgent care centres based at both hospitals providing care 24 hours a day, every day for illness and injuries that are not life threatening but require urgent attention
  - d. a model where both sites provide most women and children's services
  - e. a model where both sites continue to provide the vast majority of outpatient services and diagnostic tests
2. Patients receive the very best care in the right place at the right time
3. Patients receive their care in better facilities
4. We can continue to have two vibrant hospitals in our county
5. We attract the very best doctors, nurses and other healthcare staff to work at our hospitals and have the right levels of staff working across both sites
6. We reduce the time people spend in our hospitals
7. We reduce the number of times patients need to come to hospital
8. We are more efficient with our resources

### **Recommendation 4: Consultation Findings**

The CCG Joint Committee is asked to Note that the Programme Board has confirmed by consensus that the consultation findings have presented no new viable alternative models or no new themes or key issues that might influence the preferred option.

**Recommendation 5: Preferred Option**

The CCG Joint Committee is asked to confirm the previous unanimous decision on the preferred option, Option 1, in accordance with (a) the recommendation from the Programme Board; and (b) the following mitigations within the final DMBC:

- 5.1 Travel and Transport Report and mitigations plan (Appendices 3 and 4 respectively)
- 5.2 Equality Impact Assessment (EIA) recommendations and mitigation plan (Appendix 2) is aligned with the previous recommendations from the Integrated Impact Assessments (IIAs) carried out in 2016 and 2017, (Appendix 16).
- 5.3 Progress on Out-of-Hospital Care Strategies for both Shropshire and Telford and Wrekin CCGs to be described and to focus on co dependencies in assuring the delivery of the acute model assumptions (Appendices 11 and 12 respectively).<sup>3</sup>
- 5.4 A clear description of the services on each site, particularly around service provision at the Urgent Care Centres (Section 9.3)
- 5.5 Reconfirming affordability, including the patient flow assumptions since the PCBC was approved; noting that further refinement will be included within the Outline Business Case (OBC) which is expected for approval in July 2019.

**Recommendation 6: DMBC**

The CCG Joint Committee is therefore asked to Receive and Approve the contents of the DMBC, including its key appendices.

**Recommendation 7: Implementation Oversight**

The CCG Joint Committee is asked to note and approve the proposal for an Implementation Oversight Group (IOG) to be established under the STP governance structure to take forward oversight of the development of the OBC and FBC. All sponsor organisations will be represented on this Group.

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<sup>3</sup> The out-of-hospital care strategy for Powys has also been considered throughout the process and progress needs to be described.

## **16.0 Conclusions and Next Steps for the Decision-making Process**

In conclusion, the Future Fit Programme has, in collaboration with its sponsor organisations and stakeholders over the last five years, developed a number of proposals for changing the configuration of acute hospital services for the populations of Shropshire, Telford & Wrekin and parts of Powys that rely on the services of The Shrewsbury and Telford Hospital NHS Trust. These proposals will both improve the quality and safety of care for the whole population and increase the system sustainability for the next generation.

It has taken over five years to get to this point, longer than anticipated and to the frustration of many, including the public, whilst services have also become even more fragile. However, during this time the Programme has been able to develop additional assurances around its processes and decision-making that must now give confidence to the public and to the regulators that, taking account of the consultation findings, it is time to proceed to the final decision-making process.

Following the Future Fit Programme Board receiving the formal independent Consultation Findings Report, the Equality Impact Assessment Report, the content of key mitigation plans, it has made a series of final recommendations to the Joint Committee of Shropshire and Telford & Wrekin CCGs, as set out above.

On behalf of the two CCGs, the Joint Committee will now act as the decision-making body to receive and approve or otherwise the recommendations set out in this DMBC.

# Digital Transformation Implementations 23/24

## Due for completion April 2023 - March 2024

### EPR Phase 1

- PAS & ED Systems replaced
- Wardboards replaced
- Theatre system upgrades and integrate with CareFlow.
- Patient observation system upgrades and integrated with CareFlow.
- 30 downstream systems integrated
- Reporting updated

### Digital transformation projects

- Digital Pathology
- Advanced clinical noting
- Single Sign-on

### Divisional projects (committed)

- TMON Dialysis
- Endoscopy Washers Phase 2
- Stream& Triage at RSH ED
- Heart Assessment Database
- CDC & Renal unit
- CTGs connected to Badgernet
- W&C patient information screens
- Glucose Meter Replacement
- Aria MedOncology upgrade
- Da Vinci Robot
- SAU Whiteboard

Divisional projects with digital dependencies not listed here are not included in the 23/24 Digital Roadmap, and no commitment to delivery can be given regardless of operational plan inclusion.

## Due for completion April 2024 – December 2025

### EPR Phase 2 & Digital Solution Implementations

- Careflow connect
- Bluespier Pre-op Assessment
- Badgernet Neonatal
- Advanced clinical noting
- Vitals Paeds
- Flow and Capacity
- Electronic Prescribing and Medicines Management
- Laboratory Information Management System
- Digital Order Comms Results & Reporting
- Data warehouse development
- Windows 11/Office 365
- Cyber Security measures
- Network Refresh
- Patient Engagement Portal
- Population Health Management (system-wide benefit)
- Remote Monitoring (system-wide benefit)

### Divisional projects (unconfirmed)

Pending prioritisation



# Digital Programme roadmap



# Hospitals Transformation Programme Social Value Strategy

## Purpose of this Document:

This document sets out our commitments to social value in our social value charter and describes our local priorities and the outcomes we want to create for the people who will be involved in, and influenced by, the delivery of the HTP contract. We have set out what we will do in partnership with our PSCP to embed these commitments in the build programme to drive value. We are committed to maximising the social, economic, and environmental impact of this investment and this document describes how we intend to achieve this.

The strategy was developed through consultation with HTP and wider system stakeholders, a review of the local landscape, existing local strategic priorities and requirements and recommendations from national policy and legislation.

When incorporated effectively, social value will help reduce health inequalities, drive better environmental performance, and deliver even more value from investment. Central government policy requires that all procurement undertaken by NHS organisations will contribute to social value and net zero carbon goals. A Social Value Strategy is required for the Hospital Transformation Programme Outline Business Case and to support the procurement process.

## VERSION CONTROL:

Appendix ref.	Version	Date Issued	Summary of Change	Owner's Name
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Author

# Contents

Executive summary.....	4
Our Social Value Charter .....	6
<b>1. Context .....</b>	<b>7</b>
1.1 Background to social value .....	7
1.1.1 What is social value? .....	7
1.1.2. Legislation.....	7
1.1.3. Policy .....	7
1.1.4. The approach to social value .....	7
1.1.5. Social value in the context of the HTP .....	7
1.2 The local landscape .....	8
<b>2. Social Value of the Investment.....</b>	<b>10</b>
2.1 COVID-19 Recovery.....	10
2.1.1 Description.....	10
2.1.2 Our priorities .....	10
2.2 Tackling Economic Inequality.....	11
2.2.1 Description.....	11
2.2.2 Our priorities .....	11
2.3 Fighting Climate Change.....	12
2.3.1 Description.....	12
2.3.2 Our priorities .....	12
2.4 Equal Opportunity.....	13
2.4.1 Description.....	13
2.4.2 Our priorities .....	13
2.5 Wellbeing.....	14
2.5.1 Description.....	14
2.5.2 Our priorities .....	14
<b>3. Securing Social Value Through Procurement .....</b>	<b>15</b>
3.1 The role of procurement.....	15
3.2 Key procurement considerations.....	15
<b>4. Requirements of the contractor.....</b>	<b>16</b>
4.1 Pre-tender engagement .....	16
4.1.1 Local Partnering and Stakeholder Engagement .....	16
4.2 KPIs and performance obligations .....	17
4.2.1 KPIs or Core Reporting Metrics.....	17
4.2.2 Performance Obligations .....	17
4.2.3 Approach to KPI Selection.....	18

4.2.4 Social Value Proportionality Test .....	18
4.2.5 Procurement considerations for KPI selection .....	18
4.3 Contractual Clauses, Performance Indicators and Obligations .....	19
4.3.1 National Policy and International Standards .....	19
4.3.2 Additional Social Value Contract Clauses .....	19
4.4 Demonstration of Social Value through CITTB Questions.....	20
<b>5. Working with the contractor .....</b>	<b>21</b>
5.1 Approach to monitoring delivery through the contract .....	21
5.1.1 KPI reporting thresholds .....	21
5.1.2 KPI reporting intervals .....	22
5.2 Approach to demonstrating delivery .....	22
5.2.1 Social Value Impact Reporting .....	22
5.3 Working with the contract to maximise social value .....	23
5.3.1 Stakeholder Mapping.....	24
Systems and processes for stakeholder involvement .....	25
<b>6. Summary and Conclusion .....</b>	<b>26</b>
6.1.1 Embedding Priorities .....	26
6.1.2 Enabling Change .....	26
6.1.3 Conclusion .....	26
<b>Annexes.....</b>	<b>27</b>
Annex 1: Next Steps.....	27
Annex 2: Sources Reviewed .....	27
The Shrewsbury and Telford Hospitals NHS Trust Anchor Ambitions.....	28
Annex 3: KPI selection checks .....	28

## Executive summary

The primary purpose of the Hospitals Transformation Programme (HTP) is to improve the environment for delivering modern, safe, and effective healthcare from dedicated, fit-for-purpose buildings to significantly improve the health of the population and their experience of care, as well as making the Trust an employer of choice. The improvements to the hospitals are likely to result in significant improvements in the health of our population as a direct result of improved delivery care but there is also a substantial opportunity for us to leverage our scale and position within the region to maximise the social value created through the delivery of the scheme. The social determinants of health – where people live, their education, income, and physical and social environment are thought to be the main contributors of overall health status<sup>1</sup>.

Investment in our sites represents a significant contribution to levelling up Shropshire, Telford and Wrekin and will result in the creation of two vibrant hospital sites in Shrewsbury and Telford. £312m investment in hospital facilities could result in c.£200m GVA benefit<sup>2</sup> on the local economy. There are collective local and national ambitions to optimise the social value created through the infrastructure investment.

This strategy identifies additional opportunities to create social value through the delivery of the HTP contract with a framework of measures and KPIs linked to outcomes which have been identified as valuable to the local community. In the first section, we set out our commitments to improving the social, economic, and environmental impact of the scheme and describe the outcomes we will deliver for the local population. The second section of this strategy describes how the procurement process will support this, including a consideration of qualitative evaluation questions, contractual obligations, and KPIs that will maximise the social value of the investment in a way that is of most benefit to the local population. This section is intended to complement the broader procurement strategy for HTP, which will set out in detail the proposed procurement process, and approach to managing the relationship with the supplier throughout the contract.

The HTP has a significant opportunity to deliver impact across the 5 key themes from the Social Value Model. Key priority outcomes and activities for each theme are identified in our [Social Value Charter](#).

- The COVID-19 pandemic has had a considerable impact on the population in Shropshire and many people have experienced the effects of poorer mental health, financial worries, and food and employment insecurity for the first time. The HTP will help local communities to manage and recover from the impact of COVID-19.
- Shropshire is one of the most rural local authorities in the country, making it more challenging to provide the infrastructure required to support economic growth. There are comparatively few large employers and there are fewer jobs than there are workers<sup>3</sup>. The HTP will create new businesses, new jobs, and new skills and increase supply chain resilience and capacity.
- All NHS procurement must contribute to the commitment to achieve Net Zero Carbon by 2045. The Trust has a robust Net Zero Carbon Strategy, however, there are additional opportunities for effective stewardship of the environment through our travel and transport and waste management initiatives and the development of the infrastructure itself.
- The Trust is already working to ensure everyone is treated with respect and dignity underpinned by clear values and behaviours, fair processes, and we are a place where people are nurtured and developed and diversity. The HTP has an opportunity to

<sup>1</sup>Social Value Briefing: Using the Social Value Act to reduce health inequalities in England through action on the social determinants of health - IHE (instituteofhealthequity.org)

<sup>2</sup> Direct and indirect discounted GVA benefit. [See annex](#)

<sup>3</sup> Nomis - Official Census and Labour Market Statistics - Nomis - Official Census and Labour Market Statistics (nomisweb.co.uk)

extend this to the delivery of the scheme and ensure the effects are cascaded through the supply chain.

- The transformation of Shrewsbury and Telford Hospitals is likely to have a significant impact on the wellbeing of staff and patients. The HTP will utilise the opportunity to improve health and wellbeing and community cohesion.

While this Social Value Strategy has been developed in preparation for the award of a PSCP and the Outline Business Case. It is intended to remain a live document that must be iterated to optimise the social value created in response to evolving needs of the community and capabilities of suppliers. This strategy will develop in response to ongoing engagement with suppliers and HTP stakeholders and be updated and amended where required.



## Our Social Value Charter

### COVID-19 Recovery

We will leverage our relationships with wider public services to contribute to innovation and productivity.



The HTP will deliver this commitment by:

- Providing employment and training opportunities for those who were impacted by the pandemic
- Supporting local businesses to participate in the scheme
- Supporting local MSMEs to participate in the scheme

### Economic Inequality

We will create economic prospects that will help improve the health and wellbeing of our population.



The HTP will deliver this commitment by:

- Creating jobs for local people
- Creating and supporting training and education opportunities to improve the skills of the workforce
- Diversifying the supply chain and actively creating opportunities for local businesses of all sizes

### Fighting Climate Change

We will reduce our environmental impact and footprint and influence sustainable practices in our local environment.



The HTP will deliver this commitment by:

- Supporting green transport initiatives
- Promoting resource efficiency and waste reduction
- Improving biodiversity through the provision of green spaces
- Influencing partners to support environmental protection

### Equal Opportunity

We will promote a culturally sensitive, inclusive and accessible environment



The HTP will deliver this commitment by:

- Taking action to increase representation of people with disabilities in the workforce
- Embedding accessibility in to the HTP's planning and delivery
- Ensuring the jobs we create pay the National living wage
- Taking action to reduce the risks of modern slavery in the supply chain

### Wellbeing

We will make our system a great place to work by creating an environment where people choose to work.



The HTP will deliver this commitment by:

- Minimising disruption for existing Trust employees during construction and reconfiguration
- Influencing partners to minimise disruption during delivery of the contract



## 1. Context

### 1.1 Background to social value

#### 1.1.1 What is social value?

Social value is the value attributed to economic, social, and environmental outcomes that tangibly contributes to the wellbeing, resilience, and sustainability of society. In other words, the positive improvement an organisation delivers to society.

#### 1.1.2. Legislation

The Public Services (Social Value) Act 2012 requires anyone who commissions public services to *consider* how they can also secure wider social, economic, and environmental benefits. The Act is a tool to help commissioners increase the value for money out of any procurement.

#### 1.1.3. Policy

The most significant driver of social value is Procurement Policy Note 06/20 (PPN 06/20) which was introduced by the government in 2020 as an update to the Social Value Act 2012, as a new model to deliver social value through government's commercial activities. PPN 06/20 *requires* social value to be explicitly evaluated in all central government procurement. It is mandatory as of the 1st of January 2021 for central government departments, executive agencies, and non-departmental government bodies. From 1st April 2022, NHS England extended the reach of PPN 06/20 to the commissioning and purchase of goods and services by NHS organisations, as well as to organisations acting on behalf of such commissioners and purchasers.

#### 1.1.4. The approach to social value

Cabinet Office and the Department for Digital, Culture, Media and Sport (DCMS) have worked with departmental commercial and policy teams and supplier representative bodies to develop the Social Value Model to help implement the policy. Social value is described through a series of priority themes and policy outcomes which are important to deliver and measure through commercial activities.

The 5 themes within the Social Value Model and PPN 06/20 are

1. COVID-19 Recovery
2. Economic Inequality
3. Fighting Climate Change
4. Equal Opportunity
5. Wellbeing

There are 8 associated policy outcomes that flow from these themes, and a number of linked reporting metrics which can be used to evaluate the social value offers during the tender process and assess the delivery of these during the contract by measuring the impact of interventions and achievement of the outcomes. Measures can present both qualitative, quantitative, and monetised value.

Within each of the 8 policy outcomes, there is a menu of Model Award Criteria and Sub-Criteria from which contracting authorities can select the most relevant and proportionate for the contract.

#### 1.1.5. Social value in the context of the HTP

The HTP forms a key part of an overarching vision to transform health and care services across Shropshire, Telford and Wrekin. The primary goal of the redevelopment is to resolve longstanding challenges of duplicated and fragmented services in an ageing infrastructure that is not fit for delivery of twenty-first century healthcare. This itself will drive improvements to

patient care and outcomes that will impact the local population. Additionally, through the transformation of Shrewsbury and Telford Hospitals, there is an opportunity to create wider positive economic, social, and environmental impact through the programme’s design, construction, operation, and associated developments. These will in turn influence the wider determinants of health such as quality of work, income, education, and the physical and social environment.

Through a review of the local landscape, local strategic priorities and ambitions<sup>(see annex)</sup>, and relevant policy and legislation we have identified the themes, outcomes, and potential measures which are likely to deliver the most benefit to the population we serve.

The HTP is within a key phase in the final preparation of the Outline Business Case, in preparation for Trust approval and submission to NHSE in April 2023. In tandem with this, the Trust will begin market engagement in February 2023 to support the appointment of a preferred Principal Supply Chain Partner (PSCP).

To support this, it is critical that social value is considered and captured as part of the Business Case process to ensure that social, environmental, and economic outcomes are delivered in addition to the HTP’s primary outcomes, and that social value forms a key part of the procurement decisions to ensure wider benefits are realised throughout the commissioning cycle. The development of a social value strategy is iterative and will be subject to review beyond OBC to refine the commitments and priorities and maximise the social value delivered through the scheme.

## 1.2 The local landscape

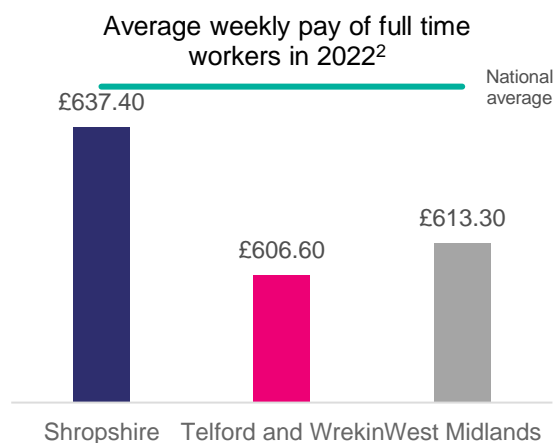
### 1.2.1. Population challenges and opportunities

We serve a population of around 487,000 people across Shropshire, Telford, and Wrekin, who live in a large and diverse landscape of urban and rural areas. Local Health and Wellbeing Board strategies highlight a number of challenges faced by the local population which could be influenced by the HTP. These are described below.

### 1.2.2. COVID-19 Recovery

Beyond COVID-19 infection, we know the pandemic response has impacted on our health and wellbeing in significant and far-reaching ways. Many people have felt the effect of poorer mental health, financial worries, and food and employment insecurity for the first time. The percentage of children claiming free school meals is 50% higher than pre-pandemic<sup>1</sup> and local charities report significant increase in demand across foodbanks. Many people were forced to take lower paid employment as a result of the pandemic and average weekly wages in the region are lower than the national average<sup>2</sup>.

Figure 1: Average weekly pay of full time workers



### 1.2.3. Economic Inequality

The region supports a primarily small-business economy. Self-employment is high and there are comparatively few large employers<sup>3</sup>. Key sectors include land-based industries, health, education, retail, and manufacturing. Shropshire is ranked 192<sup>nd</sup> most income-deprived and

<sup>1</sup> Percentage of all pupils eligible and taking free school meals in Telford and Wrekin | LG Inform (local.gov.uk)

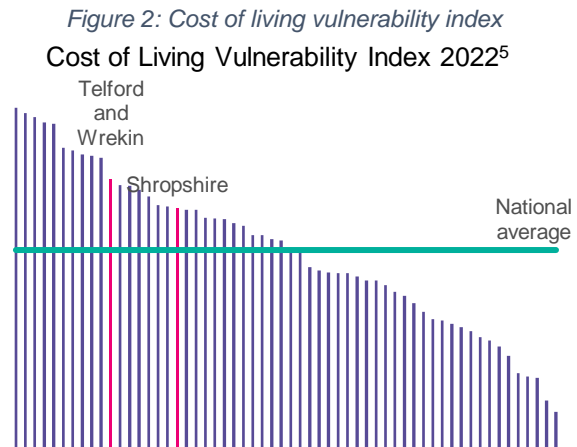
<sup>2</sup> Nomis - Official Census and Labour Market Statistics (nomisweb.co.uk)

<sup>3</sup> Employment and economy | Shropshire Council

Telford and Wrekin the 60<sup>th</sup> most income deprived out of a total of 316 local authorities in England<sup>1</sup>.

Average weekly pay in the region is lower than the national average<sup>2</sup>. The region has a higher relative risk of those who are already vulnerable being pushed into destitution by the current cost of living crisis<sup>3</sup>.

In 2021, the proportion of young people not in education, employment, or training (NEET) in Shropshire was higher than the regional and national average<sup>4</sup>. The long-term unemployment rate was slightly lower than the national average, but the economic inactivity rate was slightly higher<sup>5</sup>.



### 1.2.4 Fighting Climate Change

In addition to the Net Zero Carbon and energy efficiency requirements of the scheme, there are additional key opportunity areas which can all be addressed during the delivery of the scheme. These are also key areas of opportunity highlighted in the Trust Green Plan. They are travel and logistics, making greater use of accredited certification routes (e.g., BREEAM), and embedding social value outcomes in procurement. The most recent travel and transport study noted that there are several local postcodes which are poorly connected by public transport and footway and cycleway provision is intermittent, although there are good links to national cycle route 81. Cycle parking facilities are underutilised and there is insufficient availability of car parking spaces, suggesting there is an opportunity to make better use of alternative modes of transport to the sites. The delivery of the HTP is likely to result in a significant increase in daily traffic to and from the sites, compounding the existing pressures on parking and transport.

### 1.2.5. Equal Opportunity

The Trust and System ambitions to make our hospitals a great place to work have been impeded by the COVID-19 pandemic. We advocate strategies that seek to prevent illness and tackle inequalities to support our vibrant regional economy. Our objectives are to engage with our communities to create inclusive healthcare, empower others to be part of our inclusion journey, and embed key performance measures to monitor our progress and celebrate our success. In the West Midlands, there are 53,000 working age people who are economically inactive due to short or long-term sickness who report that they want a job<sup>5</sup>.

### 1.2.6 Wellbeing

Operational plans are in place to ensure the care and safety of patients, however, there are 6,860 FTEs at the Trust (as of the end of the 2021/22 fiscal year) who will face significant disruption to their daily working lives during the delivery of the contract. Changes to regular working location; commuting patterns and movement around the sites; and the potential disruption from noise, dust, and vibration can all negatively impact the workforce.

<sup>1</sup> [Exploring local income deprivation \(ons.gov.uk\)](https://ons.gov.uk)

<sup>2</sup> [Nomis - Official Census and Labour Market Statistics \(nomisweb.co.uk\)](https://nomisweb.co.uk)

<sup>3</sup> [Cost of Living Vulnerability Index in Telford and Wrekin | LG Inform \(local.gov.uk\)](https://local.gov.uk)

<sup>4</sup> [Public health profiles - OHID \(phe.org.uk\)](https://phe.org.uk)

## 2. Social Value of the Investment

### 2.1 COVID-19 Recovery

#### 2.1.1 Description

The COVID-19 pandemic has exacerbated existing economic and social challenges and created many new ones. Beyond COVID-19 infection, we know the pandemic continues to have an impact on our lives. Many people are still experiencing effects on their health and working lives. During COVID-19 many people in Shropshire, Telford and Wrekin lost their job or had to take lower paid and less stable employment.

The HTP has an opportunity, in partnership with the PSCP, to aid the recovery of local communities and economies, primarily through employment, re-training and return to work opportunities, community support, developing new ways of working and supporting the health of those affected by the virus.

#### 2.1.2 Our priorities

This theme and related outcomes and measures are particularly relevant when the contract involves the recruitment, re-training, and other return to work opportunities for those left unemployed by COVID-19 and where the contract offers opportunities to support businesses to manage and recover from the impacts of COVID-19.

The HTP will support the following outcomes and measures. These were prioritised for the Social Value Strategy from a range of options in the Social Value Model and share a commitment with SaTH Anchor Ambitions ([see Annex](#)) and local Health and Wellbeing Board Strategies.

#### Outcome 1: Creation of opportunities for those impacted by COVID-19

We will provide employment opportunities to those who lost their jobs or had to take lower paid employment because of the pandemic.

We will provide work placements throughout the contract and opportunities for training and skills development for people who have been impacted by the pandemic.

#### Outcome 2: Support for community recovery

We will support the local primarily small-business economy by increasing local contracts and spending with local suppliers.

We will advertise supply chain opportunities locally and openly to ensure they are accessible to local businesses.

#### Outcome 3: Support for business recovery

We will drive business creation and growth, especially in the context of COVID-19, by increasing contracts and spend through local micro, small, and medium enterprises (MSMEs).

We will structure the supply chain selection process in a way that encourages participation by new and growing businesses and demonstrate collaborative ways of working.

#### **Example measures to embed in the contract as KPIs or contractual obligations**

- Number of full time equivalent (FTE) employees hired on the contract who are registered as unemployed because of COVID-19
- Meaningful work placements that pay minimum or national living wage (as appropriate)
- Total amount (£) spent in local supply chain through the contract
- Total amount (£) spent through contract with local micro, small and medium enterprises (MSMEs)
- Volunteering / community-led initiative hours contributing to COVID-19 recovery



## 2.2 Tackling Economic Inequality

### 2.2.1 Description

Creating businesses, jobs and skills and increasing supply chain resilience and capacity supports our Widening Participation work where we are strengthening our links with schools and colleges to support workforce supply for the future and our contributions as a Cornerstone Employer, supporting careers education for young people in our local community. Developing the skill sets of the current and future workforce is the essential enabler for this. There is an opportunity for overlap and contribution to the economic aspects of COVID-19 recovery by creating outcomes and measures linked to this theme.

Shropshire, Telford and Wrekin is a primarily low-wage economy and there are comparatively few large employers. Whilst local long-term unemployment rates are slightly better than the national average, the economic inactivity rate is slightly higher and the number of people in employment has fallen since the pandemic.

### 2.2.2 Our priorities

This theme and related outcomes and measures are particularly relevant when the contract involves opportunities for business creation and growth and the recruitment, training, and retention of a contract workforce.

The HTP will support the following outcomes and measures. These were prioritised for the Social Value Strategy and share a commitment with local Health and Wellbeing Board Strategies and system pledges to harness the potential of the health and care system to contribute to innovation, productivity, and good quality work opportunities.

#### Outcome 1: Opportunities for economic growth

We will create new jobs for local residents and target recruitment of people who may face barriers to employment, including people who were not previously in work or education.

#### Outcome 2: Opportunities for employment and training

We will create apprenticeships or other recognised training placements for the local population.

We will support educational attainment relevant to the contract to address skills gaps and result in recognised qualifications.

#### Outcome 3: Diversifying the supply chain

We will engage with small, medium, and large suppliers and VCSEs throughout the supply chain. There will be a “Meet the Buyer” event run by the Trust/ICS procurement function and attended by the PSCP, giving the opportunity to local, regional, and national businesses to meet the PSCP and support the PSCP to develop its local third-party contractor base.

We will advertise supply chain opportunities locally and openly to ensure they are accessible to local businesses. This may include encouraging subcontracting opportunities and splitting contracts into smaller lots, which are manageable for micro-enterprises and SMEs.

#### **Example measures to embed in the contract as KPIs or contractual obligations**

- Number of full time equivalent employees (FTE) hired on the contract who are NOT in Employment, Education or Training
- No. of weeks of apprenticeships or T-Levels (Level 2,3, or 4) provided on the contract (completed or supported by the organisation)
- Number of non-apprentice training opportunities created
- Number of contract opportunities awarded to SMEs/ VSCEs
- Value of contract opportunities awarded to SMEs/VSCes



## 2.3 Fighting Climate Change

### 2.3.1 Description

In October 2020, NHS England published 'Delivering a Net-Zero National Health Service', a report that details the scale of the environmental problems faced by the NHS and the country. This report sets ambitious targets requiring all NHS Organisations to become Net Zero by 2040 for the NHS Carbon Footprint and by 2045 for the NHS Carbon Footprint Plus. The document is a milestone for NHS Organisations in that they now have key targets to achieve by the 2030s and 2040s.

HTP has clear strategies to safeguard effective stewardship of the environment to ensure negative impacts are mitigated or minimised, and future assets are environmentally resilient. Social value priorities are aligned with these and provide additional environmental improvements and do not replace the assessment and management of the environmental impacts of the core contract elements which are embedded in the OBC.

### 2.3.2 Our priorities

This theme and related outcomes and measures are particularly relevant when performance of the contract, or the way in which the contract is delivered, could result in environmental protection and improvement. This includes contributing to achieving Net Zero. The HTP will support the following outcomes and measures. These were prioritised for the Social Value Strategy and share values with Trust and ICS Green Plans and SaTH Anchor Ambitions.

#### Outcome 1: Delivering additional environmental benefits

We will deliver additional environmental benefits through improving air quality by offsetting carbon emissions through energy efficiency measures. The PSCP must have an environmental strategy which is embedded proportionately to all procurement within the contract.

We will embed Modern Methods of Construction (MMC) in the design principles of the scheme and will include principles of circularity and waste reduction.

We will design green spaces into the scheme to enhance the natural environment.

#### Outcome 2: Influencing partners to support environmental protection

We will support and promote green transport initiatives. Parking on site is an existing challenge and provision must be made for the additional contractors expected. Cycle to work, cycle hire, public transport, and use of nearby park and ride facilities will reduce vehicle miles and carbon emissions associated with contractor travel and cycle schemes will have additional health benefits for those utilising them.

We will ensure catering providers prioritise reducing food waste and set food waste reduction targets.

#### **Example measures to embed in the contract as KPIs or contractual obligations**

- Savings in CO2e emissions on contract achieved through de-carbonisation (i.e., a reduction of the carbon intensity of processes and operations, specify how these are to be achieved) against a specific benchmark.
- Carbon emission reductions through reduced energy use and energy efficiency measures - on site
- Vehicle miles saved on the project through green transport initiatives
- Total volume of recycled materials against a relevant benchmark
- Number of green spaces created under the contract

## 2.4 Equal Opportunity

### 2.4.1 Description

Central government has set out a vision for a society where everyone is ambitious for people with disabilities and people with long-term health conditions, and where people understand and act positively upon the important relationship between health, work, and disability. Policy outcomes reflect the commitment to create a workforce that reflects the diverse range of customers it serves and the community in which it is based. In Shropshire, Telford and Wrekin the proportion of people reporting a limiting long-term illness or disability is 1% higher than the national average.

In the broader sense, government is committed to giving everyone in the country the opportunity to fulfil their potential and has an ambition that all work should be fair and decent.

### 2.4.2 Our priorities

This theme and related outcomes and measures are particularly relevant when it is likely that there will be under-representation of people with disabilities and under-development of people with disabilities in the contracted workforce. There must be opportunities to employ and develop more people with disabilities. Vulnerability to modern slavery threats is a consideration in the contract supply chain for matters relating to the delivery of the contract.

The HTP will support the following outcomes and measures. These were prioritised for the Social Value Strategy and share values with Trust and ICS Green Plans and SaTH Anchor Ambitions.

#### Outcome 1: Demonstrate action to increase the representation of people with disabilities in the contract workforce

We will ensure the representation of people with disabilities in the contracted workforce is representative of the diverse communities we serve. We will have inclusive recruitment panels ensure job adverts and descriptions are inclusive and promote our flexible culture.

We will embed accessibility statements to the HTP and apply this to the delivery of the contract.

#### Outcome 2: Demonstrate action to support people who may be underrepresented in the workforce in developing new skills relevant to the contract

We will create employment and training opportunities targeted to those who may face barriers to work. This may include people with disabilities and people who are underrepresented in the workforce.

#### Outcome 3: Demonstrate action to identify and manage the risks of modern slavery in the delivery of the contract, including in the supply chain

We will ensure that all new employment opportunities pay the National Living Wage.

We will encourage ethical procurement practices and all supply chain partners will be required to submit a Modern Slavery Policy ahead of contract award.

#### **Example measures to embed in the contract as KPIs or contractual obligations**

- Number of FTE employees with a disability hired on the contract
- Total percentage of people with a disability on apprenticeship schemes under the contract, as a proportion of all people on apprenticeship schemes
- Total percentage of FTE people from groups under-represented in the workforce employed under the contract, as a proportion of the total FTE contract workforce
- Number of people in under-represented groups on apprenticeship schemes
- Percentage of companies in the supply chain mapped as appropriate to reduce modern slavery risks

## 2.5 Wellbeing

### 2.5.1 Description

Benefits that can be delivered through social value are an important tool in improving wellbeing. This is separate and in addition to the population health benefits derived from the core deliverables of the HTP.

The transformation of Shrewsbury and Telford Hospitals offers a significant opportunity to improve the wellbeing of patients, staff, the local community, and supply chain partners. HTP, STW ICS, and both Trusts share commitments to reducing health inequalities and improving wellbeing and health outcomes for the local population.

It is recognised that the HTP will have a significant impact on the health and wellbeing of existing Trust employees, including the impacts of dust, noise, disruption to travel, and significant disruption to working patterns as people will be required to work from unfamiliar and often changing locations during the transformation.

Government encourages employers to better support all employees, including those with mental health problems, to remain in and thrive through work. There is also a central government ambition to thrive, connect with each other, and give back to communities as part of the drive to level up the UK economy. A key area through which organisations and communities can come together to make a difference is volunteering.

### 2.5.2 Our priorities

This theme and related outcomes and measures are particularly relevant when the health and wellbeing of the contract workforce is important to the performance of the contract and there are opportunities to improve it, and where the contract involves engagement with the local community. The HTP will support the following outcomes and measures.

#### Outcome 1: Demonstrate action to support health and wellbeing

We will take action to minimise the impact on the wellbeing of existing Trust employees. If not already a member, the PSCP shall register to the Considerate Constructors Scheme and maintain membership for the duration of the contract. The Code of Considerate practice will be adhered to. Considerate constructors must manage their impact on their neighbours and the public, including ensuring courteous and respectful language and appropriate behaviour in and around the construction activity, providing a safer environment, preventing unnecessary disturbance, and reducing nuisance for the community from their activities, and proactively maintaining effective engagement with the community to deliver meaningful positive impacts.

#### Outcome 2: Influence staff, suppliers, customers, and communities through the delivery of the contract to support health and wellbeing

The PSCP will have policies in place which support the health and wellbeing of staff. This will be provided to the HTP as a “Code of Conduct” which will be cascaded through the supply chain.

#### **Example measures to embed in the contract, either as KPIs or contractual obligations**

1. Percentage of companies implementing measures to improve health of employees
2. Percentage of companies implementing Mental Health at Work commitment
3. Initiatives taken or supported to engage people in health interventions (e.g., stop smoking, obesity, alcoholism, drugs etc.)
4. Number of people-hours spent supporting local community integration
5. Percentage of Supply Chain partners supporting local community integration

### 3. Securing Social Value Through Procurement

#### 3.1 The role of procurement

The role of procurement is to translate the desired outcomes into the right contracts and select the contractor or contractors that will deliver these in a way that optimises value for money. While the procurement team will not directly realise the social value outcomes of the scheme, they have a critical role as an enabler: some of the activities that realise social value can be implemented using procurement mechanisms as outlined below.

Social value will be considered through the multiple stages of the procurement process, including through quality evaluation award criteria and tender stage and performance obligations or KPIs. This includes testing bidders' proposals for delivering:

- specified wider benefits alongside the core contract deliverables; and
- contract objectives in a way that respects and adheres to broader social value commitments.

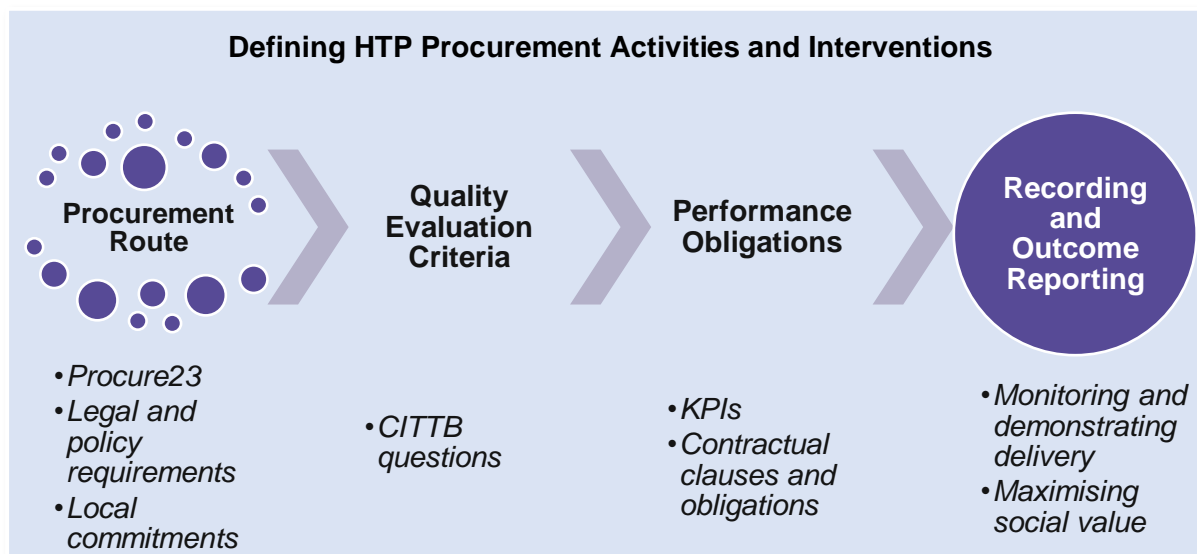
#### 3.2 Key procurement considerations

The delivery of social value through procurement is a continuously evolving objective, which needs to be balanced against other priorities such as achieving value for money and ensuring that the contract is managed in a way that ensures the delivery of the best possible outcome.

Performance monitoring requirements of social value will be embedded into the contract and will be specific about the project requirements in respect of social value and will ask for tangible and measurable conditions of the contract which will be monitored throughout contract delivery and with a view of delivering long term value for the public.

Social value deliverables will be revisited, reviewed, and refined following pre-determined supplier engagements and stakeholder consultations, ensuring they remain relevant, proportionate to expectations, and allow for innovation.

Figure 3: The HTP Procurement Activities and Interventions points that could be used for implementing social value



## 4. Requirements of the contractor

### 4.1 Pre-tender engagement

The preparation and planning stage of a procurement process is possibly the most significant stage in respect of embedding social value. This is because it is the stage at which key decisions are made on the procurement process, award criteria, and contract conditions.

The selected procurement route (CCS, ProCure23 Framework Lot3) contains 8 potential PSCP candidates for the HTP competition. This framework supports the government’s social value policies, with a focus on local supply chain spend, apprenticeship opportunities and reduction of pollution, including Carbon Reduction Policies in alignment to PPN 06/21 ‘Taking account of Carbon Reduction Plans in the procurement of major government contracts.

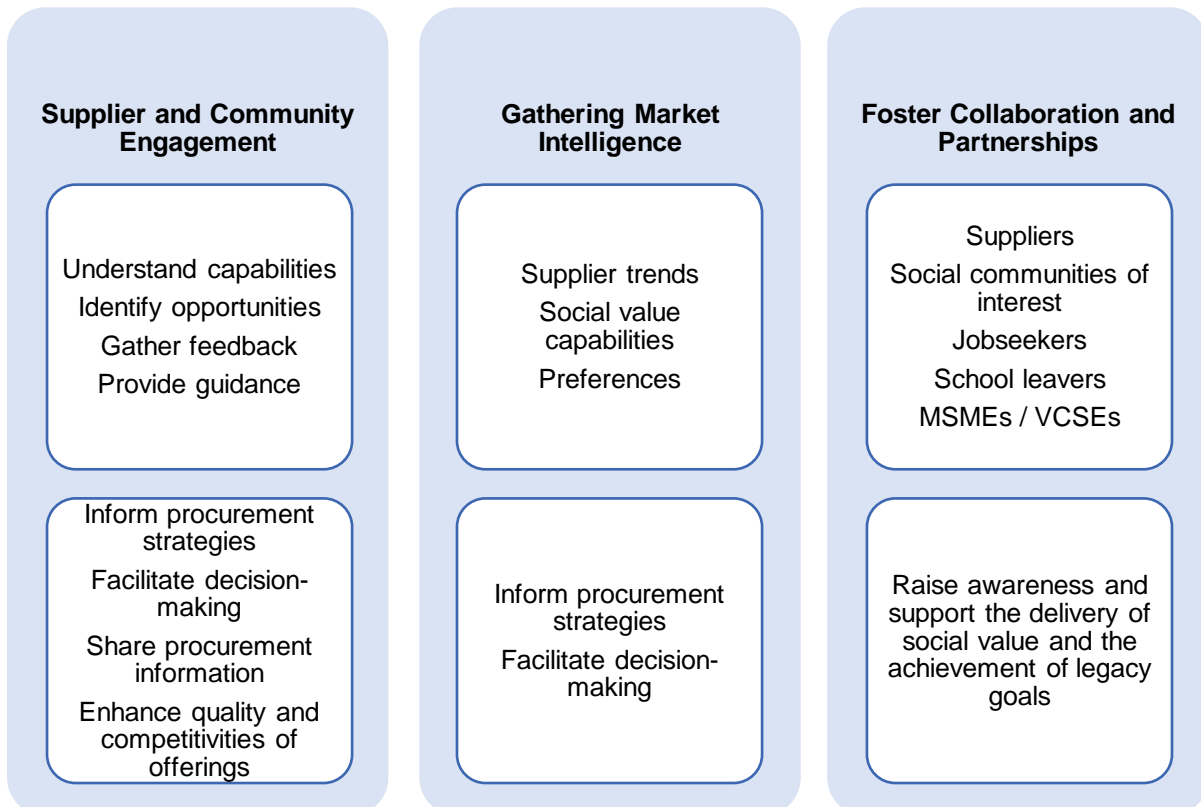
ProCure23 provides flexibility to tailor social value requirements in each further competition and the HTP will capitalise on this to ensure mechanisms are put in place to translate the delivery into meaningful impact for the local community.

The HTP will carry out supplier engagements, sharing a clear specification, social value objectives and legacy goals for this investment. This will ensure potential bidders have no doubt as to what the HTP hopes to achieve for the local population, embed social value at the heart of the competition, and promote meaningful and innovative input.

#### 4.1.1 Local Partnering and Stakeholder Engagement

Initial engagement activities with the PSCPs will be used to test the market capabilities, engage key local stakeholders, and promote social value objectives to be delivered. For example, holding “Meet the Buyer” events, which will include suppliers, existing HTP partners, local businesses and communities of interest, and potential jobseekers. The feedback from this market engagement will be used to produce technical specifications which align to the capabilities of suppliers and meet the identified needs of the local population, resulting in achievable social value contractual requirements which deliver real and long-term benefit.

Figure 4: Meet the Buyer Objectives





## 4.2 KPIs and performance obligations

### 4.2.1 KPIs or Core Reporting Metrics

These are the numeric outputs related to how the supplier will deliver the quantitative aspects of social value under the contract, encourage accountability, and help establish SMART targets (Specific, Measurable, Achievable, Relevant, Time-bound).

It is essential that the selected Award Criteria and Reporting Metrics used at tender stages, are clearly linked to the social value deliverables in the tenderer's proposal for the HTP contract.

### 4.2.2 Performance Obligations

These are not award criteria so cannot influence who is chosen as the successful bidder, however, provide flexibility to account for a broader number of deliverables.

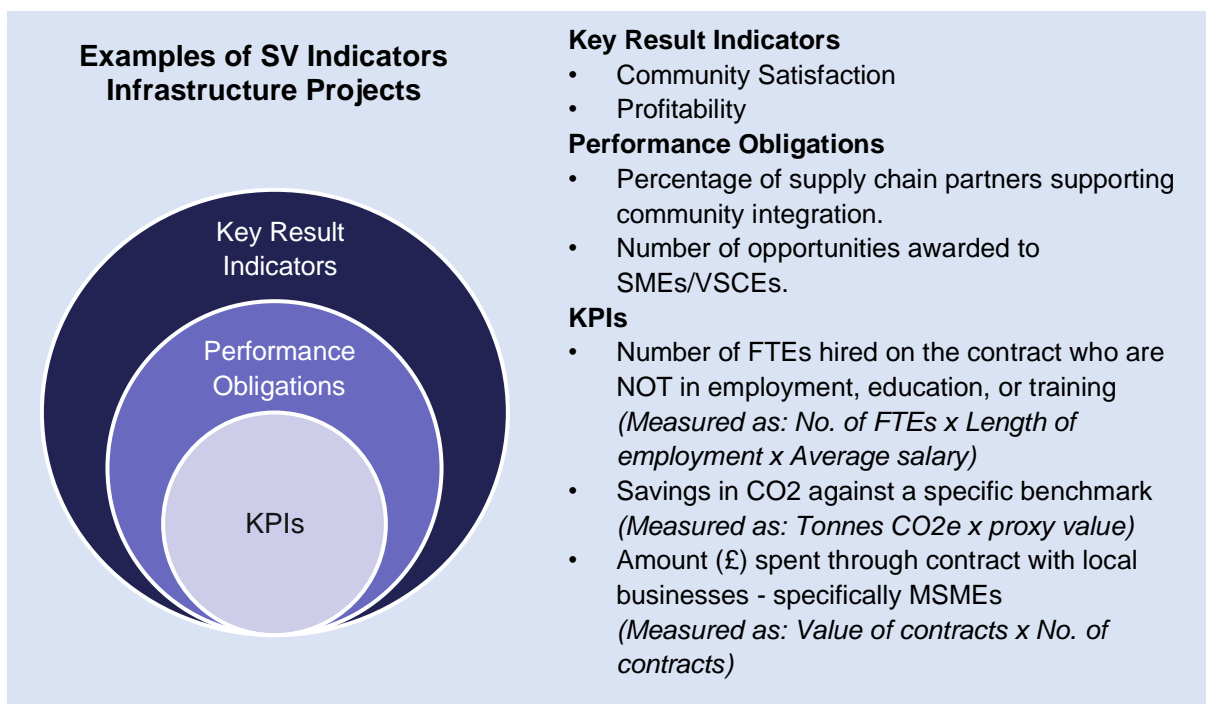
Bidders will be required to accept the contractual conditions to submit a valid bid and are required to implement the terms when performing the contract.

The selected social value KPIs and performance obligations comprise a combination of a deliverable and a numeric element, by which performance of that deliverable is to be measured.

Following market testing, supplier and local community engagement, and procurement considerations in alignment to the selected procurement route (P23), the HTP will finalise the selection of relevant core KPIs and performance obligations ensuring the incorporation of healthcare/NHS design and construction specific requirements, which will then be supplemented to the contract through additional social value clauses.

To achieve a profound and long-lasting impact, in addition to KPIs and performance obligations, the selected supplier will be required to adhere to the trust Code of Conduct expectations and update or create (should this not exist) their own Supplier Code of Conduct to ensure that the requirements are cascaded through the supply chain.

Figure 5: Examples of social value indicators





### 4.2.3 Approach to KPI Selection

While there are many social value KPIs applicable, relevant to the delivery of this contract and aligned to local priorities, it is not possible, or efficient, to track everything. Not all measures are important enough to track and too many measures create unnecessary work that ultimately won't be useful.

In selecting the appropriate KPIs, the HTP has taken a bottom-up approach. This approach required the definition of many metrics relevant to the selected themes and desired local outcomes, engaging relevant stakeholders and narrowing down the selection to a reduced number of potential social value evaluation criteria through an iterative process. The final selection will be tested with the market to ensure the final selection deliver the most value to the local population.

### 4.2.4 Social Value Proportionality Test

The following conditions must be tested against any potential KPIs.

*Are they relevant:* KPIs must be sufficiently related to the subject-matter of the contract e.g., what will be delivered? How?

*Are they proportionate:* KPIs are required to be framed specifically to meet the requirement. Weighting should also be proportionate to the importance of social value outcomes in relation to the procurement.

*Will they result in un-equal treatment:* Contracting authorities must not treat tenderers in similar situations differently and must not treat tenderers in different situations the same.

*Will they result in discrimination:* Contracting authorities must not discriminate against tenderers on grounds of nationality.

### 4.2.5 Procurement considerations for KPI selection

A clear link needs to be maintained between the development of procurement strategies and the crafting of the specification and award criteria.

Do not gold plate the social value benefits. It is important to balance the social value benefits with delivery of the core purpose of the contract.

The optimisation of value for money remains important, however procurement teams should take the view of what constitutes value for money that includes the improvement of social welfare or wellbeing

Consider their organisational capability and capacity, with regard to the procurement skills and resources required to drive these along with value for money as well as remediation/breach clauses likely to be required if these are not met.

#### **Outcome preselection for Market test**

In alignment to National Governmental Policy, existing local commitments, and priorities and the through the incorporation of engagement outcomes with key stakeholders to the HTP and the programme, a menu of 9 desired outcomes have been pre-selected.

- |   |   |
|---|---|
| 1. Amount (£) spent through contract with local businesses - specifically MSMEs (Covid) | 5. People currently not employed, in Education or Training                                  |
| 2. Amount (£) spent in local supply chain   | 6. Education/Training = No. of weeks of apprenticeships or T-level (completed or supported) |
| 3. Unemployed as result of Covid  | 7. Savings in CO2   |
| 4. Focus on 16-17 year olds   | 8. Vehicle Miles/Cycling Scheme   |
|   | 9. Recycled Material in Weight  |

These outcomes will be further narrowed down, to define the core social value objectives and focus through the delivery of the contract.

At tender stage, the suppliers will be required to provide specific activities, method statements and delivery plans to meet the HTP selected core social value delivery aspirations.

KPI's relevant to the outcome selection will be incorporated into the contract and represent the primary focus for social value delivery through procurement activities and interventions.

## 4.3 Contractual Clauses, Performance Indicators and Obligations

### 4.3.1 National Policy and International Standards

HTP will adopt the standard social value provisions from contract model NEC4 within the CCS, ProCure 23 Framework; ProCure23 (P23) is the fourth generation of NHS England's route to market for the provision of design and construction services to NHS capital projects.

NEC4 standard clauses will be supplemented with further additional clauses specific to the "healthcare/NHS design and construction requirements" and social value clauses referring to conditions of contract designed to achieve local social, environmental, economic, and cultural added value outcomes, through the delivery of the contract.

Amongst the various procurement benefits delivered through the selected route to market (P23), this framework provides alignment to governmental and NHS national policy, adopting the principles of the government's Construction Playbook, modern construction delivery and a focus on sustainability and social value. In addition, by following the [PPN06/20 guide](#) to using the Social Value Model, the HTP will ensure it meets the Social Value Act 2012, Equality Act 2010 and contribute to The United Nations Sustainable Development Goals.

### 4.3.2 Additional Social Value Contract Clauses

These clauses should be tested with the market for relevance, appetite and to assist in capturing social value through the delivery of the contract.

- The supplier shall report on how much they spend directly with local (geographical area to be agreed) SME or VCSE organisations in the delivery of the contract
- The Supplier shall comply with the responsibilities described within ISO 14001 Environmental Management System or equivalent
- The Supplier shall consider the relevance of sustainability at all stages of the lifecycle in the provision of Services, including the consideration of commercial needs, the minimisation of negative impacts, and the maximisation of positive impacts on society and the environment.
- The Supplier shall seek to mitigate sustainability impacts, such as the reduction of waste (paper and equipment).

- The Supplier shall work with the Customer to identify opportunities to introduce innovation, reduce cost and waste and ensure sustainable development is at the heart of their operation.
- The supplier shall develop and invest in skills development and apprenticeships to build a more skilled and productive workforce and reduce the risks of supply constraints and increased labour cost inflations.

#### 4.4 Demonstration of Social Value through CITTB Questions

Initial tenders will be evaluated according to specified quality and price criteria. The quality questionnaire will incorporate a minimum of 10% weight to the social value element to the HTP.

When developing the Client Invitation to Tender Brief (the 'CITTB') for the PSCP procurement process, the HTP will be using the P23 Call-Off Tool for setting the qualitative evaluation questions. There are 5 criteria within the standardised P23 criteria headings that will be included, one of which is social value & Net Zero Carbon. Questions will be based on the Social Value Model's Model Evaluation Questions and reflect local commitments and priorities as defined through the HTP Social Value Strategy.

The HTP will set a question for social value which, in alignment to the local requirements and Social Value Model guidance;

- Must meet the evaluation requirements, and appropriately reflect STW priorities and carries an equal weighting, so no subject is favoured more than another
- Has a suggested wordcount per question (500 to a maximum 1000 words)
- Includes no more than three tender questions within this criterion (one of which must be 'Fighting Climate Change')

Social value quality questions must be related to the subject matter of the contract, proportionate to the value of the contract, and their application should ensure compliance with the principles of equal treatment and non-discrimination.

Tenderer's responses will be evaluated against award criteria based on the Social Value Model's Model Award Criteria and Sub-Criteria in the same way as the evaluation of any other quality aspect in procurement.

Response guidance for tenderers will be clear on what the HTP is looking for in the response, assist the HTP in assessing the quality of the tender, provide a basis for fair and transparent scoring, and help shape the specification and development of KPIs.

### Example Quality Question for Social Value

Using a maximum of [insert number] characters describe the commitment your organisation will make to ensure that opportunities under the contract deliver the [insert policy outcome] and [insert award criteria]. Please consider the following items on your response:

1. Your “method statement” for the social value commitment that you intend to implement (or are currently operating)
2. A timed project plan and process, including how you will implement your commitment during the delivery of this contract
3. How you will influence staff, suppliers, customers, and communities through the delivery of the contract to support the Policy Outcome, e.g., engagement, co-design/creation, training and education, partnering/collaborating, volunteering.
4. Please explain how you will monitor and report on your activities

Response Guidance: Tenderers are advised that a page count limit of 1 page of A4/500-1,000 words apply to this question. If the page count exceeds this limit, only the 1 page of A4 will be evaluated. Responses must be written in English with text of font ‘Arial’ size ‘11’.

## 5. Working with the contractor

### 5.1 Approach to monitoring delivery through the contract

The implementation of social benefits can only be as successful as the monitoring mechanisms included in the final contract. Effective contract management is vital.

To ensure that social value objectives are delivered, it must be possible to measure and quantify the outcome they pursue. Reporting metrics for procurement driven activities and interventions will be based on the Social Value Model’s Reporting Metrics and will determine how the tenderer will establish and deliver the social value aspects of the contract.

Any award criteria and reporting metrics are for the social value deliverables of the contract and will not be based on the tenderer’s general corporate policies. At the award stage, the HTP will incorporate the social value deliverables in the winning PSCP’s proposal into the contract.

A Social Value Code of Conduct will be provided to the HTP, along with a method statement for use within the contract, as a requirement to the winning PSCP ensuring that the social value agreed principles and commitments are cascaded and embedded with the supply chain.

KPI data collection exercises will be agreed with the PSCP ensuring they are proportionate to the value of the contract, along with a review schedule and appropriate incentives and disincentives to encourage compliance.

Collecting, recording, and monitoring Social Value KPIs throughout the contract lifespan will allow the HTP and the PSCP to determine whether the contract is achieving its social value objectives.

#### 5.1.1 KPI reporting thresholds

We will develop and agree with the PSCP reporting thresholds for the most relevant social value KPI so that performance against it can be rated as one of the following:

- Good. The supplier is meeting or exceeding the SV KPI targets that are set out within the contract.
- Approaching Target. The supplier is close to meeting the SV KPI targets that are set out within the contract.

- Requires Improvement. The performance of the supplier is below that of the SV KPIs targets that are set out within the contract.
- Inadequate. The performance of the supplier is significantly below that of the SV KPIs targets that are set out within the contract.
- Recorded elsewhere. Data that is published by the department separately (a link should be provided).

### 5.1.2 KPI reporting intervals

Though the default is to report on social value KPIs on a 3-monthly basis, it may be more suitable if reporting is 6-monthly or annual.

For example, a KPI reflecting a commitment to recruit and train a defined number of full-time equivalent employees in a year may be more effectively assessed on an annual basis.

## 5.2 Approach to demonstrating delivery

Understanding the social value created through the contract delivery is dependent upon a robust approach to measurement. This can be used to forecast and measure impact and support the value for money aspect of the contract.

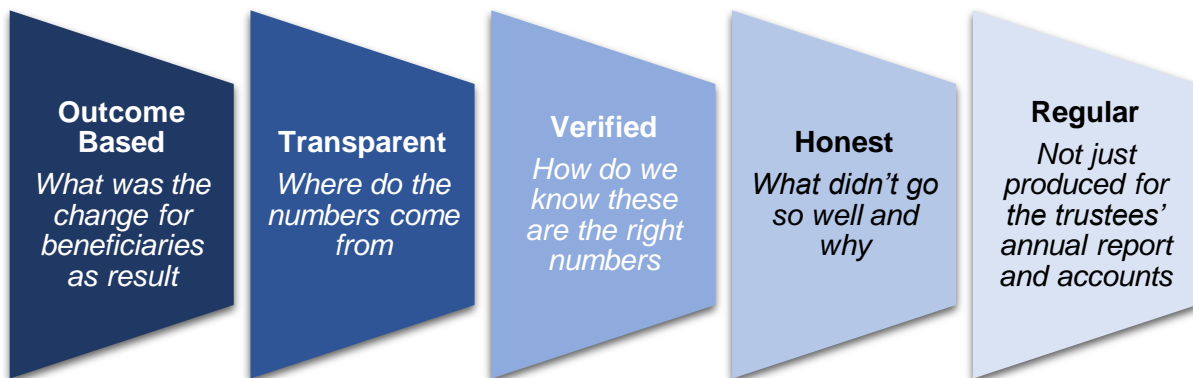
### 5.2.1 Social Value Impact Reporting

Impact reporting will be used to communicate the strategy used to convey the change created by the activity within the defined geography of activity and through the contract and how it was made. An impact report is not just a description of the stakeholder activities affecting the change but should also include an analysis of the difference it made.

- *Quantitative metrics* will be used to report tangible outcomes and impacts on HTPs primary social value focus such as the selected KPIs, e.g. the number of local jobs created, the amount of carbon emissions reduced, the number of people trained and educated, or the amount of spend through MSMEs and VCSEs in the region.
- *Qualitative analysis* will be used to share data such as stakeholder feedback and testimonials, to understand the subjective experiences and perceptions of the impact of social value initiatives.
- *Case studies and storytelling* will be used to showcase specific examples and case studies of social value initiatives and their impact, to illustrate the value and benefits in a compelling and accessible way. This method can be used to relate a particular topic to a targeted audience for example to a local stakeholder community group.
- *Stakeholder engagement and consultation* will be used to involve key stakeholders and partners in evaluating and reporting on the impact of social value initiatives, through surveys, focus groups, or other forms of engagement, for example MSMEs/VCSEs in the broad supply chain.
- *Impact Assessments* This method involves conducting detailed assessments of the impact of social value initiatives, using a range of methods and data sources, to understand the short and long-term outcomes and benefits.
- *Reporting Standards* This method involves using recognized reporting standards such as The National TOMs framework which is widely recognized as the best standard for measuring and reporting social and environmental value. TOMs utilises proxy values to estimate the impact of interventions and these values are then utilised to estimate the total social value delivered.



Figure 6: Principles of Impact Reporting



### 5.3 Working with the contract to maximise social value

In accordance with the Contract Management Principles set up by the government, the HTP will implement “In terms of contract management” activities, as described by the Trusts Contract Management policy, through the contract lifecycle.

The implementation of these principles will:

1. Ensure that the contracts are understood by all those who will be involved in their management.
2. Be clear about accountability, roles and responsibilities and encourage a mature commercial behaviour about what drives supplier performance and behaviour.
3. Set up and use strong governance arrangements to enable a differentiated approach based on risk and allow strategic oversight.
4. Establish a regular reporting cycle, that aligns with organizational or project timelines, and that is supported by relevant data and information systems, to ensure the accuracy and reliability of impact reporting.
5. Accept that change will happen and plan for it, creating flexible approaches to change joint working with the local community, local suppliers across the different categories of spend and in partnerships with MSMEs and VCSEs.
6. Work towards Continuous Improvement, value for money and enable the capturing of innovation through working as a fully integrated team.

Enable the linking with the organisation and/or government wide SRM programmes.



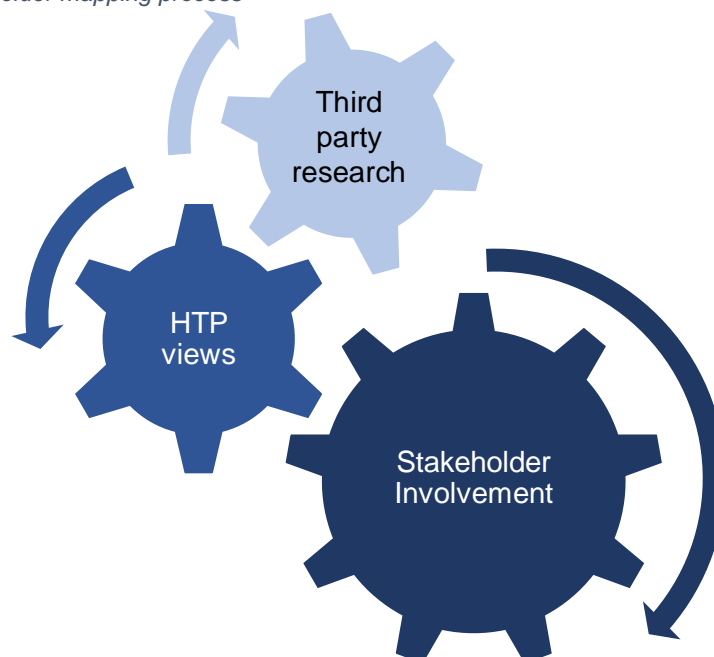
Figure 7: Core In-Contract Management Activities



### 5.3.1 Stakeholder Mapping

Stakeholders are those people or organisations that experience change as a result of your activity – and they are best placed to describe the change. This principle means that stakeholders need to be identified and then consulted throughout the analysis. This means that the value and the way that it is measured, is informed by those affected by, or who affect, the activity.

Figure 8: Stakeholder mapping process



*Local Communities of Interest*

Local Councils  
The public  
Carers  
Volunteers  
Environmental groups

*Partner Networks*

Charities and VCSEs  
NHS partners  
Schools & Colleges  
Job Centres  
Adult Learning Centres

*Stakeholders carrying out the activity*

PSCPs  
Local Supply Chain  
Local businesses

*Stakeholders affected by the activity*

Patients  
Residents' associations  
Hospital staff

The HTP will revise this list of stakeholders as we progress our analysis to ensure new stakeholder groups and subgroups (emerging due to differences in outcomes experienced) are accounted for.

Systems and processes for stakeholder involvement

It is best practice to have a systematic approach to stakeholder involvement and to set this out in a planning document or policy. Doing this encourages reflection and creates opportunities to modify or extend the way you are engaging with your stakeholders.

A Stakeholder involvement plan will cover the following:

- *Ethics policy:* setting out parameters for data collection and what is appropriate and in the best interests of the HTP and stakeholder groups.
- *Who is responsible for data collection:* Having a named individual responsible for involving stakeholders and for identifying and resolving any conflicts means that is more likely to get done
- *Which stakeholder groups will be involved and when:* stakeholder groups and the approach to selecting which people are representative of each group should be set out in the plan.
- *What methods will be used for data collection:* The chosen methods for data collection and justification for it should be included in the stakeholder involvement plan.
- *What resources are required?* The scope of the analysis will be one of the main drivers of the amount and type of stakeholder involvement and therefore the resources required.
- *Closing the feedback loop:* To establish trust, transparency, and accountability, it is critical that the results of the stakeholder involvement exercise are communicated back to participants.

## 6. Summary and Conclusion

The creation of two vibrant hospital sites in Shrewsbury and Telford through the investment of £312m in hospital facilities will not only resolve some of the long-standing challenges faced by the Trust, but also create significant positive impact on the wider determinants of health and the local economy. The wider determinants of health are thought to be the most significant contributors to overall health status, meaning embedding social value in the delivery of the scheme can compound the positive effects on the health of our population. Our ambitions for our local population, and for those who will be involved in the delivery of the scheme, have been described in this document.

We have an opportunity to deliver social value across the 5 themes of the Social Value Model and create impact where the people of Shrewsbury, Telford and Wrekin really need it. In partnership with our PSCP, we can influence recovery from the lasting effects of the COVID-19 pandemic and support the local economy by creating jobs and training prospects and supporting local businesses of all sizes. We can contribute to our collective goal to achieve net zero carbon while protecting and enhancing the natural environment. We will achieve all of this by recruiting and retaining the best people, with an inclusive and diverse workforce. This includes retaining and protecting our existing workforce from any potential disruption during the delivery of the scheme.

### 6.1.1 Embedding Priorities

Maximising the social value impact of the HTP requires social value to be embedded throughout the project life cycle, from design to operation and looking forward to the legacy of the HTP.

**Procurement:** While social value is unlikely to be realised during the procurement phase, sustainable procurement practices are essential enablers for the social value impact delivered by the scheme.

**Construction and Delivery:** PSCPs will be best placed to deliver social value if mechanisms are put in place by the HTP. This involves setting expectations and commitments from the pre-engagement phase through to award of the contract.

**Operation:** As the HTP moves into the operational phase, there is an opportunity to create the social value legacy of the scheme by handing over key relationships and embedding ongoing activity into operational plans and ensuring legacy components of the strategy are incorporated into a Trust or System Social Value Strategy. Where possible, measures should continue to be reported on. Outcomes can build on good practices developed during the design, procurement, and delivery of the HTP.

### 6.1.2 Enabling Change

Social value is about creating actions that make tangible change. To ensure this strategy continues to enable the maximum impact, it must remain a live document which is revisited and refreshed as required. Outcomes and measures must remain aligned to current objectives and specific needs of the local area.

### 6.1.3 Conclusion

In creating this social value strategy, we have assessed the additional economic, social, and environmental outcomes that will be most beneficial to residents of the local area. This strategy document will shape the final contract with the PSCP, and the activities undertaken throughout delivery of the contract. Delivering the outcomes identified in this document will be a shared endeavour between the HTP and the PSCP and will require the contributions of many individuals. The challenges we face are not necessarily unique, but we are in a unique position in the region to leverage our scale and partnerships to improve the lives of our patients, our staff, and the wider communities we serve. We have an opportunity to position ourselves as an exemplar organisation for delivering social value.

## Annexes

### Annex 1: Next Steps

Three categories of next steps resulting from the Social Value Strategy development

#### A. Strategic Next Steps

- Consider using TOMs (or other) SV measuring tool to capture and report SV further than the defined KPIs., PIs, etc
- Create a Social Value team – this could involve Volunteers, Charities, apprenticeships, work experience, etc and assign roles and responsibilities
- Engagement with local community/sectors directly via Council/Charities

#### B. Closing the implementation gap through the project lifecycle

- Produce a stakeholder map including current partners to the existing hospitals
- Implement a Stakeholder Management System – Annex on excel tab
- What can be done to ensure Park and Ride/Cycle arrangements become legacy for the area(s)
- Consider partnering with organisations that can help deliver social value in a creative way such as local community groups or organisations who specialise in the needs identified

#### C. Supply Chain

- Close collaboration through the project will help identify opportunities for further Social Value creation
- Embed social value into contract management to ensure social value commitments agreed at the procurement stage are actually delivered.
- Capture and report on the delivery of social value outcomes – both quantitative and qualitative (stories) and good and not so good in reflection.
- Share case studies and lessons learned, and seek continuous improvement, not only on creating social value but also on minimising adverse social impacts.

### Annex 2: Sources Reviewed

#### Documents reviewed

##### Local

- Draft ICS Strategy
- SaTH Trust Values
- STW ICS Values and Pledges
- JSNAs
- Local HWWB Strategies
- STW Annual Report and Accounts 2021-2022
- STW ICS Green Plan 2022-2025
- SaTH Green Plan Draft 2021-2026
- SaTH Trust Anchor Strategy 2022-2027
- SaTH and ICS Equality, Diversity & Inclusion Strategy

##### National

- Public Services (Social Value) Act 2012
- Social Value Model PPN 06 20
- Treasury Green Book
- NHS LTP
- NHS Social Value Guidance
- GCF Guide to using the Social Value Model
- A Green Future: Our 25 Year Plan to Improve the Environment
- Delivering a Net Zero NHS

## The Shrewsbury and Telford Hospitals NHS Trust Anchor Ambitions

As an Anchor organisation in Shropshire, Telford & Wrekin we will positively contribute to our local area:

- We will be an employer of choice providing access to a great place to work, providing fair pay and conditions and support the health and wellbeing of our staff
- We will support local supply chains and build organisational capacity for overall social value of our community
- We will maximise our resources and estate by using more creative use of building, spaces, and our workforce to support wider community
- We will collaborate with all our partners from across all sectors in the community to integrate our delivery of place-based care
- We will work together to reduce our environmental impact and footprint to influence sustainable practices in our local environment without exhausting natural resources or causing severe ecological damage

### Annex 3: KPI selection checks

The following considerations should be made when selecting KPIs for implementation.

1. The data collection exercises should not be unnecessarily onerous, and the associated costs should be proportionate to the value of the contract.
2. Consider if the project has the right resources, policies, and processes in place to manage the key stages of commercial delivery
3. Consider if the project has the necessary capability and capacity, regarding the procurement skills and resources required to deliver value for money (including benchmarking their own performance)
4. KPIs suitability and relevance should be reviewed frequently and updated, if necessary, to ensure they remain relevant to the contract
5. Every KPI should be assigned to somebody, a person, or a team
6. Consider what will happen if KPIs are not met

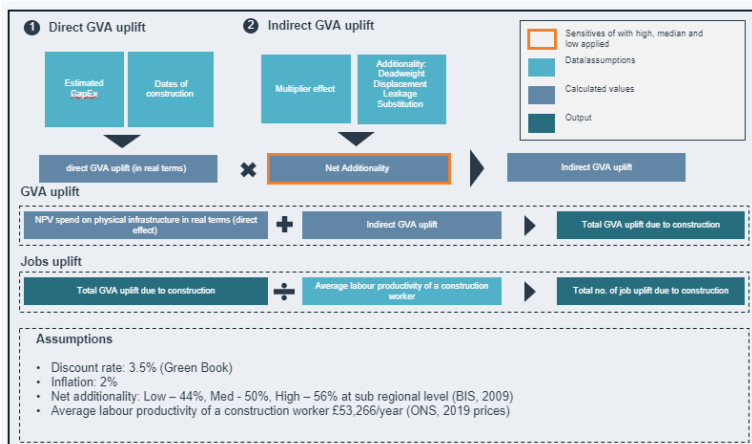
### Annex 4: GVA Calculation

Typical scale of GVA benefit in other schemes is around 50% of the scheme value.

Direct impact is the increased income from the contracts/temporary construction jobs.

Indirect impact is the potential wider economic benefit generated.

Methodology:



## Assumptions

CapEx: £312,000,000

Spend Start Date: 2023

Spend profile: 20% annually over 5 years

Additionality:

	Upside	Core	Downside	Source
Leakage	0%	17%	39%	<a href="https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/191512/Research_to_improve_the_assessment_of_additionality.pdf">https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/191512/Research_to_improve_the_assessment_of_additionality.pdf</a>
Deadweight	1%	6%	11%	<a href="https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/191512/Research_to_improve_the_assessment_of_additionality.pdf">https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/191512/Research_to_improve_the_assessment_of_additionality.pdf</a>
Displacement	28%	39%	50%	<a href="https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/191512/Research_to_improve_the_assessment_of_additionality.pdf">https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/191512/Research_to_improve_the_assessment_of_additionality.pdf</a>
Net additionality scaling	71%	47%	27%	

Type 1 Multipliers

GVA multiplier	2.19	<a href="https://www.ons.gov.uk/economy/nationalaccounts/supplementaryandusatables/datasets/ukinputoutputanalyticaltablesdetailed">https://www.ons.gov.uk/economy/nationalaccounts/supplementaryandusatables/datasets/ukinputoutputanalyticaltablesdetailed</a>
Job multiplier	2.48	<a href="https://www.ons.gov.uk/economy/nationalaccounts/supplementaryandusatables/datasets/ukinputoutputanalyticaltablesdetailed">https://www.ons.gov.uk/economy/nationalaccounts/supplementaryandusatables/datasets/ukinputoutputanalyticaltablesdetailed</a>
Multiplier chosen	2.19	

Productivity assumption

Output per job in construction	£57,526.00	<a href="https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/datasets/labourproductivitytables110andr1">https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/datasets/labourproductivitytables110andr1</a>
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Discounting

Discount rate (non QALY)	3.5%	Green Book
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# ST&W STP Estates Strategy (Draft)

**16 JULY 2018**

Sustainability



Emergency Centre



EC

Local Planned  
Care Services



LPC

Home is normal



Community Units



CU

Diagnostic and  
Treatment Centre



DTC

Health Hubs



HH

Empowerment  
for patients and  
clinicians



New ways of  
working





## Disclaimer:

The options set out in this document are for discussion purposes. The involved NHS bodies understand and will comply with their statutory obligations when seeking to make decisions over estate strategies which impact on the provision of care to patients and the public. The options set out do not represent a commitment to any particular course of action on the part of the organisations' involved.

In respect of any request for disclosure under the FoIA: This is a confidential document for discussion purposes and any application for disclosure under the Freedom of Information Act 2000 should be considered against the potential exemptions contained in s.22 (Information intended for future publication), s.36 (Prejudice to effective conduct of public affairs) and s.43 (Commercial Interests). Prior to any disclosure under the FoIA the parties should discuss the potential impact of releasing such information as is requested.

Issue Ref.	Version Date	Status / Summary of changes	Owner / Author
Version 1	27/03/2018	Version 1.12 of 'Estates Workbook' used as the initial template for converting to STP Estate Strategy template. This provides additional slides, added for capturing enhanced detail	Becky Jones, Maggie Durrant
Version 2	16/07/2018	Formatting, financial and wording adjustments following input from partner organisations & communication/engagement STP lead	Maggie Durrant/ Paul Gilmore



# ST&W STP Estates Strategy - Contents

## - Foreword

By Clive Wright, Executive Lead for STP Estates Strategy Group

## - Setting the Scene

Our Vision, Priorities & Ambition

## - Executive Summary

### Section A – Estate Strategy

- Future Fit Programme – Overview in 3 slides
- STP Transformation and Vision
- Timeline of key STP activities Jan-Sept 2018
- ST&W STP Governance
- ST&W STP Example of interlinked enabling work streams
- A1 ST&W STP Estate Planning Governance
- A2 ST&W STP Service Strategy and Estates Implications
- A3 Estates progress against key service strategy & programmes
- A4 Performance Indicators
  - SaTH Success metrics to 2022/23
  - SCHT Success metrics to 2022/23
  - RJAH Success metrics to 2022/23
  - MPFT (formerly SSSFT) Success metrics to 2022/23
- A5 Sustainability & Transformation Initiatives
- A6 Progress of Approved Estate Projects
- A7 Prioritised Estate Projects Submissions for Wave 4
- A7 Prioritised Estate Projects Pipeline for Wave 5
- A8 Headline Financial Impacts – Investment and Disposal
- A9 Road Map: Critical Decisions & Activities

### Section B – STP Capital Prioritisation

- B1 Introduction
- B2 STP capital schemes below £100m
- B3 STP capital schemes above £100m
- B4 Prioritisation Supporting Narrative  
Key Next Steps & Summary
- B5 STP leadership sign-off

### Annex 1: - ST&W STP Estates Data Summary and Sources

- Data Summary and Sources
- Estates Composition

### Annex 2: - ST&W STP – Appendix to Section B. Internal Organisation Responsible for Funding

### Annex 3: - Supplementary Information about our STP

### Annex 4: - STP Estates Directory

- Joint STP Local Estates Forum & One Public Estate Delivery Group Membership



## Foreword



by Clive Wright, Chief Executive Shropshire Council  
*Executive Lead for the ST&W STP Estates Strategy Group*

“As the Senior Responsible Officer for the Shropshire, Telford & Wrekin STP Estates Work stream and Lead Officer for Shropshire’s One Public Estate Programme, I fully support the collaborative and innovative approach we are taking to deliver the services needed by our communities.

Our projects demonstrate that we are learning from the best, whilst also being pioneering and understanding the unique context of our county in which ‘one size does not fit all’. We are bringing the Local Authorities Place Shaping role into the partnership domain.

There is real opportunity to support transformation within the health and social care system and more widely across the whole of public, community and voluntary services to deliver massive improvement as well as savings.

By listening to our communities and the rationalisation of our buildings based on community need, rather than the short-term location of services, we are enabling further self-sufficiency, confidence and resilience to grow. By investing in people, including our front line staff, and providing them with modern work places and the tools they need to do the job, not just now but into the future, we are driving many service improvements as well as the efficiencies necessary to manage within available resources.

It is fantastic to see all organisations working together towards a common goal of having the healthiest population in the UK and I want to thank everyone involved for their enthusiasm, hard work and the trust they have put into our ambitious but deliverable programme.

This Estates Workbook, together with the One Public Estate Asset Mapping work, provides the baseline data upon which the transformational work can be built. The transformation we envisage is about creating truly fantastic, high quality places for people.

**We put people first, we are ‘people’ and not ‘building’ focused.**

It is a great pleasure to be working with colleagues from other organisations and our communities to make sure we get the next steps right in developing our places, including key market towns, hamlets and villages. What we do next will be critical to how we are able to sustain good health, high quality of life and properly support people into the future, bringing the best of modern life together with protecting our rich heritage.”



## Setting The Scene: Our Vision for Health and Care services in Shropshire, Telford & Wrekin

Our ST&W STP Estate Strategy is an 'Enabler' to our STPs Priorities in brief these are:-

- **Focusing on neighbourhoods** to prevent ill health and promoting the support that local communities offer to help people lead healthier lives and encourage them to care for themselves where appropriate.
- **Multi-disciplinary neighbourhood care teams** working closer together supporting local people with long-term health conditions, and those who have had a hospital stay and return home needing further care.
- **Community services** that are safe, accessible and provide the most appropriate care.
- **Redesigning urgent and emergency care**, creating two vibrant 'centres of excellence' to meet the needs of local people, including integrated working and primary care models.
- **Technology will be exploited** to avoid people having to travel large distances where possible – especially important to people living in the most rural communities in Shropshire and Powys.
- **Involving local people** in shaping their health and care services for the future.

**Workforce Development** Supporting those who deliver health and social care in Shropshire, Telford and Wrekin, developing the right workforce, in the right place with the right skills and providing them with local opportunities for the future.

*Full Details are at the link below:*

<https://www.england.nhs.uk/systemchange/view-stps/shropshire-and-telford-and-wrekin/>





We have an inclusive approach, these organisations are contributing to the delivery of Shropshire, Telford & Wrekin STP priorities.



Shropshire  
Clinical  
Commissioning  
Group



Shropshire Community Health NHS Trust



GP out of hours service



Midlands Partnership  
NHS Foundation Trust  
A Keele University Teaching Trust

Robert Jones and Agnes Hunt  
Orthopaedic Hospital NHS Foundation  
Trust



NHS  
Telford and Wrekin  
Clinical Commissioning Group



NHS  
The Shrewsbury and  
Telford Hospital  
NHS Trust







## ST&W STP ambition is simple:

**Prevention will be at the heart of everything we do:** – ‘in the home to hospital care’

In line with the GP Five Year Forward View priorities, we plan to invest in, reshape and strengthen primary and community services so that we can provide the support people in our communities need to be as mentally and physically well as possible.

We want everyone in Shropshire, Telford & Wrekin to have a great start in life, supporting them to stay healthy and live longer with a better quality of life.

Our STP is the culmination of a wide range of local organisations, patient representatives and care professionals coming together to look at how we collectively shape our future care and services. This strong community of stakeholders is passionate, committed and realistic about the aspirations set out in this document.

Our thinking starts with where people live, in their neighbourhoods, focusing on people staying well. We want to introduce new services, improve co-ordination between those that exist, support people who are most at risk and adapt our workforce so that we improve access when its needed.

We want care to flow seamlessly from one service to the next so that people don't have to tell their story twice to the different people caring for them, with everyone working on a shared plan for individual care.

**The aim of our ST&W STP Estates Strategy is to embed this ambition into our investment programmes.**

**This strategy document is our *current* position statement.**

**It identifies our direction of travel.**

**It will be refined as our journey progresses.**



## Executive Summary (1 of 5)

### Context

This Estates Strategy and consequent estates implications are contextualised within the backdrop of our whole system with the following currently key impactors:

- **FUTURE FIT** is a commissioner led programme which aligns with the Acute Hospitals Reconfiguration proposal; (co-ordinated in SaTH by the Sustainable Services Group (SSG)). The outcome of public consultation, which commenced 30 May18 and will last for 14 weeks, will determine details of capital spend, including the £312m approved in Wave 3
- **Financial Deficit:** The STP control total for 18/19 is a deficit of £5.5m; through transformational programs and committed progress towards an effective ICP, the STP is focused on delivering continued financial efficiencies throughout the region in future years.
- **Local pressures:** An area that is hugely diverse, many people live in relatively deprived urban communities; a geographical area with people living in remote rural areas where journey times are long and public transport poor, with a higher than national average ageing population, insufficient 'attract' to recruit and retain young people, coupled with the need for more affordable and step-up/step-down housing plus economic and political pressures to achieve value for money.

### Key Policy Work-streams and Programmes

- Acute and Specialist Services
  - Emergency & Urgent Care, Planned Care
  - Community Services, Early diagnosis, Primary Care
  - Children & Youth Services, Mental Health, Social Services
  - Health and Wellbeing, Prevention, Independence, Self-Care
- Future Fit** (inc SSG)  
**Out of Hospital Offer**  
**Home is normal**



Population in footprint is approx. 470,000 people, plus outlying populations, notably Powys accessing services within Shropshire.

### Principles

#### Overview of emerging STP healthcare models

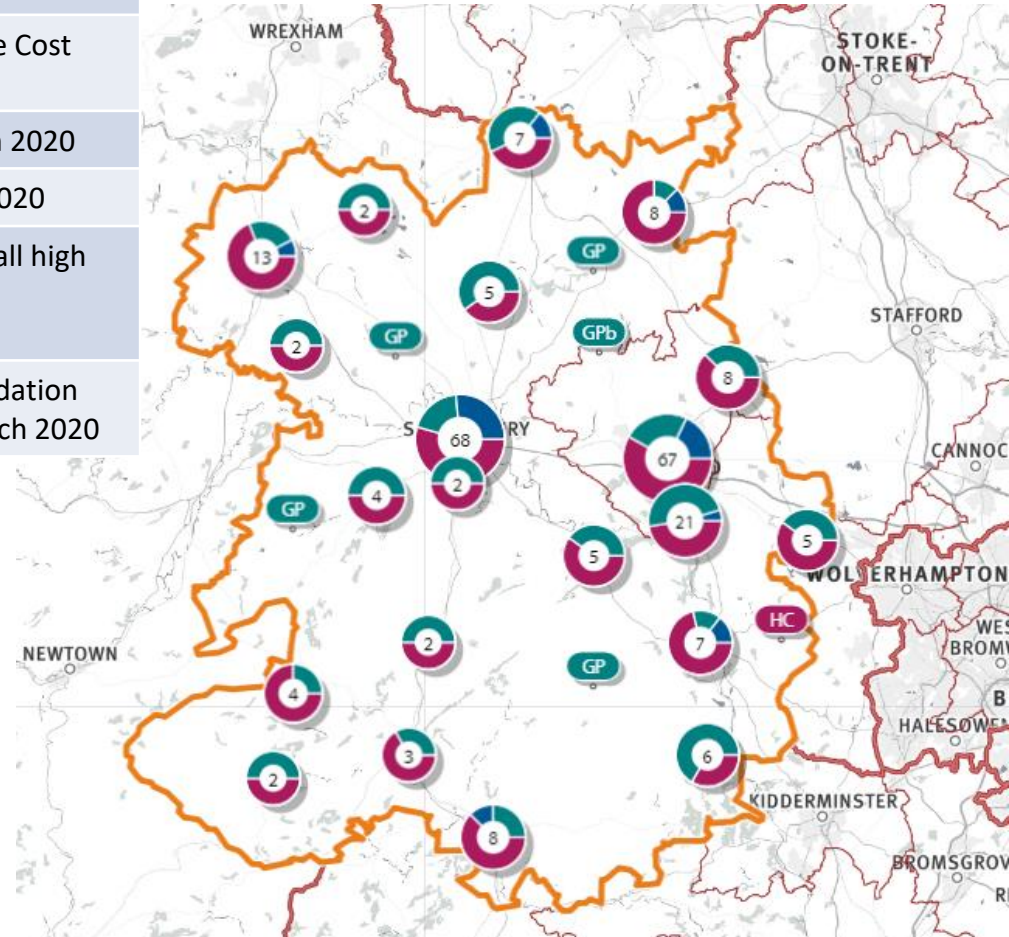
- Improving relationships & commitment at all levels
- Increasing transparency, progressing Integrated System Working
- Capital Plans & Asset Management aligning with clinical strategies



## Executive Summary (2 of 5)

Current Estate (exc. MPFT and WMAS)	Planned Estate (exc. MPFT and WMAS)
219,000 m2	<212,000m2 (subject to FF)
£30.3m FM Cost + £6.4m Premises Pay	<£182 sq/m total FM Estate Cost
30% non-clinical	<30% non-clinical by March 2020
4% unoccupied	2% unoccupied by March 2020
£65.1m (net) backlog maintenance £ 4.9m (net) high-risk backlog maintenance	Plans in place to eradicate all high risk back-log maintenance
87% Community accommodation utilisation	95% Community accommodation utilisation achieved by March 2020

This map is taken from the SHAPE Database, and indicates Estates, Primary and Secondary care coverage for **Shropshire, Telford & Wrekin STP**



### Map Legend

- NHS Property Services Locations
- NHS Provider Trust Locations
- NHS Shropshire, Telford & Wrekin CCG locations

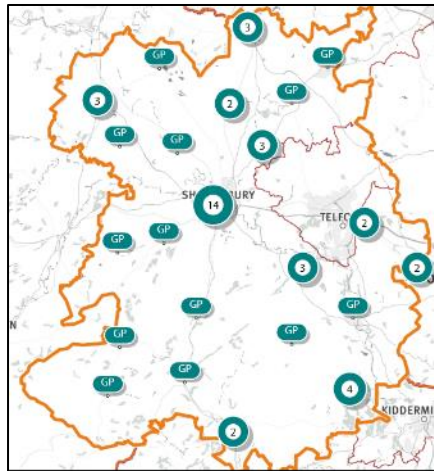
Location maps  
'by Organisation'  
are on the  
following slide





## Executive Summary (3 of 5)

### ST&W STP Location maps 'by Organisation'



Shropshire CCG (SCCG)



Telford & Wrekin CCG (TWCCG)



Shrewsbury & Telford Hospitals NHS Trust  
(SaTH)



NHS Property Services



Shropshire Community Health Trust (SCHT)



Robert Jones & Agnes Hunt Orthopaedic  
Hospital NHS Foundation Trust (RJAH)



Midlands Partnership Foundation Trust (MPFT) –  
formerly South Staffordshire & Shropshire  
Foundation Trust (SSSFT)



## Executive Summary (4 of 5)

### Capital Investment Summary:

#### Estate prioritisation

- £312m associated with acute hospital reconfiguration, details dependent on consultation
- Projects improving patient experience, value for money and facilities fit to deliver care in the 21<sup>st</sup> century

#### Capital investment requirements

£475.3m over the next 5 years, comprising (inc. SSSFT @100%):

- £387.7m – New Land and Buildings
- £35.5m – Routine Building & Maintenance
- £18.7m – Backlog Building & Maintenance
- £18.0m – Plant, Machines & Equipment
- £15.4m - IT

#### Identified funding comprising

- £1.5m – Identified Disposals (with est valuation STC)
  - £2.4m – ETTF
  - £5.1m – Grants & Donations
  - £27.0m – Loans (SSSFT @100%)
  - £127.3m – Internal Funding
  - £312.0m – PDC (to be further defined)
- £475.3m Total Capital Funding (over 5 years)

Unfunded priority projects in the next two to three years will be considered suitable for funding from STP wide surplus land disposals, subject to timing and governance. PPP options are being explored regarding funding potential.

### Summary of Surplus Land & Housing Opportunities

As part of the development of this revised STP estate strategy, there has been careful consideration of land likely to become surplus to requirements that can potentially be taken forward for planning and disposal in the next five year period:

The review has identified 8 sites that have the potential to release surplus land that would allow upward of 90 housing units. Site valuations and housing opportunity estimates are still pending and are subject to change and successful planning consents.

#### The opportunities have been RAG rated for delivery as follows:

- Green (already vacated) – 2 sites
- Amber (occupied sites but well advanced) 0 sites
- Red (complex sites) – 6 sites

The red sites will require a currently undetermined capital investment and is partly enabled by the concepts of primary/community hub programmes.

The key sites to take forward are:

- Site A - Land & demountable building forming ex Malling Health Centre, Telford Hospital (TWCCG)
- Site B - Land between Malling Health Centre site and Severn Hospice, Telford Hospital (TWCCG)
- Site C - Old Accommodation Blocks and associated land / parking, Shrewsbury Hospital (SaTH)



## Executive Summary (5 of 5)

### Summary Conclusions:

**Property can play an important role in making our STP more cost efficient and enable service improvements**

- *Estate developed to be more fit for purpose, flexible and cost-effective; with future estate plans service and not building led.*
- *Best use of assets, collaboration and integration to be embedded with decisions based on a wider system view, person and service focused, rather than on organisational self-interest*

### Case for change

- Our STP vision sets out ambitious plans for transformed neighbourhood services; safe and effective hospital care; ways in which new technology can be harnessed; and how gaps in the workforce can be filled and financial resources better spent.
- This will have an impact on the **efficiency, size and utilisation of current and future estate utilisation, investments, and disposals**.

### Delivering primary, community and social care

- Listen to, involve and work with our system communities in **the shaping of our buildings** and **with supported technology for service provision**. **Addressing and reducing Back-log maintenance**
- Reduction of Backlog maintenance for SaTH is dependant on the final outcome of the acute hospital reconfiguration option consultation
- Carrying out an asset mapping process so we can match the current assets, against the future service need and identify what we will still need and what can become an opportunity for disposal to recycle into developing the future estate. **Well connected services & communities**.

### Right services – right places

- This process starts with **mapping the need** to identify the demography of the area; establish what the population and associated service needs are and then identifying current services and where they are provided from. This is then layered up with understanding where future housing developments and additional infrastructure will be built, and any potential available areas of land.

### Delivering a fit for purpose estate

- **Better use of void/shared/bookable space**. Facilitating system change through encouraging work to be done once by involving all partners in initial discussions, thus looking at the bigger picture and understanding the wider implications of organisational decisions.
- **Finance strategy and capital priorities**
- **Rationalisation** in non NHS/public owned estate. Reducing the financial deficit, voids, improving efficiencies

## **Summary of Key Next Steps and Critical Decisions**

Develop into a detailed, robust, whole STP Strategy, based on community need, with each constituent organisation delivering its key aspect of the overarching strategy.

**When all the Future Fit evidence has been considered, and a final decision from the two CCGs announced, we will have greater understanding of service delivery requirements, and the very considerable estate changes required to meet these needs**





# Section A – ST&W STP Estate Strategy

## Transformation of Health and Social Care

... what does this mean for our estate?



The slides in Section A provide an overview of our STP vision and priorities, our Governance structure, and current key work-streams areas. The likely impacts for Estates, as an enabling component, is a ‘golden thread’ which is present for all, but at variable stages of detail, *at this point in time*.

Local Government Association Cabinet Office

### 2. Context in Government: Reform

Government Hubs	MoD Footprint Strategy: Early disposals	Network Rail creating company to deliver receipts & housing	DfE – 500 new Free Schools by 2020
NHS Strategic Estates Plans & Sustainability and Transformation Plans	Courts & prisons Reform: courts sales; 9 new prisons	DWP PFI contract ends 2018	DVSA soon to announce surplus depots

<http://www.local.gov.uk/onepublicstate>

We have a long-term vision that will deliver **community hubs**, **disposal opportunities** and a **reduction in estate costs** across the footprint, through more **effective utilisation**, a reduction in the estate and **better quality** buildings; achieved by a **whole system strategic approach**, enabling transformation of services through a clear focus on **community, innovation and delivery**.



**Working Better Together**

A fully detailed ST&W STP Estates Strategy cannot be comprehensively specified until **the outcome and final decisions relating to The Future Fit programme are agreed and ratified. This process can't begin until the consultation on options is completed, analysed and decision approved.**



## ‘Final decisions relating to The Future Fit programme must be agreed and ratified.’

The NHS Future Fit programme was the name given to the project to review the future of health services in the County and the hospital services provided at the Royal Shrewsbury Hospital, Shrewsbury and the Princess Royal Hospital, Telford. This four year programme entered its **14 week public consultation process on 30 May18**. All feedback will be collated and analysed by an independent company, with a report produced for consideration by Shropshire and Telford & Wrekin CCGs as part of their decision-making process. It will be considered alongside other pieces of work that are underway, which include travel and transport considerations including ambulance travel times.

The Future Fit Programme is made of three elements – the acute reconfiguration aspect, co-ordinated by Sustainable Services Group and the community/primary care elements – Care Closer to Home (Shropshire) and Neighbourhood Working (Telford & Wrekin)

**In addition**, other pieces of work requested by the West Midlands Clinical Senate, NHSE and members of the CCG Governing Bodies, must also be completed and considered. These include:-

- Work to model the care we will need to deliver in the community
- What might need to be done to lessen the impact for women & children and older people, their families & carers particularly around travel.
- Understand how the Urgent Care Centre at the Planned Care site will be staffed, by skilled professionals to deliver high level of care for children
- Understand the effect of proposed changes on demand for both emergency & non-emergency ambulance and patient transport services
- Ensure we are considering new ways of working in the future including new staff roles

[www.nhsfuturefit.org](http://www.nhsfuturefit.org)

The options being consulted on are specified on the next slide.

**Option 1 is the preferred option for both CCGs.** This would result in the Emergency Care site at the Royal Shrewsbury Hospital (RSH) and the Planned Care Site at the Princess Royal Hospital (PRH), with Urgent Care Centres at both sites. The main reasons for this are:

- RSH can continue to be a Trauma Unit
- Fewer people would have to travel further for emergency care
- It better meets the future needs of our population, especially in Shropshire and mid-Wales
- It offers the best value for money over the long term.

**The outcome of the Future Fit programme consultation is a critical milestone for our STP Estates Strategy. Until a final decision is ratified, uncertainty associated with capital spend will remain, including the £312m approved in Wave 3**



**The Future Fit programme consultation.**

**Option 1:**

**Emergency Care site is**  
Royal Shrewsbury Hospital, Shrewsbury

**Planned Care site is**  
Princess Royal Hospital, Telford

**This is our preferred option.**  
Having the Emergency Care site at the Royal Shrewsbury Hospital would mean:

- it can continue to be a Trauma Unit
- fewer people would have to travel further for emergency care
- it would better meet the future needs of our older population, especially in Shropshire and mid Wales
- it offers the best value for money over the long term

You can read more about this on page 24.



- |  |  |
|--|--|
| <b>At the Royal Shrewsbury Hospital:</b><br>24-hour Emergency Department (ED)<br>Critical Care Unit<br>Ambulatory Emergency Care Unit (AEC)<br>Emergency surgery and medicine<br>Complex planned surgery<br>Women and children's consultant-led inpatient services | <b>At the Princess Royal Hospital:</b><br>Planned inpatient surgery<br>Day case surgery<br>Endoscopy<br>Breast inpatient services<br>Medical wards |
|--|--|

- |   |  |
|---|--|
| <b>At both sites:</b><br>24-hour Urgent Care Centre<br>Adult and children's outpatient services<br>Day Case Renal Unit<br>Tests (diagnostics) | Midwife-led unit<br>Antenatal Day Assessment Unit<br>Early Pregnancy Assessment Service (EPAS)<br>Maternity outpatients and scanning |
|---|--|

**Option 2:**

**Emergency Care site is**  
Princess Royal Hospital, Telford

**Planned Care site is**  
Royal Shrewsbury Hospital, Shrewsbury



- |  |  |
|--|--|
| <b>At the Princess Royal Hospital:</b><br>24-hour Emergency Department (ED)<br>Critical Care Unit<br>Ambulatory Emergency Care Unit (AEC)<br>Emergency surgery and medicine<br>Complex planned surgery<br>Women and children's consultant-led inpatient services | <b>At the Royal Shrewsbury Hospital:</b><br>Planned inpatient surgery<br>Day case surgery<br>Endoscopy<br>Breast inpatient services<br>Medical wards |
|--|--|

- |   |  |
|---|--|
| <b>At both sites:</b><br>24-hour Urgent Care Centre<br>Adult and children's outpatient services<br>Day Case Renal Unit<br>Tests (diagnostics) | Midwife-led unit<br>Antenatal Day Assessment Unit<br>Early Pregnancy Assessment Service (EPAS)<br>Maternity outpatients and scanning |
|---|--|





- Work Relating to Model(s) of care we are developing to deliver in the community
- Ensuring we are considering new ways of working

Interdependent & Critical to the success of the Future Fit Programme (Acute Hospitals Reconfiguration, SSG) are our parallel transformational change developments in:

- Neighbourhood Care Services,
  - Aligning Workforce,
  - Promoting Health, Well-being & Prevention
  - Enhanced use of technology,
  - Embracing new ways of working,
  - Achieving Value for Money
- Integral to Future Fit are:
- Non-elective hospital admission reductions
  - Reduction of non-elective admissions from care homes
  - Reduced length of stay for intermediate care beds
  - Reduced spend on care home placements

Our approach to specific Community needs, recognises the Locality and Geographical variations in our footprint; urban v rural, their specific histories, experiences, change readiness states and associated complexities, with the resultant emergence of two approaches

**Out of Hospital Programme**  
**Telford & Wrekin**

- Services & Activities will be closer to home
- Community hubs / joint use of space / fit for purpose
- Well connected services & communities
- Supported with technology (local digital roadmap)
- Better use of void / shared / bookable space
- Rationalisation in non NHS/public owned estate

“So what for estates?”

- ❖ Suitable estates to enable service delivery
- ❖ Maximising use of current resources
- ❖ Better partnering to reduce vacant & void space
- ❖ Increase suitable sharing opportunities
- ❖ Identify refurbishment, redevelopment & disposal opportunities in addition to the development of new facilities

**Care Closer To Home Programme**  
**Shropshire**

**Estates Impact & Enabler:**

**Hubs** – designed to house Extended Primary Care, Community Services, Social Care, SCCH Workforce

**Spokes** – Core GP and Practice Nurse services.

**Utilising existing estate** but with a requirement for some **review and modernisation**



*By working together as an integrated system, we plan to ensure people get the best treatment - whenever and wherever they need it - and to share patient information more effectively to avoid duplication and wasted effort. Our plan identifies where £74 million might be used differently and more effectively to provide more care, closer to home for the same money.*



### Our Programmes and Priorities

- \*Acute services reconfiguration, reduced levels of surgical intervention  
Redesign urgent and emergency care, creating two vibrant 'centres of excellence' to meet the needs of local people, including integrated working and primary care models
- \*Focus on neighbourhoods to prevent ill health and promote the support that local communities offer to help people lead healthier lives and encourage them to care for themselves where appropriate
- \*Multi disciplinary Neighbourhood Care Teams to work closer together supporting local people with long term health conditions and those who have had a hospital stay and returned home needing further care
- \*Ensure all community services are safe, accessible and provide the most appropriate care
- \*Make the best use of technology to avoid people having to travel large distances where possible



### Built on our enabling programmes

**Leading and Working Differently – focuses on giving the health and care workforce the skills and expertise needed to deliver new models of care.**  
**Programmes include:**

- Working differently
- New ways of delivery
- Single Leadership voice
- Shared care record
- Intelligent working
- Self care
- Independent living
- Digitally enabled services
- Continuing digital operations
- Enabling health technologies



### Overseen by all Partners

**System Leadership Team – Comprises of Chief Executives, Chairs and key stakeholders from across the Shropshire Telford & Wrekin system, as follows:**

- Shropshire Clinical Commissioning Group
- Telford & Wrekin Clinical Commissioning Group
- Shropshire Community Health NHS Trust
- The Shrewsbury and Telford Hospital NHS Trust
- Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Midlands Partnership Foundation Trust (MPFT) – formerly known as South Staffordshire & Shropshire Healthcare NHS Foundation Trust
- ShropDoc (GP out of hours service)
- Shropshire Council
- Telford & Wrekin Council
- Powys Teaching Health Board
- Healthwatch Shropshire
- Healthwatch Telford & Wrekin



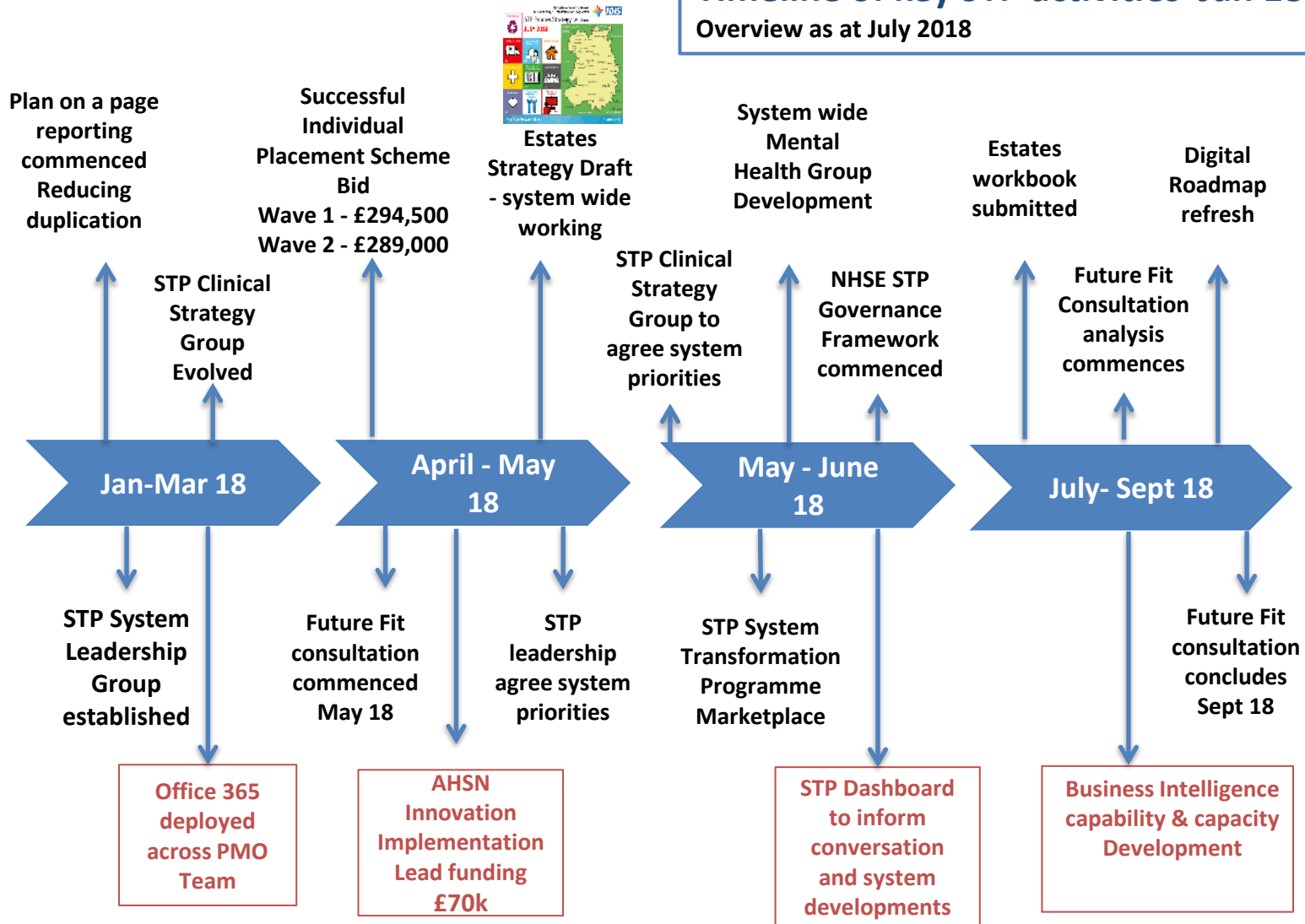
### Outcomes

#### Health and Wellbeing

- Helping more children and young people grow, develop and achieve
- Stay healthier for longer, leading to fewer people classified as overweight or obese, smoking, and drinking alcohol
- Taking control over own care
- Equal standard of care
- Improved health outcomes
- Improved access to services 7 days a week
- More joined up care
- More opportunities to be cared for closer to home
- Improve patient experience



**Timeline of key STP activities Jan 18 - Sept 18**  
Overview as at July 2018







# ST&W STP Governance



Strategic Estates Group is an *'enabling programme'* within the overall Shrewsbury, Telford & Wrekin STP Governance Framework

**STATUTORY ORGS**  
Requirement to adhere to own governance procedures

Provider Boards  
Commissioner Boards  
Local Authority Cabinets

- Telford & Wrekin CCG
- Telford & Wrekin LA
- SaTH
- RJAH
- ShropCom
- MPFT (formerly SSSFT)
- Shropshire CCG
- Shropshire LA

**ST&W STP System Leadership Group**  
(System CEOs)

- ST&W Health & Wellbeing Boards
- ST&W Joint Health Overview Scrutiny Committee

**ST&W STP Clinical Strategy Group**  
(System Clinical Leads)

**STP Transformation Programme Delivery Board**

- ST&W System Enablers
- ST&W Strategic Workforce Group
- ST&W Communication & Engagement
- ST&W System Back Office
- ST&W Strategic Estates Group**
- ST&W Digital Enablement Group
- ST&W System Finance Group



- ST&W System Partners On Programme Delivery Board**
- HealthWatch Telford & Wrekin
  - Local Pharmacy Committee
  - Shropshire Partners in Care
  - Powys Teaching Health Board
  - Severn Hospice
  - ShropDoc
  - West Midlands Ambulance Service
  - Patient Groups
  - Voluntary Sector
  - Welsh Ambulance Trust
  - Wider independent organisations
  - System Neighbours
  - HealthWatch Shropshire
  - Subject Matter Experts

Updated Version 3.0  
Feb 2018



# ST&W STP Example of interlinked enabling work streams

## Workforce Enablement Programme

### Local workforce challenges:

- An ageing workforce
- Different expectations of the younger workforce, eg increased part-time and flexible working
- Recruitment challenges & high vacancy rates, related to national workforce shortages within particular professions, varying terms and conditions, geographical rurality,
- Cultural challenges, with some staff groups or individuals presenting resistance to change
- Uncertain future supply of staff, with difficulty attracting students to some courses, placements and recruitment to jobs upon qualifying
- Future Fit/SSG consultation outcome potential to hinder recruitment

Creating a more **mobile / integrated workforce**, with new ways of working, including:

- Hot Desking; Virtual Offices
- Flexible work-base locations, including non-NHS traditional facilities in the voluntary sector / public estate
- System workforce modelling will inform estate requirement

### Estates Impact:

- Digital connectivity; bandwidth and networks; cyber-security
- Different work space layouts
- New clinical models with altered usage of spaces /Out-of-hours/ Extended access
- Key-worker housing

## Local Digital Roadmap (LDR)



### Benefits to the economy;

- Make the **best use of technology** to avoid people having to travel large distances where possible
- Consistent levels of **assurance** to the relevant boards.
- **Efficiency** in data connections to all those participating organisations – facilitate 'hot desking' / joint use of space
- Efficiency in sharing relevant information **across organisations** enhanced by geographical proximity
- Digital interoperability promoting modernisation and efficiency of paperless systems

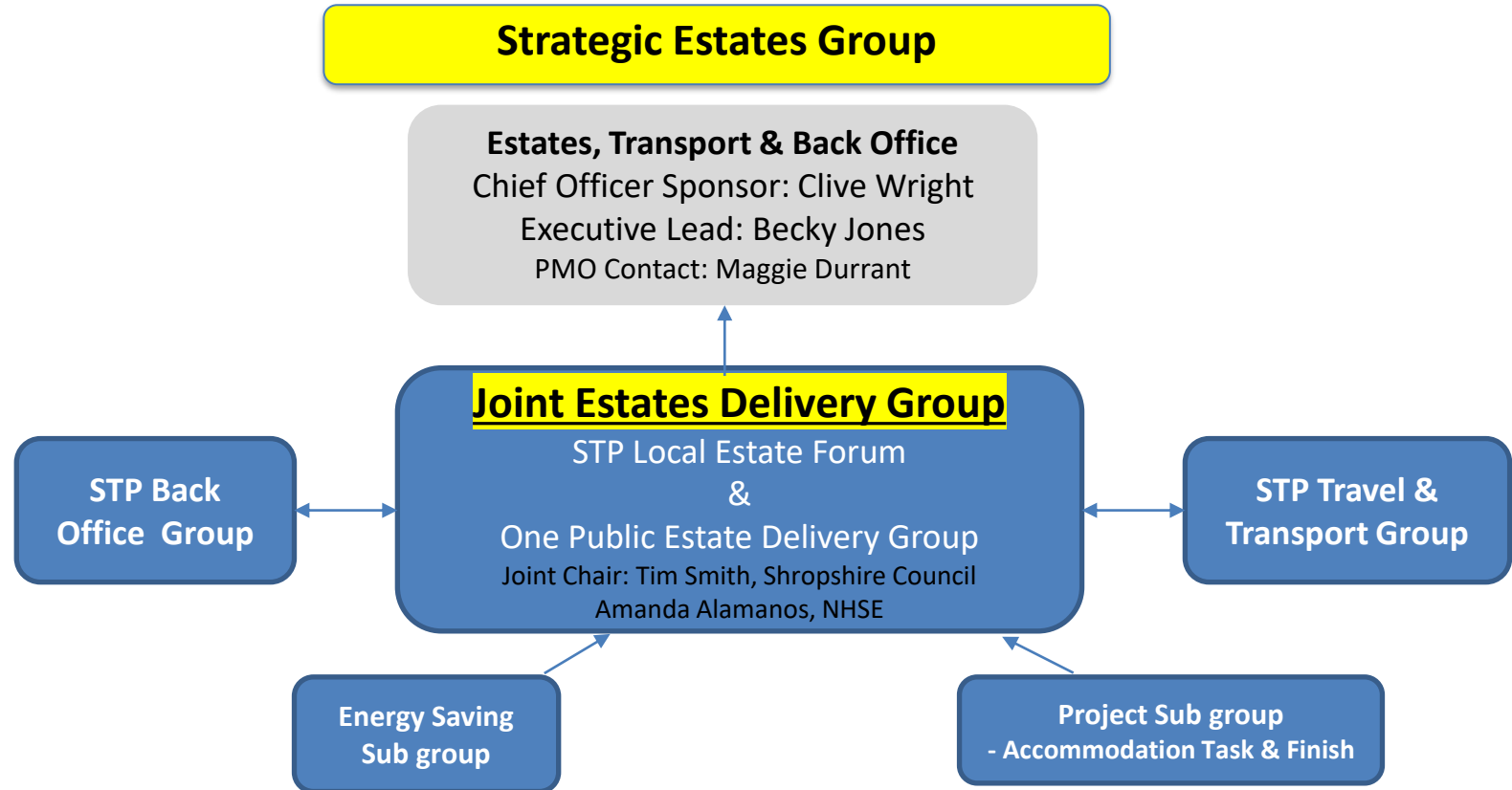


## A1. ST&W STP Strategic Estates Group Governance (1 of 4)

Progress made / current activities	Commentary
<b>Estate SRO</b>	Clive Wright (Chief Executive Shropshire Council) <i>Executive Lead for the ST&amp;W STP Estates Strategy Group</i>
<b>Lead Strategic Estates Adviser</b>	Becky Jones, Strategic Estates Adviser
<b>Form of estates governance model established</b>	Organisational structure, reporting and decision-making - The Local Estates Forum (LEF), delivery group of the ST&W STP estates workstream and the Shropshire One Public Estate (OPE) delivery group have combined into a JOINT LEF/OPE Delivery Group *See next slide
<b>Status of resource delivery plan to support STP estate transformation initiatives</b>	ST&W STP PMO is financially resourced and supported by partner organisations to deliver whole system priorities.  <ul style="list-style-type: none"> <li>• ST&amp;W STP Estates Strategy (<i>Workbook</i>) is the <b>What</b> i.e. partners' data, projects, priorities etc.</li> <li>• Detailed Delivery Plan is the <b>How</b> i.e. linking estates delivery with clinical service requirements</li> <li>• STP capital bids are <b>Implementation</b> i.e. using Workbook and Detailed Delivery Plan (DDP) to inform</li> </ul>
<b>Estate Planning resources supporting the STP and partner organisations</b>	Please refer to slide 19 – ST&W STP Governance and slide 22 – ST&W STP Estates Governance Maggie Durrant – ST&W STP Programme Manager Paul Gilmore – ST&W STP Finance Lead Caroline Reid-Smith, Programme Manager, Shropshire, Telford & Wrekin Estates Partnership, Shropshire Council



## A1. ST&W STP Strategic Estate Governance (2 of 4)



The STP Local Estates Forum (LEF), delivery group and the Shropshire One Public Estate (OPE) delivery group combined into a JOINT Estates Delivery Group with the inaugural meeting held 30 May 2018. This collaboration affords opportunities for wider system understanding and greater partnership working.

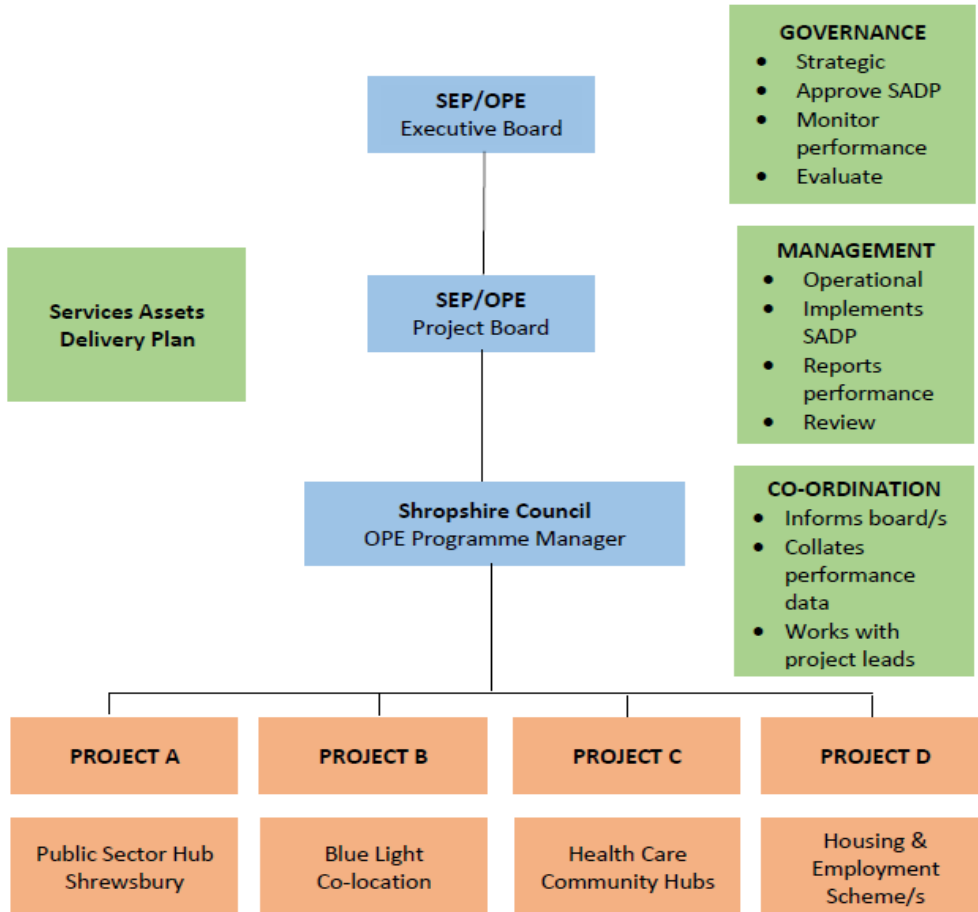
Specific responsibilities for OPE funded projects remain under the governance of the Shropshire Estate Partnership, as detailed on the following slide:



# A1. ST&W STP Strategic Estate Governance (3 of 4)

## Shropshire Estates Partnership

### GOVERNANCE & MANAGEMENT STRUCTURE



ST&W STP (new) Estate JOINT Delivery Group links to Shropshire Council Estates Partnership

#### Projects A & C below have secured OPE funding:

#### **Project A Public Sector Hub, Shrewsbury**

– £75K - development work for Shropshire County Offices ‘Shirehall’.

- Opportunities for STP partners & commercial lets; short, medium & long-term use.
- Supports more flexible utilisation of our workforce, and the potential for revenue savings (including back office)

#### **Project C Health Care Community Hubs**

– £75K (OPE) Whitchurch – **New Medical Centre**. A Wrekin Housing Trust, Shropshire CCG & Shropshire Council partnership. OBC completed.

- Includes step-up/step-down facilities, will provide ideally-equipped, multi-use spaces supported by innovative IT (enabling the practices to deliver new telemedicine and telecare services), enhanced primary care services.
- Additional potential collaboration with a proposal for concurrent development of co-located community and residential facilities including a Whitchurch Community Hub and Wrekin Housing Trust Extra Care housing



## A1. ST&W STP Estate Planning Governance (4 of 4)

Name of STP Partner Organisations	Estate Strategy (yes/no)	Status (Live / Draft)	Date of Last Board Approved Estate Strategy	Comments
Shrewsbury & Telford Hospitals NHS Trust (SaTH)	Yes	Draft	Not approved as yet	Revisions will be informed once public consultation has been completed and a final decision made regarding the reconfiguration of acute hospital services.
Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (specialised)	Yes	Live 2014-19 with new Draft now in progress	2014	The live strategy is an evolution of a long running document. The new draft document includes an ambitious building programme in line with corporate objectives
Shropshire Community Health NHS Trust (SCHT)	Yes	Live/ Approved	April 2016	5 year dynamic strategy
Telford & Wrekin Clinical Commissioning Group	Yes	Live / Approved	2018-2022	Reviewed annually
Shropshire Clinical Commissioning Group	Yes	Live / Approved	January 2018	The plan focuses on primary care
Midlands Partnership Foundation NHS Trust (MPFT) – formerly South Staffordshire & Shropshire Foundation Trust (SSSFT)	Yes	Live /Approved	March 2017	As SSSFT this was a 5 year dynamic strategy  Details of review under new organisation pending.
Shropshire Council	Yes	Live/ Approved	2015-2018/9	Review commences Autumn 2018
Telford & Wrekin Council	Yes	Live/ Approved	2016	5 year dynamic strategy





## A2. ST&W STP Service Strategy & Implications

### Objectives

To ensure that the healthcare estate meets the needs of patients, service users, staff, carers and visitors to acute, community, mental health and primary care services delivered to the people of Shropshire and Telford & Wrekin.

- **That estate is accessible, efficient and safe.**
- That the opportunity to develop the overall healthcare economy is critically and invasively assessed to **offer best models** in accordance with best business case practice. One Public Estate bid for funding to undertake **option appraisal and feasibility work to rationalise** the healthcare estate
- To create a One Public Estate infrastructure that **brings together** all public sector estate planning across the public sector for Shropshire, Telford and Wrekin and recognises the potential for **community assets** to be used as a base for service delivery.

### Outcomes

- An integrated and co-ordinated healthcare estate relevant to redesigned patient /service user and staff pathways under the STP
- **Reduction in estate**
- Reduction/removal of backlog maintenance
- Estate aligning with and utilising the **One Public Estate** agenda
- Utilisation **aligned with Carter review**
- Reduction in annual revenue costs
- **Flexible estate** that will enhance a dynamic healthcare economy

### Progress to date

- One Public Estate bid for funding to undertake option appraisal and feasibility work to rationalise the healthcare estate
- Data collection exercise and continued population of electronic asset management system.
- NHS Property Services Estates Workbook updated (Feb18) with summary of existing projects and draft implementation priorities
- Working group including Directors of F&E, CCGs and NHS Property Services
- Shropshire One Public Estate bid received £75,000 funding for Whitchurch New Medical Centre (Spring 18)
- Future Fit Public Consultation commenced 30/5/18 (14wks)

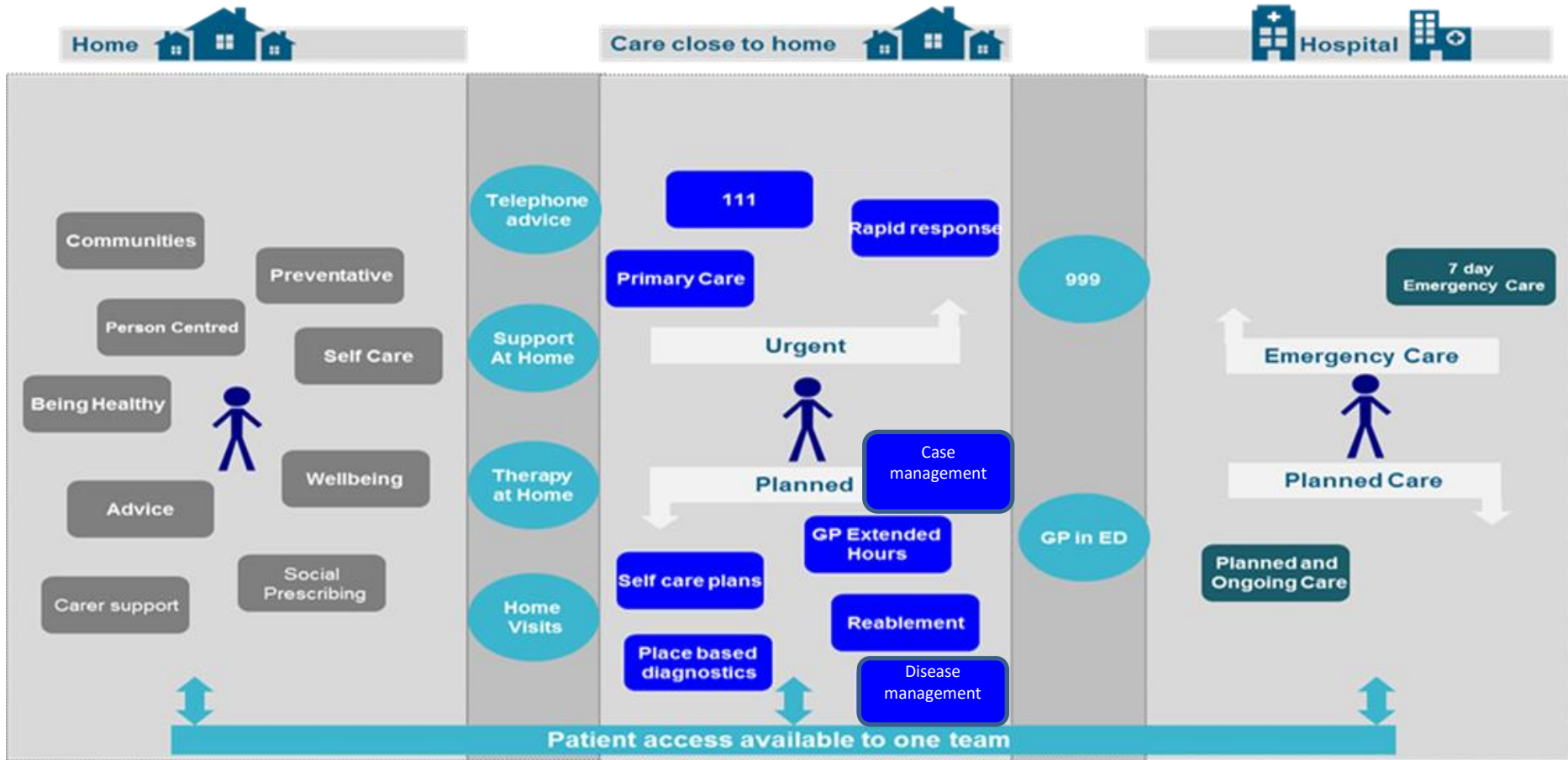
### Key milestones

- Completion of data capture exercise – achieved March 2018
- Overarching and adopted estate strategy aligning with the estate outcomes and key STP outcomes – Summer 2018
- Agree estates priorities – Summer 2018
- Future Fit public consultation & analysis completed – Winter 18
- Feasibility/option appraisal models with supporting financial overview – Autumn 18
- Outline rationalisation - timescales specific to each project - tbc
- Outline business cases – timescales specific to each project - tbc
- Detailed rationalisation plan timescales specific to each project - tbc



# A2. STP Service Strategy & Implications

## Planned, Preventative and Urgent Care



The above is a schematic representing our focus on collaboration & integration of our Clinical Service Delivery Models



## A2. ST&W STP Service Strategy & Implications

### Key STP Service Strategy Themes:

Main STP service priorities needed to deliver FYFV:

1. To develop and implement a model for Neighbourhood / Locality Working based on supporting individual communities to become more resilient.
2. Supporting people to stay healthy
3. Developing Neighbourhood / Locality Care Teams
4. Community bed review
5. Reconfigure Hospital Services - acute reconfiguration
6. Muscular-Skeletal (MSK) and orthopaedic review
7. Deliver technology enabled care
8. Mental health
9. To continue to develop other services
10. Drive system efficiency and effectiveness to make best use of services

### Enabling Implications for Future Estate

Priority areas to address and enable services are;

- **The Neighbourhood / Locality workstream** will support the development of community services and primary care offer for patients, reviewing service locations, community bed provision and facilitating clinical and community hubs
- **A Review of the Acute hospital sites;**  
**'Future Fit'** programme proposes (*consultation dependent*):  
***Emergency Department at either Royal Shrewsbury Hospital (RSH) or Princess Royal Hospital (PRH) alongside Critical Care & Ambulatory Emergency Care.***
- The majority of planned care at the non-ED site – with an increase in day cases.
- Two Urgent Care Centres, open 24/7 – at RSH and PRH where the majority of the patients currently seen in A&E would be able to be treated.
- Address, in part, the (net) backlog maintenance of £45.7m at RSH and £9.2m at PRH.
- A review of MSK and Orthopaedic services, currently provided at Robert Jones and Agnes Hunt Foundation Trust, RSH and PRH, expanding non-surgical options closer to home
- **Review of the back office estate**
- Opportunities to reduce footprint and release capital proceeds' with respect to existing office spaces





## A3. ST&W STP Estates Progress Against Key Service Strategy & Programmes

#	Progress made / current activities	Risks, Issues and barriers
	'Future Fit' & STP combined under leadership of STP Director with PMO now fully resourced and in position to support all workstreams and enabling programmes, co-ordinating and driving the process forward.	'Future Fit' pre-dated the STP in Shropshire Telford & Wrekin and was initially managed by the acute provider. STP was initially subject to transient leadership and management
1	<p>Sustainable Services (Reconfiguration of hospital services). Pre Consultation Business Case submitted by CCG Boards to NHS England &amp; JHOSC, scrutinised / agreed that <b>Public Consultation will proceed from 30<sup>th</sup> May -5<sup>th</sup> September 2018</b></p> <p>Sustainable Services Programme continues: to:</p> <ul style="list-style-type: none"> <li>- Support Future Fit during Public Consultation with 8 exhibition events in key locations</li> <li>- Progress the workforce transformation – 5 year plan</li> <li>- Internal staff engagement during consultation</li> <li>- Technical team project phasing analysis</li> </ul>	<p><b>Public Consultation will run for 14 weeks May – Sept 2018 followed by an 8 week analysis period</b></p> <p>Consultation recommendations and outcomes are then fed back to CCG &amp; Healthcare Boards .</p> <p>DMBC (Decision making business case) by CCG will follow the consultation ahead of FBC (full business case)</p>
2	<p>Neighbourhood Working work streams also referred to as 'Out of Hospital Offer' and 'Care Closer to Home, are working to deliver the community offer for Shropshire and Telford &amp; Wrekin</p> <p>Linking in with Joint Estates Delivery Group</p>	There are clearly defined neighbourhood working groups across Telford, Shropshire and Powys. Links with the Joint Estates Delivery Group have commenced and are working together to resolve any raised barriers, issues and perceived constraints
3	Community bed review in support of Future Fit & Sustainable Services; part of a commissioned Demand and Capacity Modelling review across all provider organisations	There may be a need to consult following phase 3 (see detailed slide in Annex 3 supplementary information) of the Shropshire Care Closer to Home work. This will be informed by the system wide demand and capacity modelling due to conclude by the end of September 18.
4	One Public Estate bid successful for Whitchurch Medical Centre project, PM in post, progressing forward; engagement with STP PMO for oversight of related project governance. Supporting delivery of the community hub initiative	Timelines for grant applications; including those of associated partners. Dovetailing and co-ordination of any relevant consultations to avoid potential conflict.





## A3. ST&W STP Estates Progress Against Key Service Strategy & Programmes

#	Progress made / current activities	Risks, Issues and barriers
6	<p><b>Place Based Care Integration - Shropshire Community Needs Workshop on 27 Feb 18;</b> - engaged the expertise and knowledge of public sector delivery leads; used data in geographic layers at a very local level as evidence of emerging community need, and discussed how or if they are being addressed. <u>Key Messages and outcomes</u>: Partnership approach, executive buy-in and working together to be 'Norm'; Sharing of Data and Intelligence is vital to inform design. Next steps incl.: market town workshops to further develop specific community needs, concepts, project OBCs. <b>A similar workshop being planned for Telford &amp; Wrekin footprint stakeholders.</b> Place shaping work required to underpin out-of-hospital offers – involving stakeholders and interested parties in strategic planning</p>	<p>Potential lack of engagement, potential exclusion of interested parties – through lack of awareness. Ensuring all data has been validated and made available. Ongoing requirement to keep this up-to-date in line with estate changes. Potential lack of agreement on locations from which to deliver services</p>
7	<p><b>Back Office Sub Group</b> established with cross-working links to LEF/OPE Meetings re-focused:- MLCSU to deliver Collaborative Back Office Options Appraisal; Accelerating design and implementation of a collaborative back office in form of a Public Sector Partnership across the STP, incl. generating further leadership buy-in for the Public Sector Partnership; establishing the right Governance; Undertake 'Bottom up' functional level design work - holding workshops with trusts and SMEs from each of the back office functions; to generate momentum, engagement and lock in the strategic direction of the back office collaboration; Agree CCG Involvement - representatives to align programmes of work and develop common direction of travel; Develop Outline Business Case and funding; Mobilise for quick win opportunities, focus on voids and efficiencies.</p>	<p>LEF representative to sit on Back Office Sub Group moving forwards to ensure linkages are in place, with PMO support. Loss of focus from Back Office sub-group during latter part of 2017, with competing local pressures; re-focused in 2018, but maintaining focus and momentum still a risk</p>
8	<p>Terms of Reference for the following groups are being developed or refreshed to reflect system partnerships and collaboration across our system:</p> <ul style="list-style-type: none"> <li>- Joint Estates Delivery Group (formerly separate Local Estates Forum / One Public Estate Delivery Group)</li> <li>- Clinical Design Group evolved into a STP Clinical Strategy Group</li> <li>- STP Partnership Board evolved to a System Leadership Group</li> <li>- Finance Group evolved to a Strategic Finance Group</li> </ul> <p>Ensuring that health priorities, quality, safety and concerns regarding clinical pathways and STP plans make sense, linking in with other work-streams and enabling groups, to consider impacts, considerations and opportunities; including estates.</p>	<p>Lack of availability of clinicians to attend and inform group meetings. Clarity needed on group membership of each and robust approach for integration with other STP programme elements.</p>





## A4. Performance Indicators - Shrewsbury and Telford Hospitals

### Success Metrics to 2022/23

Indicator	Current	Planned	Progress against targets
Estate Running Costs (£/m2)	£170/m2 (total cost £19,766k)	Awaiting Model Hospital data and targets for 16/17 data	
Non-Clinical Space (%) (Carter Metric max 35%)	32.4% (total area 37,718m2) Estimated Average Cost £6,395k Estimated Average Cost Above Carter £0k	The STP intends to meet the Carter Metric benchmark by 2021	
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	2.6% (total area 3,060m2) Est. apportioned cost above Carter £25k Est. apportioned cost for unoccupied Floor Space £519k	The STP intends to meet and maintain the Carter Metric benchmark by 2021	
Functional Suitability	SaTH – Six facet survey data identifies that both hospital sites require significant investment to attain an acceptable standard. 31% of the assets at RSH and 65% of the assets at PRH are in an acceptable condition/satisfactory performance	Prioritised investment programme to deal with back log maintenance to form part of Sustainable Services Group programme and out-of-hospital work-streams will greatly impact on achievable timelines and quality of estates; an ongoing process.	Pending decision making business case
Condition	Back log maintenance & Critical Infrastructure; Back log maintenance includes high risk) £54,876k High Risk Backlog £3,913k Significant Risk £26,441k	SaTH – awaiting outcome of Future Fit which will partially address the required investment and the poor condition areas. Sustainable Services Group programme and out-of-hospital work streams will improve future estate and thereby reduce backlog and CIR maintenance.	
Naylor benchmarks	No disposals identified in 5 year capital plan from 18/19 Financial Plan Returns.	The STP intends to meet the Naylor benchmarks by 2021. Achieving planned disposals and release capital where possible, reducing running costs. Future potential 'old' residence land surplus at RSH on completion of the SSG project. Disposal potential following completion of the site re-development. Adjoining the RSH site, DHSC land could be disposed of at the same time. Potential surplus land adjoining PRH, owned by NHSPS (ex-Malling Health site) and a strip of land owned by DHSC.	Outline potential future land disposal opportunities identified.



## A4. Performance Indicators - Shropshire Community Health Trust

### Success Metrics to 2022/23

Indicator	Current	Planned	Progress against targets
Estate Running Costs (£/m2)	£190m2 (total cost £2,725k)	Efficiencies reviewed through CIP plans and increased utilisation of floor space and non-clinical space reviews	
Non-Clinical Space (%) (Carter Metric max 35%)	38.5% (total area 5,504m2) Estimated Average Cost £1,048k Estimated Average Cost above Carter £94k	The STP intends to meet the Carter Metric benchmark by 2021	Carter considered with each business case. Opportunities to reduce non-clinical space being reviewed in conjunction with availability to increase utilisation of floor space
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	13.2% (total area 1,892m2) Est. apportioned cost above Carter £292k Est. apportioned cost for unoccupied Floor Space £360k	The STP intends to meet and maintain the Carter Metric benchmark by 2021	Opportunities to increase floor utilisation above 95% being considered in conjunction with reducing the non-clinical space.
Functional Suitability	Unknown % of the assets are in an acceptable condition / satisfactory performance		
Condition	Back Log Maintenance & Critical Infrastructure; Back Log Maintenance £1,295k High Risk Backlog £290k Critical Infrastructure Risk £370k <b>Total Back Log &amp; CIR £1,955k</b>	Address the backlog programme via risk prioritisation, recorded through risk register	Capital Management Group approves the backlog programme and monitors progress against the programme
Naylor benchmarks	No disposals identified in 5 year capital plan from 18/19 Financial Plan Returns.	The STP intends to meet the Naylor benchmarks by 2021. To achieve planned disposals and release capital where possible, reducing running costs	No Disposals identified presently. Integrated review as part of occupied floor space and non-clinical space reviews and planned improvements and functional suitability reviews



## A4. Performance Indicators - Robert Jones & Agnes Hunt FT

### Success Metrics to 2022/23

Indicator	Current	Planned	Progress against targets
Estate Running Costs (£/m2)	£223m2 (£7,865k)	Already achieving benchmark cost – efficiencies sought through CIP programme (4%)	CIP programme being monitored
Non-Clinical Space (%) (Carter Metric max 35%)	31.4% (total area 11,065m2) Estimated Average Cost £3,762k Estimated Average Cost above Carter £0k	Maintain and improve upon Carter Metric	Carter Metric benchmark achieved – Carter considered with each business case
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	1.1% (total area 386m2) Est. apportioned cost above Carter £0k Est. apportioned cost for unoccupied Floor Space £131k	Maintain and improve upon Carter Metric	The site is highly utilised, the areas previously temporarily closed have now re-opened
Functional Suitability	RJAH – requires investment  61% of the assets are in an acceptable condition / satisfactory performance	Prioritise areas identified in six facet survey through the capital programme.	Capital Management Group monitors progress against the capital programme
Condition	Back Log Mtce & Critical Infrastructure; Back Log Mtce £6,694k High Risk Backlog £709k Critical Infrastructure Risk £2,008k <b>Total Back Log &amp; CIR £9,411k</b>	Address the backlog programme via risk prioritisation, recorded through risk register	Capital Management Group approves the backlog programme and monitors progress against the programme
Naylor benchmarks	RJAH Land Disposal - 2.5 Hectares identified as surplus land on EFM	The Trust Estates Strategy identifies opportunities to release land for disposal	Land identified as low value; general area identified as having long term housing stock. The area is therefore a low priority nationally



## A4. Performance Indicators - Midlands Partnership FT (formerly SSSFT)

### Success Metrics to 2022/23

Please Note: The data within this slide relates to the organisation "SSSFT" i.e. pre-dates change to "MPFT"

Indicator	Current	Planned	Progress against targets
Estate Running Costs (£/m2)	£193m2 (total cost £2,446k)		
Non-Clinical Space (%) (Carter Metric max 35%)	38.4% (total area 4,859m2) Estimated Average Cost £939k Estimated Average Cost above Carter £83k	The STP intends to meet the Carter Metric benchmark by 2021	
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	7.8% (total area 988m2) Est. apportioned cost above Carter £130k Est. apportioned cost for unoccupied Floor Space £191k	The STP intends to meet and maintain the Carter Metric benchmark by 2021	
Functional Suitability	Unknown % of the assets are in an acceptable condition / satisfactory performance		
Condition	Back Log Maintenance & Critical Infrastructure; Back Log Maintenance £155k High Risk Backlog £0k Critical Infrastructure Risk £0k <b>Total Back Log &amp; CIR £155k</b>		
Naylor benchmarks	Although located in Shrops, disposals are registered with Staffs STP, (as their primary STP)	The STP intends to meet the Naylor benchmarks by 2021. To achieve planned disposals and release capital where possible, reducing running costs	



## A5. Sustainability & Transformation Initiatives (1 of 2)

### In order of priority –

Key STP projects identified where implementation required to enable wider STP strategy (revenue savings >£1mpa)

STP initiative	Estates Impact and Enablers	Est. Net Revenue Benefits (£m pa)	Project Status / Funding Strategy	Est. Delivery Year	Gross Capital Required (£m)	Disposal receipts (£m)	Comments and Interdependencies
1. Sustainable Services Group (SaTH) Reconfiguration of acute hospital services	Consolidate acute services with clear linkages to out of hospital offer. Realignment of Emergency Services	2023/24 – <b>gross</b> saving of £14.2m pay cost (further details TBC)	CCGs PCBC completed, Future Fit consultation stage commenced 30/05/18 Capital funding for Future Fit approved Wave 3	2023/24	£270 (20/21) Plus £42 (22/23) Total £312	TBD	<b><u>Public consultation will run for 14 weeks from 30 May18 - Sept 2018; followed by an estimated 8 week analysis period.</u></b> Consultation recommendations and outcomes are then fed back to CCGs. Final submission will follow the consultation.
2. Neighbourhood Working Groups (Telford & Wrekin) & Care Closer to Home (Shropshire)	Outcome will support future estate requirement type to deliver out of hospital offers	TBD	Work-streams established and moving forwards	2018-23	TBD	TBD	Links with acute and community reconfiguration projects and supported by estates work-stream, includes capacity and demand modelling, NHSE assurance
3. Transformation focused on prevention and supporting people to stay healthy	Asset mapping taking place to identify potential hubs, cross cutting with OPE and work-streams	TBD	Early strategy development	2021/22	TBD	TBD	Will support delivery of main work-streams and help to transform care delivery. OPE bid put in



## A5. Sustainability & Transformation Initiatives (2 of 2)

### In order of priority –

Key STP projects identified where implementation required to enable wider STP strategy (revenue savings >£1mpa)

STP initiative	Estates Impact and Enablers	Est. Net Revenue Benefits (£m pa)	Project Status / Funding Strategy	Est. Deliver Year	Gross Capital Required (£m)	Disposal receipts (£m)	Comments and Interdependencies
4. Improve offer for muscular-skeletal services	Opportunities to deliver care pathways differently, with increased requirement for service provision closer to home	£4.1m (TBC)	CCGs working with their Provider Trusts, programme in place	2020/21	TBD	TBD	Links with wider transformation aspect of service delivery through work-streams
5. Local Maternity & New-born Services Review and Family Hub modelling	Reconfiguration Proposals to re-model Midwife Led Services are being developed	£800k (TBC) – further connected benefits TBD	Consultation period anticipated during late 2018	2020/21	TBD	TBD	Service transformation will impact on estate usage including: midwifery-led v consultant-led service, capacity for inpatient, antenatal and post-natal care services,
6. Make best use of services	Back office review of relevant premises, facility services and associated efficiencies	Full Scope TBD	Early strategy development	2020/21	TBD	TBD	CCG administrative bases are amongst some premises currently being looked into

The STP partners will investigate the potential benefits that can be accrued by moving from physical to digital records across the economy. It is exceptionally unlikely that all paper will be removed however a significant proportion of interchanges can be digital. The major issue that the LHE is faced with are the legacy records and how to digitise them (or not). We should test the solutions that are currently in use by various partners as well as market test the range of products/services that are available. Potentially this will provide economies not only in physical media production; but significant estates savings as the storage requirements are rationalised.





## Planned Capital Expenditure (Summary analysis 1 of 2)

CAPITAL EXPENDITURE PLAN - Scheme Category	2018/19	2019/20	2020/21	2021/22	2022/23	5yr Sum
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
IT	4,525	2,950	2,600	2,700	2,600	15,375
Plant and machinery/equipment/transport/fittings/other	4,666	3,136	3,054	3,054	3,054	16,964
Routine Maintenance (non-backlog) - Land, buildings and dwellings	7,318	7,285	7,010	7,310	7,610	36,533
Backlog Maintenance - Land, buildings and dwellings	1,885	4,436	4,361	4,011	4,011	18,704
New Build - Land, buildings and dwellings	8,886	28,706	122,100	96,000	132,000	387,692
<b>Total STP (PROVIDER)</b>	<b>27,280</b>	<b>46,513</b>	<b>139,125</b>	<b>113,075</b>	<b>149,275</b>	<b>475,268</b>

Routine Maintenance (non-backlog) - Land, buildings and dwellings	2018/19	2019/20	2020/21	2021/22	2022/23	5yr Sum
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
RJAH	1,500	900	450	400	700	3,950
SaTH	4,008	4,575	4,700	5,050	5,050	23,383
SHROPCOM	410	410	460	460	460	2,200
SSSFT	1,400	1,400	1,400	1,400	1,400	7,000
<b>Total STP (PROVIDER)</b>	<b>7,318</b>	<b>7,285</b>	<b>7,010</b>	<b>7,310</b>	<b>7,610</b>	<b>36,533</b>

Backlog Maintenance - Land, buildings and dwellings	2018/19	2019/20	2020/21	2021/22	2022/23	5yr Sum
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
RJAH	400	300	300	300	300	1,600
SaTH	1,085	3,786	3,661	3,311	3,311	15,154
SHROPCOM	400	350	400	400	400	1,950
SSSFT	0	0	0	0	0	0
<b>Total STP (PROVIDER)</b>	<b>1,885</b>	<b>4,436</b>	<b>4,361</b>	<b>4,011</b>	<b>4,011</b>	<b>18,704</b>

New Build - Land, buildings and dwellings	2018/19	2019/20	2020/21	2021/22	2022/23	5yr Sum
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
RJAH	1,050	280	1,100	1,000	1,000	4,430
SaTH	1,166	5,000	106,000	80,000	121,000	313,166
SHROPCOM	0	0	0	0	0	0
SSSFT	4,770	23,426	15,000	15,000	10,000	68,196
<b>Total STP (PROVIDER)</b>	<b>6,986</b>	<b>28,706</b>	<b>122,100</b>	<b>96,000</b>	<b>132,000</b>	<b>385,792</b>



## Planned Capital Expenditure (Summary analysis 2of 2)

Organisation (CAPITAL EXPENDITURE PLAN)	2018/19	2019/20	2020/21	2021/22	2022/23	5yr Sum
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
RJAH	4,250	2,712	2,750	2,700	2,900	15,312
SaTH	12,115	17,115	118,115	92,115	133,115	372,575
SHROPCOM	1,460	1,460	1,460	1,460	1,460	7,300
SSSFT	7,055	25,226	16,800	16,800	11,800	77,681
<b>Sub-Total (PROVIDER)</b>	<b>24,880</b>	<b>46,513</b>	<b>139,125</b>	<b>113,075</b>	<b>149,275</b>	<b>472,868</b>
SCCG	1,900	0	0	0	0	1,900
TWCCG	500	0	0	0	0	500
<b>Sub-Total (COMMISSIONER)</b>	<b>2,400</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,400</b>
<b>GROSS CAPITAL EXPENDITURE by Organisation STP (ALL)</b>	<b>27,280</b>	<b>46,513</b>	<b>139,125</b>	<b>113,075</b>	<b>149,275</b>	<b>475,268</b>
<b>PLANNED Disposal Receipts</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>	<b>2022/23</b>	<b>5yr Sum</b>
<b>Total STP DISPOSALS (ALL)</b>	<b>0</b>	<b>0</b>	<b>(1,500)</b>	<b>0</b>	<b>0</b>	<b>(1,500)</b>
<b>PLANNED Grants and Donations</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>	<b>2022/23</b>	<b>5yr Sum</b>
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
RJAH	0	0	0	0	0	0
SaTH	(1,023)	(1,023)	(1,023)	(1,023)	(1,023)	(5,115)
SHROPCOM	0	0	0	0	0	0
SSSFT	0	0	0	0	0	0
<b>Sub-Total (PROVIDER)</b>	<b>(1,023)</b>	<b>(1,023)</b>	<b>(1,023)</b>	<b>(1,023)</b>	<b>(1,023)</b>	<b>(5,115)</b>
SCCG	0	0	0	0	0	0
TWCCG	0	0	0	0	0	0
<b>Sub-Total (COMMISSIONER)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total STP GRANTS and DONATIONS (ALL)</b>	<b>(1,023)</b>	<b>(1,023)</b>	<b>(1,023)</b>	<b>(1,023)</b>	<b>(1,023)</b>	<b>(5,115)</b>
<b>Organisation (NET CAPITAL EXPENDITURE PLAN)</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>	<b>2022/23</b>	<b>5yr Sum</b>
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
RJAH	4,250	2,712	2,750	2,700	2,900	15,312
SaTH	11,092	16,092	117,092	91,092	132,092	367,460
SHROPCOM	1,460	1,460	1,460	1,460	1,460	7,300
SSSFT	7,055	25,226	16,800	16,800	11,800	77,681
Other	0	0	(1,500)	0	0	(1,500)
<b>Sub-Total (PROVIDER)</b>	<b>23,857</b>	<b>45,490</b>	<b>136,602</b>	<b>112,052</b>	<b>148,252</b>	<b>466,253</b>
SCCG	1,900	0	0	0	0	1,900
TWCCG	500	0	0	0	0	500
<b>Sub-Total (COMMISSIONER)</b>	<b>2,400</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,400</b>
<b>NET CAPITAL EXPENDITURE by Organisation STP (ALL)</b>	<b>26,257</b>	<b>45,490</b>	<b>136,602</b>	<b>112,052</b>	<b>148,252</b>	<b>468,653</b>





## A7. Prioritised Estate Projects

### Capital Investment Pipeline – listed in priority order

Project/ Location	CCG/ Trust	Strategic Objective	Priority / Importance (Critical, High, Essential, Desirable)	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	Proposed Funding route	Business Case Status
Whitchurch community hub	Shropshire CCG/Shropshire County Council	Primary care at scale and integrated community services	High	£0.232 + VAT (TBC)	Total scheme capital circa £15.5m; £4.778 estimated cost for construction of proposed medical centre includes build efficiencies of £100k	OBC	2020/21	Up to £1m ETTF High priority scheme; future potential expansion but none current subject to outcome consultations	<b>OBC approved for primary case element by CCG.</b> Governance structures approved Project Manager appointed
New Models of Care at scale hubs – incorporating Wound Care hub, Neighbourhood Working hub and Integrated Care Team hub –	T&W CCG	Development of community hubs to deliver neighbourhood teams & out of hospital services x 4	High	TBC	TBC		2018/19	ETTF, Housing Grants, Council OPE	Neighbourhood asset review, link to OPE and STP workstreams. Opportunities will be identified during workshops Summer 2018
Shropshire – Primary Care Networks; developments around ‘Hub and Spoke’ model	SCCG	Development of community health & care hubs to deliver integrated locality teams & out of hospital service development	High	TBD	TBC	Early project planning	2018/20	SCHT capital programme / STP capital funding	Narrative



## A7. Prioritised Estate Projects

### Capital Investment Pipeline – listed in priority order

Project / Location	CCG / Trust	Strategic Objective	Priority / Importance (Critical, High, Essential, Desirable)	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	Proposed Funding route	Business Case Status
Shawburch Primary Care Centre	T&W CCG	Primary care at scale	High	Net annual savings £19k from 20/21 + £200k (Physio First Service) included in CCG QIPP + revenue impact for possible £675k TBC	Total scheme capital £4.675 + potential £675k subject to review (TBC)	OBC	2018/19 – 19/20	£675k ETTF + £675k additional funding TBC + £4,211k Private finance	<b>OBC approved – Jun 18</b>
RJAH – (Phase 1) – Parking Facilities; Hotel/key worker accommodation / Education		Sequential steps for Site to evolve, meeting Patient, Trust & STP needs	High	TBC	TBC	SOC			Narrative
TelDoc Estate Rationalisation	T&W CCG	Primary care at scale	High	TBC	TBC	OBC	2018/19	ETTF, Housing Grants, Council OPE	OBC being drafted
Hollinswood MP	T&W CCG	Primary care at scale	High	TBC	TBC	OBC			OBC being drafted
Dawley MP	T&W CCG	Primary care at scale	High	TBC	TBC	OBC	2018/19	Improvement Grants	OBC being drafted
Ironbridge MP	T&W CCG	Primary care at scale	Low	TBC	TBC	OBC	2019/20	TBC	OBC being drafted
Riverside MP	SCCG	Primary Care at Scale	Essential	TBC	TBC	OBC	2019/20	TBC	OBC being drafted
Shifnal MP	SCCG	Primary care at scale	Desirable	TBC	TBC	OBC	2019/20	ETTF + 3PD	OBC being drafted



## A8. Headline Financial Impacts: Provider own-Capital Position

Trust / FT Name	Own estates capital forecast over the next 5 years to 2022/23 (£m)	Proposed main strategy proposals (> £10m) of own generated capital	CURRENT Backlog Maintenance		FORECAST Backlog Maintenance at end of 5 year period 2022/23	
			All categories (£m)	High / significant (£m)	All categories (£m)	High / significant (£m)
Shrewsbury & Telford Hospitals NHS Trust (SaTH)	£39.9m	£0.0m	£1.1m		TBC	
Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH)	£10.0m	£0.0m	£0.4m		£1.6m	
Midlands Partnership Foundation Trust (MPFT) - formally SSSFT (stated at 100% of value)	£32.2m (SSSFT numbers)	£16.0m (SSSF numbers)	£0.0m		£0.0m	
Shropshire Community Health NHS Trust (SHROPCOM)	£4.2m	£0.0m	£0.4m		£2.0m	





## A8. Headline Financial Impacts

### Disposal Opportunities

### Surplus Land & Housing

Disposal Status	No. of Sites	Land Area (Ha)	GIA (m)	Estimated disposal value £m	Total # Estimated Housing Units	# Housing Units for NHS Staff	Gross Running Cost reduction £m	Cost to Achieve Vacant Possession (where known ) £m
1. Vacant and Declared Surplus and disposal transaction in progress [A1]								n/a
2. Vacant and Declared Surplus/ disposal subject to marketing [A1]	1	0.500	1,262	(sits with Staffs STP)				n/a
3. Vacant but not yet Declared surplus [A2]	2							n/a
4. Site occupied but OBC approved to achieve vacant possession and dispose [B, C ,D]	0							
5. Future opportunity subject to strategy/ feasibility [B, C ,D]	6	1.862	6,882		90+			
<b>Totals</b>		<b>2.362</b>	<b>8,144</b>					

### Summary by Financial Year (estimated year of disposal completion)

Deliverable / Financial Year	2017 – 18	2018 – 19	2019 – 20	2020 – 21	Remaining Years
Land Area (Ha) (Sites x 2 - SSSFT)	1.130				2.362
Estimated disposal value £m	(sits with Staffs STP)				£
Estimated Housing Units	14				
Gross Running Cost reduction £m					



## A8. Headline Financial Impacts

### Disposal Opportunities

### Surplus Land Disposals (by named site)

Site	Current status of disposal	Land Area (Ha)	GIA (m)	Estimated disposal value £
Chaddeslode House, MPFT (when still known as SSSFT) West Bank, MPFT (when still known as SSSFT)	Sold in 17/18	0.72 0.41	740 642	£825k exc disposal costs £512k exc disposal costs. NB: Although located in Shrops, <b>these disposals are registered with Staffs STP</b> as their primary STP.
Castle Lodge, MPFT (when still known as SSSFT)	On market	0.5	1262	
(Site A) (SaTH) Land & demountable building forming ex-Malling Health Centre, Telford Hospital, no longer required, but awaiting formal confirmation.	Pending Board Approval	Not Specified	Not Specified	Unknown
(Site B) (SaTH) Land between Malling Health Centre site and Severn Hospice, Telford Hospital.	Pending Board Approval	Not Specified	Not Specified	Unknown
(Site C) (SaTH) Old Accommodation Blocks and associated land / parking; Shrewsbury Hospital.	Pending Board Approval	0.7919	2377	Unknown
(SaTH) Land adjacent to Racecourse Lane, adjoining old accommodation blocks referred to above.	Pending Board Approval	0.7	Not Specified	Unknown
Sensitive Site	Pending Board Approval	Not Specified	3811.9	£1,300k
(RJAH) land opposite front entrance, across road	Land Still In Use	Not Specified	Not Specified	£200-300k est.
Diamond Jubilee House – Dawley (Telford rationalisation), (TWCCG)	Pending Board Approval	0.23	440	Unknown
14 Leonard Street – Telford (Telford rationalisation) (TWCCG)	Pending Board Approval	0.14	253	Unknown



## A9. Road Map: Critical Decisions & Activities

Decision/ Activity Required	Significance/ impact on STP strategic objectives	Timeline	Owner	Action By:
Reconfiguration of services provided within the Acute hospitals and review of sites – decisions and impacts on funding and results of consultation	Achieves desire to improve acute service provision	Awaiting end Future Fit consultation, SSG element completion expected 2026	CCGs	Consultation outcome dependent
Review GP premises, form hub locations and establish how to deliver primary care at scale	Delivery of enhanced primary and community care across Shropshire	Future Fit consultation will influence required services and locations	Neighbour Working (Out of Hospital Care offer) teams	End December 2018
Review of community beds with Demand and Capacity Modelling across Providers	Enhanced primary and community care across Shropshire, Telford and Wrekin	Future Fit consultation will influence required services and locations	Neighbourhood Work-streams and SHROPCOM	Winter 2018
Review of back and middle office functions	Make best use of services	End December 2018	Back office group	Ongoing
Outcome of review of maternity led services – expectation for decision to progress to consultation	To make best use of services and a joined up offering	NHSE assurance process to be completed. Public consultation on proposed model planned expected	Local maternity services work-stream	Winter 2018
Outcome of review of MSK work	To make best use of services and ensure a joined up offering across the footprint	No involvement by the STP in this workstream; currently with CCG leads	MSK work-stream lead director	Not Stated
Decision making processes to be better aligned to the STP	The decision making processes need to be aligned to ensure there is one agreed approach and framework for work-streams to be channelled through	End March 2019	STP System Leadership Group (System CEOs)	Ongoing



## Section B – ST&W STP capital prioritisation

The slides in Section B identify and then explicitly prioritise our capital schemes.

Tables completed relate to:

- Small-medium sized capital schemes (with a value under £100m) which require ST&W STP capital funding:
  - Only those schemes within the STP which are planned to deliver over the next five years, and for which STP capital funding is being sought are included
- There are **NO** large capital schemes (with a value in excess of £100m) currently submitted for STP funding
- Our submitted small-medium projects which require STP capital funding are ranked in order of priority.



## B2. STP capital schemes below £100m (1 of 2)

Please identify all schemes under £100m which are planned to deliver over the next five years, for which STP capital funding is requested. Note, this section should also include 'non estates' bids (eg fleet, equipment).

STP scheme name and lead organisation	18/19 (£000)	19/20 (£000)	20/21 (£000)	21/22 (£000)	22/23 (£000)	Total STP capital funding requested (£000)	Effect on backlog maintenance (£000)	Value of land disposals (£000)
Whitchurch Integrated Health Hub – Led by Shropshire CCG						No additional capital requested, listed only as a priority scheme		
Shawbirch Primary Care Centre		£75	£600			£675		
New Models of Care / Integrated Teams - Neighbourhood Hubs	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Primary Care Networks – Hub & Spoke	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
TelDoc Estate Rationalisation	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Dawley MP	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Ironbridge MP	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Hollinswood MP	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Riverside MP	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Shifnal MP	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC



## B2. STP capital schemes below £100m List

(List continued 2 of 2)

Please **identify all schemes under £100m** which are planned to deliver over the next five years, for which STP capital funding is requested. Note, this section should also include ‘non estates’ bids (eg fleet, equipment).

STP scheme name and lead organisation	18/19 (£000)	19/20 (£000)	20/21 (£000)	21/22 (£000)	22/23 (£000)	Total STP capital funding requested (£000)	Effect on backlog maintenance (£000)	Value of land disposals (£000)
RJAH – Accommodation inc key worker / Education facility / Step-down facility / Creche / commercial opportunities / Car Park			£10,000				£1,000	TBC
RJAH – (Orthotic Research & Locomotor Assessment Unit (ORLAU) – specialist facility that services the wider community	£1,000						NA	
RJAH – Veterans facility to benefit local, regional and national patients		£3,000					NA	
RJAH – DEXA Scanner – specialist facility that services the wider community			£2,000				£100	





## B3. STP capital schemes over £100m

### List (1 of 1)

**Please all large capital schemes within the STP which will likely be required over the next 10 years, irrespective of whether public funding is required. THIS COULD BE A NIL RETURN.**

Large schemes which require public funding will be assessed to a different timetable, likely specific to each scheme. It is highly unlikely any schemes will be announced as part of this wave of funding.

STP scheme name	18/19 (£000)	19/20 (£000)	20/21 (£000)	21/22 (£000)	22/23 (£000)	23/24 (£000)	24/25 (£000)	25/26 (£000)	26+ (£000)	Total (£000)	Of which public funding requested (£000)	Effect on backlog maintenance (£000)	Value of land disposals (£000)
NIL RETURN													



## B4. Prioritisation

### All schemes requesting public STP capital (1 of 1)

**Ranked in order of priority, schemes from B2 and B3 for which STP capital bid templates are being submitted.**

Ranking (1 being highest priority)	STP scheme name and lead organisation	Total requested public funding (£000)	Effect on backlog maintenance (£000)	Value of land disposals (£000)	Brief rationale for prioritisation (Should be consistent with the over-arching supporting narrative in section B4)
1	Whitchurch Integrated Health Hub – Led by Shropshire CCG	£0, listed to showcase top priority capital scheme with future bid potential TBC	TBC	£0	Opportunity to be part of a joint development, would provide community-based services and supported residential accommodation. The inclusion of Extra Care Housing on the site allows for a model of longer term prevention to be incorporated into the project. Aligns with STP objectives and vision
2	Shawbirch Primary Care Centre	£675	TBC	£0	Capital required for new build

Both these projects will enable the STP vision to be delivered. Whitchurch, in particular, is a whole system project, bringing together multiple funding resources and delivering a multitude of services to the people of Whitchurch.



## B4. Prioritisation - Supporting Narrative

Prioritisation Process – An Evaluation Panel comprised of seven representatives from across the STP assessed and ranked each of the submitted projects

Each member of the panel read and independently scored each submission using the scoring matrix and weighting (below). Scores were collated, discussed and minor adjustments to final ranking based on discussion, with all panel members in full agreement.

Scoring Category	Scoring Definition	Score Range
Unacceptable	No response to the evaluation criteria or has not provided any information about how the criteria will be met.	0
Poor	Has made some reference but with no supporting knowledge evidence or only partially addresses the criteria.	1
Good	An acceptable response in terms of the level of detail and relevance. The response is good but there are either some omissions of important issues or negative indications that reduce the extent to which the proposal will be achieved.	2
Excellent	A more than comprehensive response in terms of detail and relevance. Clearly meets or exceeds the proposal outcomes with no negative indications.	3

Evaluation Weighting Section	Evaluation Weighting Criteria	Weighting %
1	Project Acceptance Criteria	Pass/Fail
2	Leadership and Capability	10%
3	Demand Management	10%
4	Transformation, Patient Benefit, and Workforce Benefits	20%
5	Estate Infrastructure	20%
6	Financial Appraisal	40%
		100%

The results from this evaluation panel were then scrutinised and discussed at a subsequent prioritisation meeting of five ST&W organisation representatives, comprising Directors of Finance and the STP Programme Director.

They selected two prioritised projects which we will support for national consideration in the Wave 4 funding round. Their decision was based on strategic STP priorities, maturity and stage of each project and readiness for producing the required Capital Submission and Value for Money (VfM) documentation. The remaining are pipeline projects, to be developed further for consideration under Wave 5/ later funding rounds



## KEY NEXT STEPS

The STP Estates Strategy has initiated key working with: **“ALL SYSTEM PARTNERS”**

Through facilitated workshops, shared conversations recognising system interdependencies, increasing knowledge and understanding of Estates requirements across the system, both now and in the future are developing.

Further workshops are needed to progress specific market town and urban area needs.

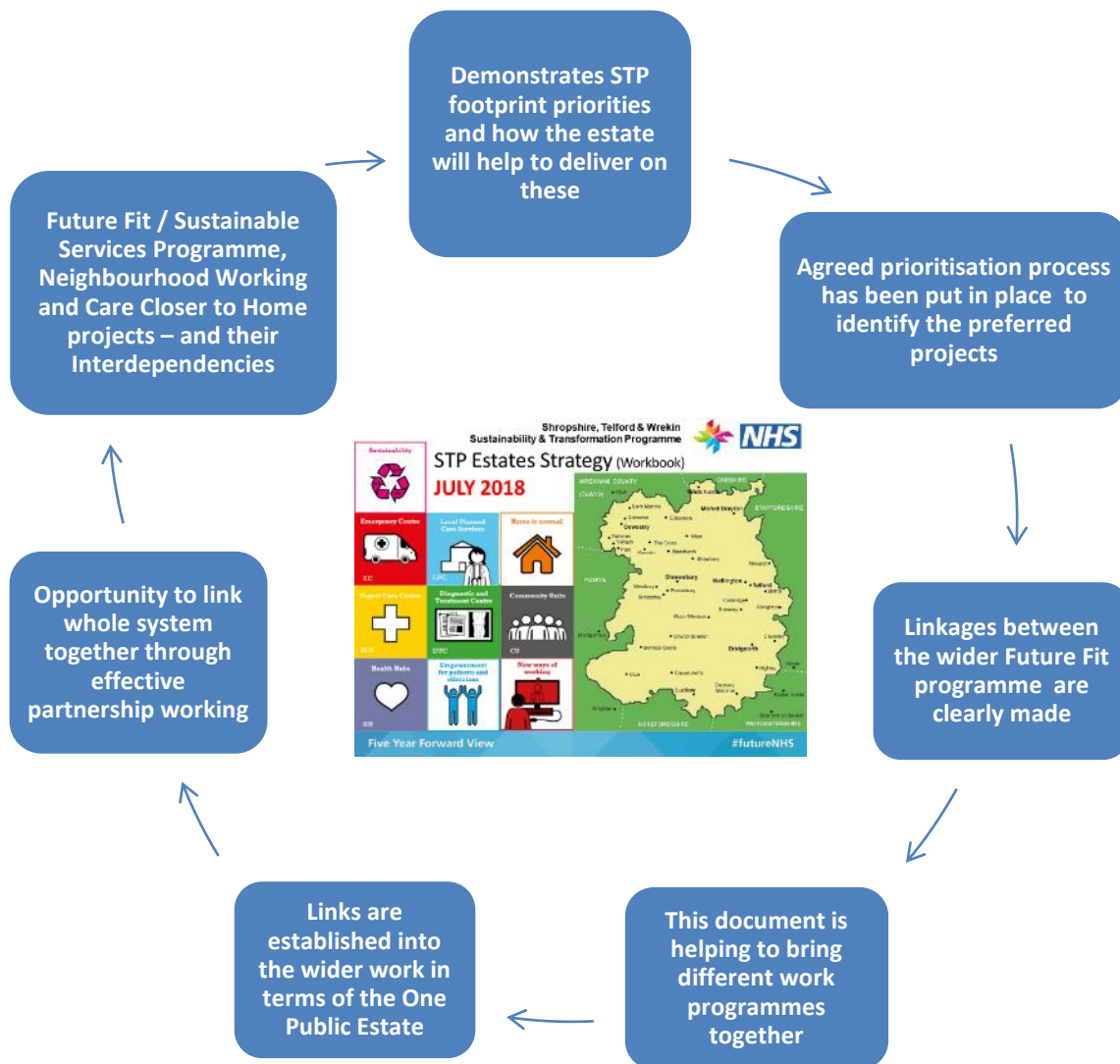
This document provides ‘high-level’ strategic direction for our STP Estates, it is looking at the bigger picture and understanding the wider implications of organisational decisions....

This now needs to develop into a more detailed document which will pull together Estate Strategies for each of our key individual organisations into a whole system estate strategy.

The outcome and final decisions relating to the Future Fit Programme will be a major determinate in our next steps plans .

Care closer to home and neighbour working are essential to Future Fit DMBC

## Summary





## B5. STP lead Sign Off

I confirm that we have discussed and prioritised our capital projects at an STP level, and the tables in Section B reflect this discussion.

This is the current view of the STP . [This remains a [draft] strategy subject to further work and engagement.]

STP lead signature

Date:

13 Jul 2018

STP lead name Phil Evans

STP lead organisation / address details

Shropshire Telford & Wrekin Sustainability & Transformation  
Partnership, Room GN 75,  
Shirehall, Abbey Foregate,  
Shrewsbury  
SY2 6ND



# Annexes

## **Annex 1: - STP Estates Data Summary and Sources**

- Data Summary and Sources
- Estates Composition

## **Annex 2: - STP – Internal Organisation Responsible for Funding**

- Appendix to Section B
- Summary of Transformation by Sector

## **Annex 3: - Supplementary Information about Our STP**

## **Annex 4: - STP Estates Directory**

- Joint STP Local Estates Forum & One Public Estate Delivery Group Membership
- Summary

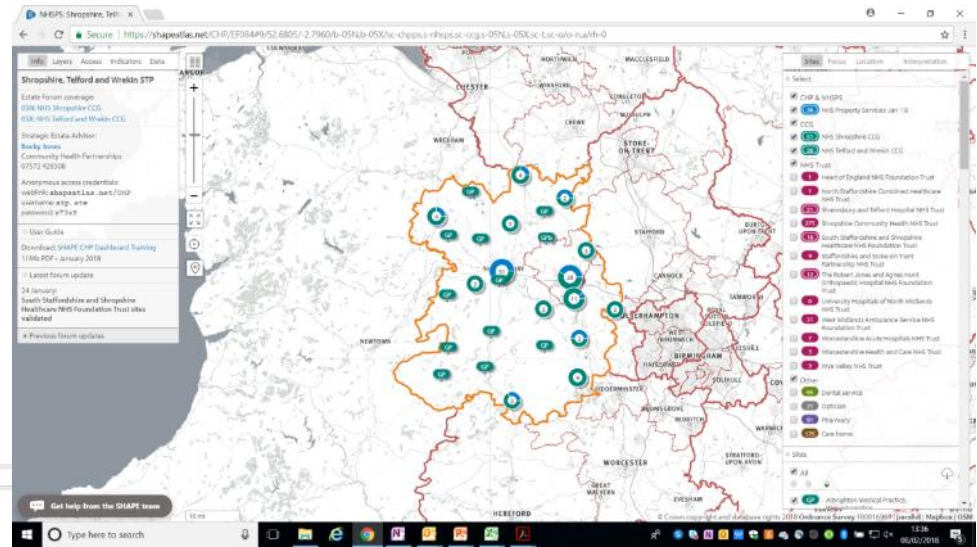




# Annex 1:

# STP Estates Data Summary and Sources

Validation & updates to SHAPE data



ERIC data 16/17 Updated figures due early 2018

hscic.gov.uk/ERIC.asp

**NHS Digital**

Hospital Estates and Facilities Statistics

Home | ERIC | PLACE

Home > ERIC

**ERIC**

The ERIC (Estates Return Information Collection) is collected and published here by the HSCIC on behalf of the Department of Health. It is the main central data collection for estates and facilities services from the NHS containing information dating back to 1999/2000 and will be added to as future returns are completed. The data provided enables the analysis of Estates & Facilities information from NHS Trusts and PCTs in England which is a compulsory requirement that NHS Trusts submit an Estates Return. The data is as provided by reporting organisations and has not been amended. The accuracy and completeness is the responsibility of the reporting organisations.

You can make specific searches via the Reports tab which allows you to build and filter your own reports on the following areas:

- Year
- Strategic Health Authority
- Organisation Type
- Data levels
- Site Type
- Sections within the return

Standard reports providing the full data set, as returned, at Trust and site level can be downloaded in Excel and CSV format via the Data Files tab. Details of the data items collected for each year can be found under the downloads section on the right hand side of the page.

**Important - please note:** Following a detailed data quality study we are currently in the process of re-collecting from sites the costs data part of the 2016/17 ERIC return, along with associated measures for unit cost calculations.

This means that figures in the reports are subject to change. We will publish the new figures in early 2018, as soon as they are available. Data users are advised to bear this in mind and to treat these figures with caution in the meantime. We apologise for any inconvenience this may cause.

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# Estates Composition (1 of 3)

## Portfolio Summary

Portfolio	No. Properties	Footprint Size (Ha)	Size GIA (sqm)	Percentage Tenure split Freehold / Leasehold	Estate Running costs pa (£m) (rent, s'charge, FM)	Back-log Maintenance £m
* Significant changes from Oct 16						
GP owned	77*	0.00	31,171 (NIA)	45/23 (9 unknown) [66%/34% of known]	£6.46m	£0.00m
NHS PS	36	0.00	24,449 – from 35 premises	13/23 [28%/72%]	£5.24m – from 25 premises	£2.26m – from 17 premises
CHP	10	0.00	17,932	100% Leasehold	£7.81m	£0.00m
Provider estate	22	189.85	151,870		£27.63m	£61.57m
Mental Health Trusts	18*	5.05 – from 5 premises	20,838 - from 8 premises	3/9/ (6 unknown) [25%/75%] of known	£2.45m from 8 premises	£0.15m from 4 premises
Community Providers	91	4.60 – from 3 premises	961 – from 3 premises	5/32/54 (other) (5%/35%/60%)	£2.73m	£1.30m
Other	n/a	10.39	42,197		£8.68m	£0.65m
<b>Totals</b>	<b>254</b>	<b>209.99</b>	<b>289,418</b>		<b>£61.00m</b>	<b>£65.93m</b>

## Functional Use Summary

Functional Uses	No. Properties	Footprint Size (Ha)	Size GIA (sqm)	Percentage Tenure split Freehold / Leasehold	Estate Running costs pa (£m)	Back-log Maintenance £m
Clinical/clinical support	Under review (410 – subject to clarification – assumed all not BO and Other)		153,086 (from 31 entries)	52/46 (53%/47%) from 98 entries	£44.6m – subject to further review	£96.6m – subject to further review
Back Office (self contained unit)	Under review (21)		12,368	10/11 (48%/52%)	£1.9m (from 11 entries)	£604k from 4 entries)
Other (eg w'house or workshop)	Under review (6)		1,872	100% Leasehold	£189k	£443k
<b>Totals</b>			<b>167,326</b>			



## Estates Composition (2 of 3)

### High Cost Sites: Estate Running Costs

Highest Cost Sites	Footprint Size (Ha)	Size GIA (sqm)	Freehold/Leasehold	Estate Running costs pa (£m)	Back-log Maintenance (net) £k	Cost per sqm	Current Site Strategy
Royal Shrewsbury Hospital	18.30	68,425	Freehold	<b>£11.3m</b>	£45,720	£166	Under Review
Princess Royal Hospital	12.40	48,153	Freehold	<b>£8.4m</b>	£9,157	£175	Under Review
RJAH	13.2	35,292	Freehold	<b>£7.9m</b>	£6,694	£223	Under Review
The Redwood Centre	4.30	11,754	Freehold	<b>£2.4m</b>	£45	£204	Under Review
Ludlow Hospital	1.23	4,832	Leasehold	<b>£0.9m</b>		£189	Under Review

### Highest Cost Locations : Backlog Maintenance

Highest Cost Sites	Footprint Size (Ha)	Size GIA (sqm)	Freehold/Leasehold	Estate Running costs pa (£m)	Back-log Maintenance (net) £k	Cost per sqm	Current Site Strategy
Royal Shrewsbury Hospital	18.30	68,425	Freehold	£11.3m	<b>£45,720</b>	£668	Under Review
Princess Royal Hospital	12.40	48,153	Freehold	£8.4m	<b>£9,157</b>	£190	Under Review
RJAH	13.2	35,292	Freehold	£7.0m	<b>£6,694</b>	£190	Under Review
Whitchurch Community Hospital		3,672	Freehold	£0.6m	<b>£705</b>	£192	
Bridgnorth Hospital		5,001	Freehold	£0.7m	<b>£470</b>	£94	Under Review



## Estates Composition (3 of 3)

### PFI and LIFT Utilisation – Nil for this STP

Highest Cost Sites	Footprint Size (Ha)	Size GIA (sqm)	Estimated Utilisation (%)	Estate Running costs pa (£m)	Cost per sqm (GIA)	Proposed STP Site Strategy	Actions taken to address under-utilised space

No current PFI or LIFT agreements identified



## Annex 2 (Appendix to Section B)

### STP – Internal Organisation Responsible for Funding

Where FUNDING SOURCE is **NOT** STP Capital Funding – for information ONLY i.e. n/a to prioritisation process

RJAH - NHS Funded 5 Year Capital Programme						
Funding Source	Project / Criteria	Sum of 2018/19 £000	Sum of 2019/20 £000	Sum of 2020/21 £000	Sum of 2021/22 £000	Sum of 2022/23 £000
Trust	CT Scanner replacement infrastructure works	400				
	TSSU Solution	600				
	Barns (Theatre) provision & plant work		100	750	750	
	Electronic Prescribing and Medicines Administration (EPMA)	50				
	MRI		400			
	Beds (New Replacement)		132			
	SOOS / MSK hub					
	New IT network	200	200			
	Outpatients / X-ray reconfiguration				250	500
	Xray rooms x2		180	350		
	Ultrasound room			50		
	Healthcare Records Building (building 2) - Improvements to working enviroment	50				
	Integrated IT system – Clinical outcomes				100	
	IT Cabin removal					
	Private patients - Ludlow refurbishment	100	100			
	Powys / Clwyd refurbishment					300
	Old Orthotics w/shop site (car park)					
	Robot pharmacy dispensing					0
	Healthcare Records Building (building 2) - reprovision of accomodation					500
	Bed Capacity Solution - Subject to business case	0				
	ORLAU capacity - Subject to business case	0				
	Project Management / Implementation Support	100	100	100	100	100
	Estates Backlog	300	300	300	300	300
	IT Investment/replacement	300	300	300	300	300
	Equipment and minor works investment/replacement	400	400	400	400	400
	Contingency	300	300	300	300	300
Trust Total		2,800	2,512	2,550	2,500	2,700



## Annex 2 (Appendix to Section B) STP – Internal Organisation Responsible for Funding

Where FUNDING SOURCE is **NOT** STP Capital Funding – for information ONLY i.e. n/a to prioritisation process

The Shrewsbury and Telford Hospital NHS Trust							Paper 6
5 Year Capital Programme 2017/18 to 2021/22 - Draft 4							
Capital Planning Group Meeting - 8th March 2018		<b>REVISED PROPOSAL</b>					
		2018/19	2019/20	2020/21	2021/22	2022/23	
		£000	£000	£000	£000	£000	
<b>Funding Available: Internally Generated Capital Resource Limit (CRL)</b>		8,450	8,450	8,450	8,450	8,450	
<b>Pre-Commitments</b>							
Schemes carried forward from old year		200	200	200	200	200	
Ophthalmology move into Copthorne Building - Phase 3		1,166					
PC In House costs of delivery of schemes		820	820	820	820	820	
Replacement Linac/CT Scanner (ref Lingen Davies Grant)		1,800	0	0	0	0	
RSH MLU/PAU - P2 FCHS		100	1,500	3,400	0	0	
Subway Duct - RSH (further phases following on from 2017/18 agreement)		200	950	700			
<b>Total of Pre-Commitments</b>		<b>4,286</b>	<b>3,470</b>	<b>5,120</b>	<b>1,020</b>	<b>1,020</b>	





## Annex 2 (Appendix to Section B) STP – Internal Organisation Responsible for Funding

Where FUNDING SOURCE is **NOT** STP Capital Funding – for information ONLY i.e. n/a to prioritisation process

The Shrewsbury and Telford Hospital NHS Trust						Paper 6
5 Year Capital Programme 2017/18 to 2021/22 - Draft 4						
Capital Planning Group Meeting - 8th March 2018						Continued
	REVISED PROPOSAL					
<b>BUDGET REMAINING FOR ALLOCATION</b>	<b>4,164</b>	<b>4,980</b>	<b>3,330</b>	<b>7,430</b>	<b>7,430</b>	
<b>Contingency Funds</b>						
Estates Contingency	250	250	250	250	250	
Medical Equipment	250	250	250	250	250	
Information Technology	250	250	250	250	250	
Non Patient Connected Equipment Replacement Fund	50	50	50	50	50	
VitalPAC/PSAG Replacement Fund	100	100	100	100	100	
Support Services Care Group Equipment Contingency/Replacement Priority 1	100	100	100	100	100	
Facilities Equipment Replacement Priority 1	50	50	50	50	50	
Patient Environment (inc Furniture) Contingency Replacement Priority 1	50	50	50	50	50	
In Year Allocations/Corporate Contingency	2,200	2,200	2,200	2,200	2,200	
<b>Total of Contingency Funds</b>	<b>3,300</b>	<b>3,300</b>	<b>3,300</b>	<b>3,300</b>	<b>3,300</b>	
<b>BUDGET REMAINING FOR ALLOCATION</b>	<b>864</b>	<b>1,680</b>	<b>30</b>	<b>4,130</b>	<b>4,130</b>	
<b>Departmental Priority 1 Schemes:</b>						
Estates Risks Priority 1: Asbestos	145	1,680	30	4,130	4,130	
Estates Risks Priority 1: Fire ( Potential Enforcement Notice)	200					
Estates Risks Priority 1: Ward refurbishment works whilst wards decanted for fire safety works	100					
Estates Risks Rated Priority 1: Roadways/pathways/external lighting	79					
Medical Equipment Replacement Priority 1	170					
IT Replacement Priority 1	170					
Radiology Replacement Priority 1 (revenue solution to be explored)						
<b>Total Priority 1 Schemes</b>	<b>864</b>	<b>1,680</b>	<b>30</b>	<b>4,130</b>	<b>4,130</b>	
<b>Surplus/(deficit) after above</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	



## Summary of transformation by sector

Model	Secondary	Community	Primary	Admin
<b>ESTATE TO REDUCE / DISPOSE</b>	MPFT (when still SSSFT) rationalisation projects release 5 sites for disposal – However, these will be recorded against Staffs STP, as their primary STP	Community bed requirements, post Future Fit outcome have potential for alteration pending configuration of community hospital provision	Some premises may be changed and replaced due to change in services. Including the potential merger of GP practices.	Administrative service utilisation of estate requires full review, outcomes of which have potential estate impacts
<b>ESTATE TO INCREASE (by 2020/21)</b>	The development of two urgent care centres at the existing two hospital sites. <i>Potential</i> development of a rehabilitation centre and Veterans Centre at RJAH.	Develop community hubs based on community need	Develop community hubs based on community need	Shirehall public sector hub development has potential to provide opportunities for changes in utilisation of estate for administrative services
<b>ESTATE TO OPTIMISE</b>	Princess Royal and Royal Shrewsbury Hospitals, depending on outcome of consultation	Understand vacant space across the ST&W STP area in order to identify opportunities for re- uses of existing space.	Programme of transformation being carried out, based on community need will identify possible opportunities	CCG and other administrative service functions will consider moving out of spaces which can be converted for clinical use



## Annex 3 – supplementary information about our STP

*Future Fit was set up in 2013 in response to the Government's 'Call to Action' which asked NHS staff, patients, the public and politicians to come together and agree what changes are needed to make our local NHS services fit for the future. Led by doctors, nurses and other healthcare staff, many members of the public across the county have been involved and since taken an active part in the design and development of the proposed model of hospital care.*

*Two Integrated Impact Assessments have assessed the potential impact and equality effects of proposed changes and taken into account as part of the CCGs process in considering and deciding upon the preferred option.*

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**Public consultation on the two options commenced 30 May 2018 for a 14 week period**  
**The outcome of this consultation will determine details of capital spend, including the £312m approved in Wave 3**

The acute hospital service elements of the Future Fit Programme internally at SaTH are now referred to as the **Sustainable Services Group (SSG)**

The **following five slides** provide an overview of the Future Fit Programme and Inter-dependencies



# Annex 3 – supplementary information about our STP

## Trying to Solve:

### Workforce Challenges

- Duplicate services on two sites presenting many workforce challenges including;
- teams spread so thinly services are vulnerable to unexpected absences and non-availability of staff
- challenging recruitment environment, difficulties recruiting the right substantive workforce to provide high quality safe care
- cost pressures for premium rate working, poor economies of scale and duplication of rotas
- Ageing workforce profile

### Condition of the existing estate

As recorded in detailed 6 Facet estates surveys undertaken in 2015/16, significant amounts of the existing SaTH estate did not achieve 'condition B' (satisfactory standard); and a substantial number of areas were 'condition D' (life expired/unacceptable)

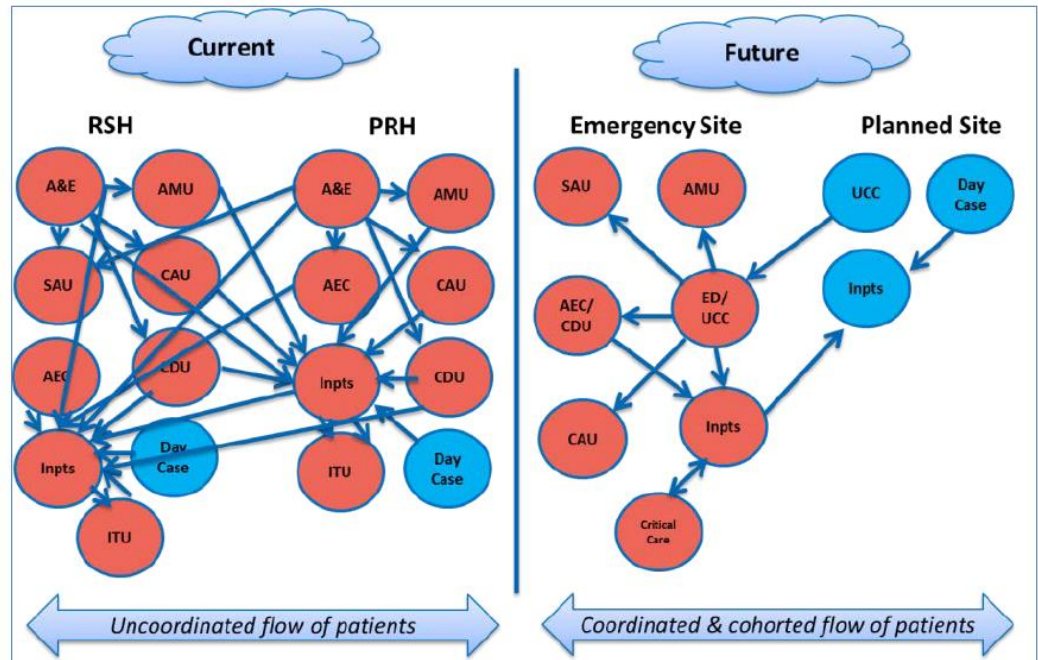
## 'Future Fit'

### Reconfiguration of acute hospital service sites (1 of 5)

A balanced-site care model whereby patients would:

- Receive acute medical care within the Emergency Site;
- Benefit from planned care with defined separation from emergency care pathways;
- Benefit from improvements in emerging shared pathways between all providers.

This leads to an improved flow of patients, as shown in the diagram below:





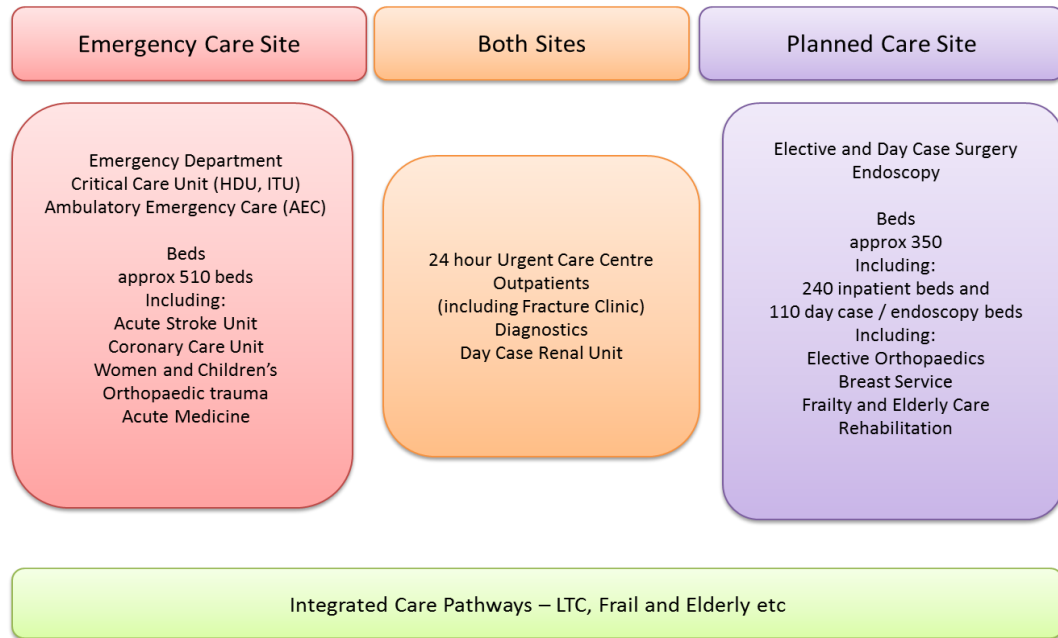
# Annex 3 – supplementary information about our STP

## ‘Future Fit’

### Reconfiguration acute hospital service sites (2 of 5)

11 neighbourhoods within Shropshire and four in Telford and Wrekin, which will be used to provide a range of services at a local level for people who need the support of primary care professionals such as GPs, social workers, community nurses, therapists and mental health workers.

New ways of working and system transformation including these Neighbourhood Care Teams will result in fewer people needing acute hospital care, and those who do would be discharged quicker.



- Future Fit identified the need to have a single ED, single CCU model
- SaTH further developed this model based on essential clinical adjacencies
- This resulted in the development of two vibrant hospital sites that splits the provision of routine planned and emergency care

NB. Inpatient bed base does not include Neonatology and Critical Care numbers





# Annex 3 – supplementary information about our STP

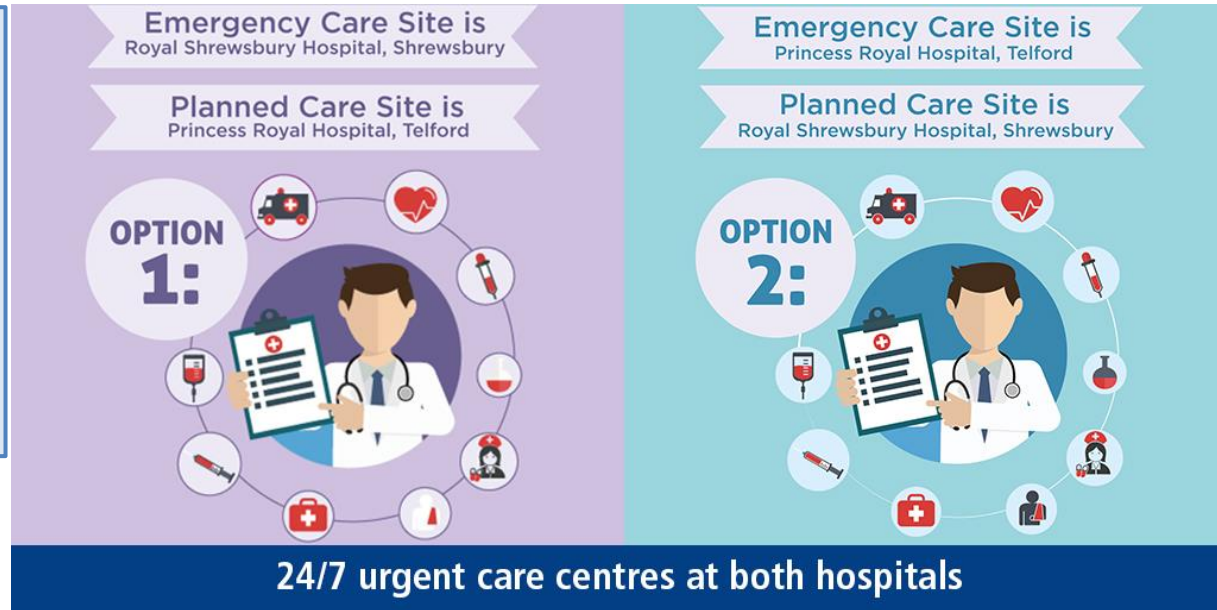
## ‘Future Fit’ Reconfiguration of acute hospital service sites (3 of 5)

The programme proposes the creation of one new fully-staffed and equipped Emergency Department, site depending on outcome of consultation. Planned care site would be on the site which does not have the Emergency Centre.

### At Both Sites:

- 24-hour Urgent Care Centre
- Adult and children’s outpatient services
- Day Case Renal Unit
- Tests (diagnostics)
- Midwife-led Unit
- Antenatal Day Assessment Unit
- Early Pregnancy Assessment Service (EPAS)
- Maternity outpatients and scanning

Option 1 is the CCGs’ preferred option, it offers the best value for money over the long term.



We have ageing buildings across our two hospitals with some in Shrewsbury dating back to the 1960s. We recognise that, in order to continue to have two vibrant hospitals, we need to invest in our buildings. A survey on the condition of the buildings at each site showed that a significant amount did not meet satisfactory standards and a substantial number of areas were found to be unacceptable, particularly at Shrewsbury. In the overall economic analysis of the options, which combines the result of the non-financial and financial appraisal, it is estimated that Option 1 would offer the best value for money over the long term.





# Annex 3 – supplementary information about our STP

## 'Future Fit' Reconfiguration of acute hospital service sites (4 of 5)

Funding will follow the patient to ensure that resource is in the optimal delivery setting



Figure 16: End to End Pathway



# Annex 3 – supplementary information about our STP

## ‘Future Fit’

### Reconfiguration of acute hospital service sites (5 of 5)

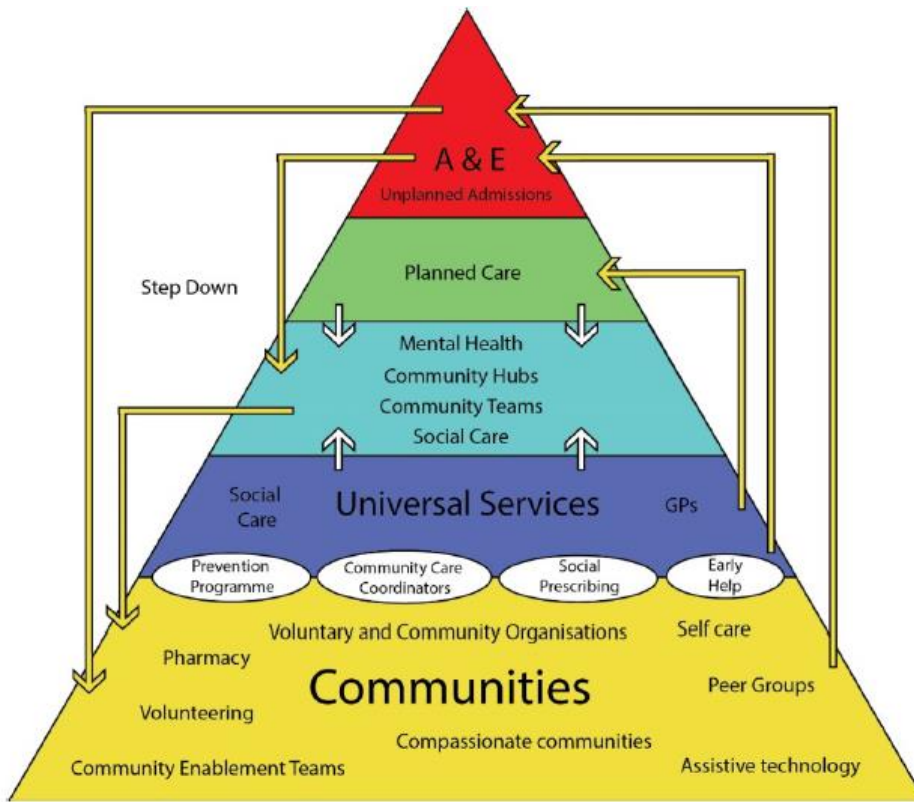


Figure 13: Shropshire Neighbourhood model of care

Interdependent and critical to the success of the acute hospital reconfiguration aspect of the Future Fit programme are parallel transformational change developments in:

- Neighbourhood care services
- Aligned workforce
- Promoting health & well-being
- Prevention
- Enhanced use of technology
- New ways of working
- Caring for Finances

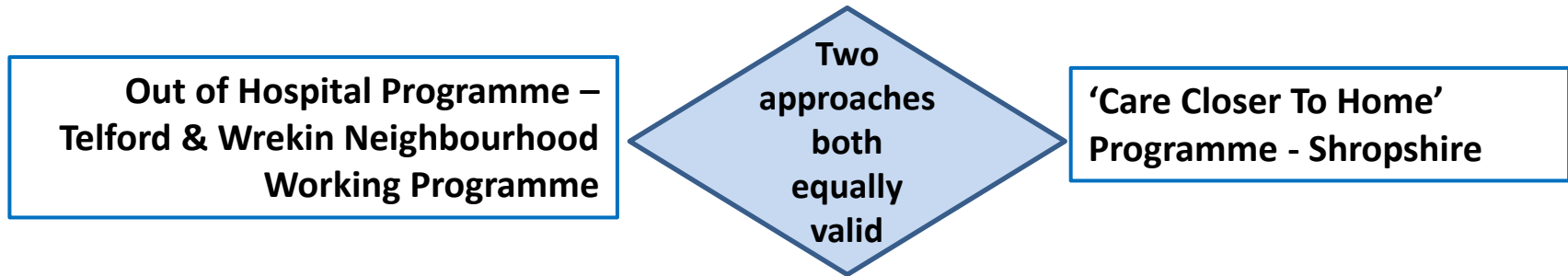
*An overview of these is provided in the following slides:-*



## Annex 3 – supplementary information about our STP

Interdependent and Critical to the success of Future Fit is our approach to specific community needs, recognising the Locality & Geographical variations in our footprint; urban vs rural, historical health configurations, experiences, change readiness states and associated complexities, with the resultant emergence of two approaches

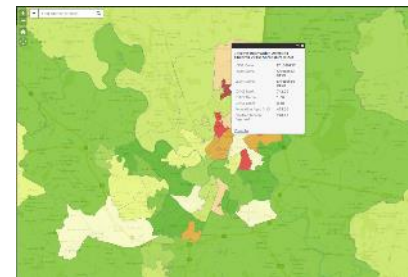
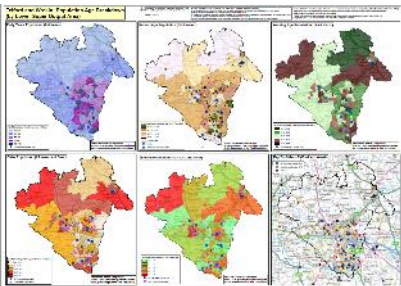
'Out of Hospital Programme' -Telford & Wrekin and 'Care Closer to Home' - Shropshire



Both approaches are using evidence-based best practice, analysis of data, and collaborative workshops facilitating whole system partner participation and engagement to inform transformation of services to meet people/patient needs, achieve capacity, capability and affordability

The short, medium and long-term impacts associated with these approaches must inform estate needs.

Whilst not yet explicitly understood, as an enabling component 'estate' is integral in these developments

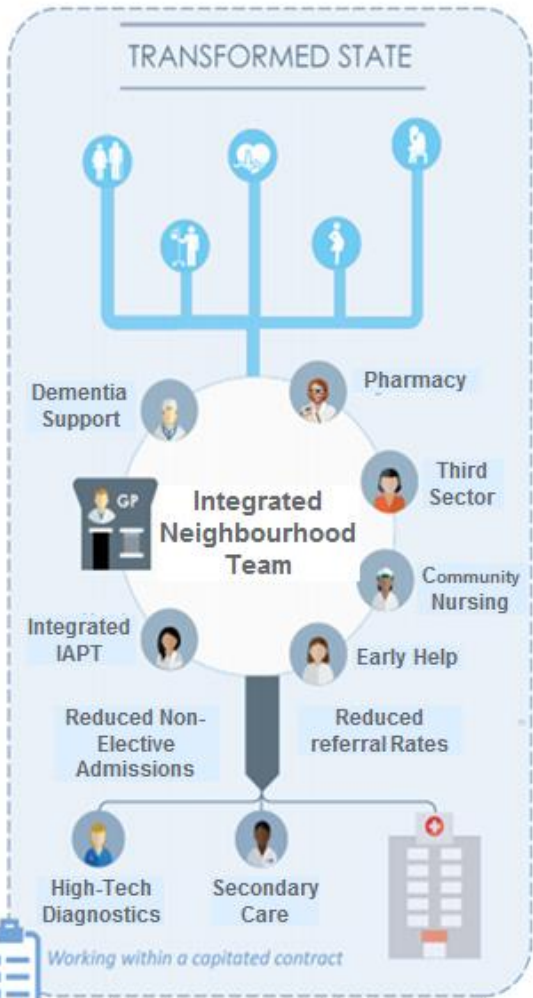




# Annex 3 – supplementary information about our STP

## Out of Hospital Programme – Telford & Wrekin Neighbourhood Working Programme

“So what for estates?”



- One team
- Estates planning integral
- Risk stratification
- Reduce social isolation
- Strengthen primary care
- Early help & support teams
- Direct care in the community
- Staff alignment around neighbourhoods
- Reduce dependency on statutory services
- Promoting community resilience
- Encouraging healthy lifestyles
- Communications and engagement

### 'Integral to Future Fit'

- Services & Activities will be closer to home
  - Community hubs / joint use of space / fit for purpose
  - Non-elective hospital admission reductions
  - Reduction of non-elective admissions from care homes
  - Reduced length of stay for intermediate care beds
  - Reduced spend on care home placements
- All above link with Sustainable Services Programme (SSP)
- Well connected services & communities
  - Supported with technology (local digital roadmap)
  - Better use of void / shared / bookable space
  - Rationalisation in non NHS/public owned estate

Stakeholder estate planning and service priority workshop being arranged for late Summer 18

Outcomes will support future estate requirement type to deliver out of hospital offers

Adapted from: <http://www.napc.co.uk/primary-care-home>





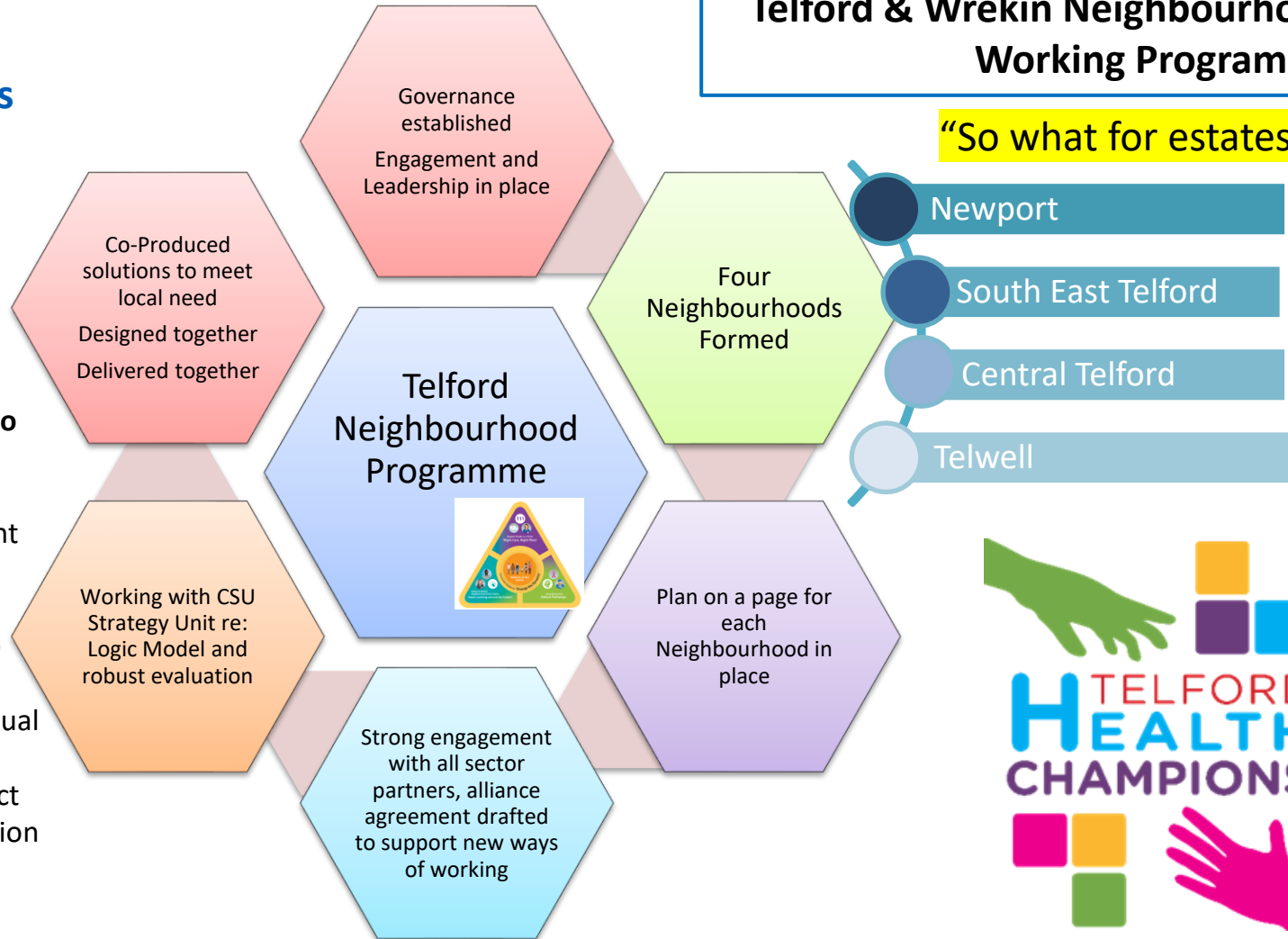
# Annex 3 – supplementary information about our STP

**Out of Hospital Programme –  
Telford & Wrekin Neighbourhood  
Working Programme**

## Telford Neighbourhoods – how it all fits together – delivering transformation

### Case Study Examples to showcase progress

- Diabetes Management
- Hypertension Management
- Mental Health Hub branches
- Citizens Advice – virtual team
- Wound healing project
- Community information portal
- Health Champions





# Annex 3 – supplementary information about our STP

## Out of Hospital Programme – Telford & Wrekin Neighbourhood Working Programme



### “So what for Estates?”

Ensure suitable estates enable delivery, maximising use of current resources, better partnering to reduce vacant & void space, increase suitable sharing opportunities, identify refurbishment, redevelopment & disposal opportunities, in addition to the development of new facilities to support the delivery of neighbourhood working



NHS and LA keen to work on potential shared space to support collaborative working – seeking out such opportunities







# Annex 3 – supplementary information about our STP

## Shropshire's 'Care Closer To Home' Programme



**Estates Impact & Enabler:**

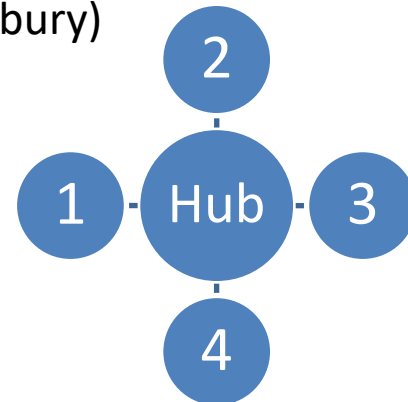
**Hubs** – designed to house Extended Primary Care, Community Services, Social Care, Community Workforce

**Spokes** – Core GP and Practice Nurse services. Utilising existing estate but with a requirement for some review and modernisation

“So what for estates?”

Only by offering patients (and staff) a new and different alternative to the current service model, **working as a system/community** which comprises effective, tailor-made care package of care, will it be possible to reduce the burden on the NHS of repeated acute admissions and overall bed days.

Hub and spoke model centred on major Market Towns – potentially 6-7 hubs (plus Shrewsbury)



### Primary Care at Scale

30 -50,000 patients is likely to be the mandated size of primary care networks

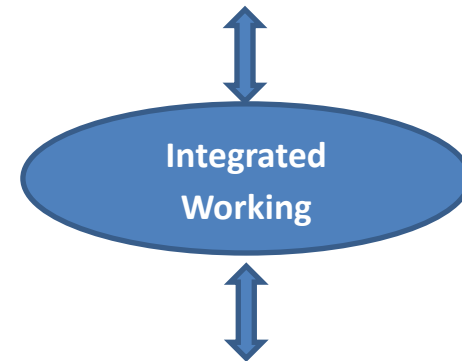


## Annex 3 – supplementary information about our STP

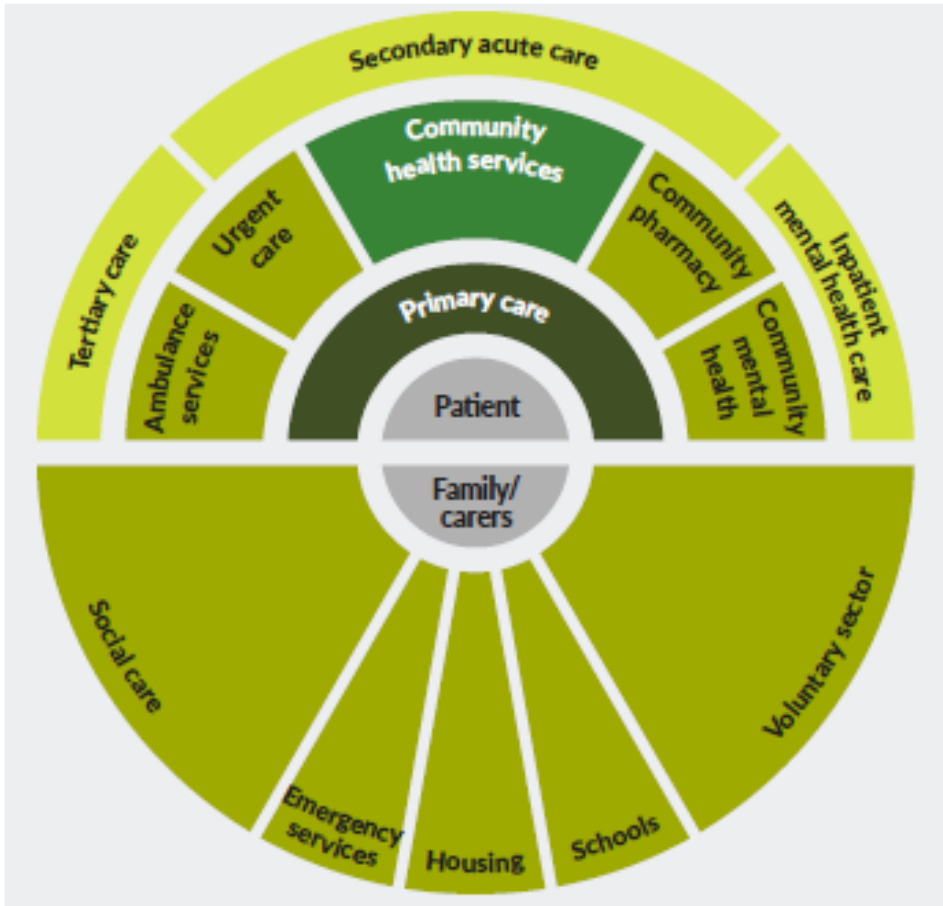
### Shropshire 'Care Closer To Home' Programme

“So what for estates?”

Multi-disciplinary teams (within General Practice – GPs, Advanced Nurse Practitioners, Pharmacists, Physios, Mental Health nurses, Practice Nurses, Health Care Assistants, Community Care Co-ordinators)



Links to Shropshire Care Closer to Home workforce - built around general practices with a core Locality Team including district nurses, care co-ordinators, allied health professionals, social care and matrons.






# Annex 3 – supplementary information about our STP


## Shropshire 'Care Closer To Home' Programme

### Transforming Community Services Across Shropshire



**Phase 1 Frailty Front door (presently operational)**

A dedicated Multi-Disciplinary Team (MDT) based in the Emergency Department who are responsible for the early identification, treatment, risk assessment and planning for frail and long term condition patients. This improvement will facilitate appropriate triage of patients to either the acute/community/home setting. This team will liaise and work with existing teams in the community such as intermediate care and Care Co-ordinators etc. DAART is a key focus for this process in terms of linking into existing acute frailty expertise, resources and skills, providing a responsive ambulatory care function.




**Phase 2 Primary Care Development including Local Enhanced Services & Case Management**

including Local Enhanced Services and Case Management (Collaborative design by March 2018 – Risk stratification to commence as soon as possible)

Potential to be built around general practices with a core Locality Team including district nurses, care co-ordinators, allied health professionals, social care and matrons. This element of the service will identify the case management cohort of service users, develop personalised care plans, provide the day to day care and support including wider services as necessary. For stable service users this will be the default range of services. It will provide a named lead for each service user to generate emergency care plans and to design the escalation services necessary to manage any exacerbation. The community matrons are key in the education and competence building of wider staff.

“So what for estates?”



**Phase 3 Hospital at Home/Crisis Intervention/Rapid Response/DAART and Step Up Community Beds (Collaborative design by June 2018)**

Where care needs escalate beyond the core teams, service users will move into a Hospital at Home element of the service. This will incorporate the step-up element of the intermediate care team and community beds with an enhancement to medical cover arrangements (which could include in-reach from acute consultants or alternative medical governance models) and access to IV Antibiotics etc. within the community. The specialist frailty and long term conditions teams will be part of this element of the service, both in terms of care delivery to manage exacerbations and also in an educational role to cascade skills into the core teams. A rapid response team will be established to enable intervention at pace across the Hospital at Home and Crisis functions. This team will make full use of the re-specified DAART and community bed provision.



# Annex 3 – supplementary information about our STP

Increased access and service delivery of Musculoskeletal Services needed from Community Hubs, Community Hospitals, Primary Care, Voluntary Community Sector Facilities ...

**Community-Based Musculoskeletal (MSK) service provision**

“So what for estates?”

**maximising joint use of space / ensuring fit for purpose**

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Proud to have in our county ‘RJAH’ as a world renowned specialist orthopaedic hospital ... supporting development of its community-based Shropshire Orthopaedic Outreach Service (SOOS) ...  
Estates to enable clinic locations closer to patients homes

## What do we think will make a difference?



- \* Enhancing the Shropshire Orthopaedic Outreach Service (SOOS)
- \* Offer more access to treatments like physiotherapy, psychological therapies, walking aids and weight management



- \* To reduce the number of people having hip and knee replacements, until surgery becomes the best option
- \* To ensure our money is spent on the most beneficial services for patients.

Integrated MSK Service model

Community Physiotherapy	Single Point of Access		Self-Management Fitness and Rehab	
	Clinical Assessment, Triage & Treatment Service (SOOS)			
Podiatry	OT	Secondary Care	Rheumatology	Pain Management

RJAH plans to raise an initial £1million to build a dedicated Veterans Orthopaedic Centre, that will be the first of its kind in the UK



## Shropshire and Telford and Wrekin

ACS: No

## NHSE Dashboard development - April 18 Data

Providers with a type 1 A&E site within the STP footprint



### Finance

	%	Value (£m)	Rank (x/44)	Provider /commissioner
Q2 2017/18 CCG difference to operating plan	-	-	-	Commissioner
Q2 2017/18 NHS provider difference to operating plan	-	-	-	Provider
<b>Q2 2017/18 STP difference to operating plan</b>	-	-	-	<b>Both</b>
The distance from target funding (%)	-2.51%	N/A	39	Commissioner
Estates: cost to eradicate backlog	N/A	£61.0	19	Provider

Source: NHS Improvement and NHS England

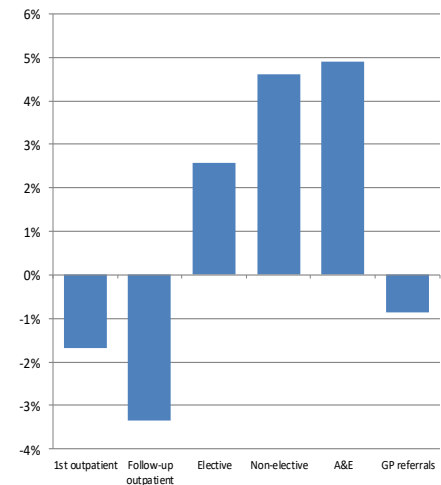
### Performance

◆ STP value

Domain	Indicator (NT = national target, EV = England Value, UQ = upper quartile)	Value	Box plot	Date	Derivation	Provider /commissioner
Hospital performance	A&E (NT=95%)	79%		Mar-18 YTD	Proportion	Provider to commissioner, then to STP
	RTT (NT=92%)	90%		Feb-18		
Patient-focused change	Primary care	Extended access to GP appointments (EV = 51.6%; UQ = 72.3%)	50%		Oct-17	Commissioner
		Overall satisfaction (EV = 84.8%; UQ = 86.7%)	86%		2017	
	Mental health	IAPT recovery rate (NT=50%)	56%		Oct-17 to Dec-17	
		Early intervention for psychosis (NT=50%)	36%		Mar-17 to Feb-18	
	Cancer	Early diagnosis (EV = 52.6%; UQ = 54.6%)	50%		2016	
		Seen within 2 weeks (NT=93%)	93%		17-18 Q3 YTD	
Transformation (source for emergency admissions is SUS data)	A&E attendances per 100,000 (EV = 36245; UQ = 36734)	26,628		Mar-17 to Feb-18	Rate standardised by deprivation, age and sex	
	Emergency admissions per 100,000 (EV = 99; UQ = 107)	92		Mar-17 to Feb-18	Rate standardised by age and sex	
	Emergency bed days per 100,000 (EV = 491; UQ = 536)	414		Mar-17 to Feb-18	Rate standardised by deprivation, age and sex	
	GP referrals per 100,000 (EV = 21421; UQ = 22462)	17,069		Mar-17 to Feb-18	Unstandardised rate	
	DTOC per 100,000 population (EV = 0; UQ = 193)	96		Mar-17 to Feb-18	Unstandardised rate	

Providers in special measures (source: NHS Improvement)	No		Apr-18	Number in special measures	Providers attributed to lead commissioner
---	----	--	--------	----------------------------	---

### Activity



■ Year to date growth, Month 10 17/18

Source: CCG Improvement and Assessment Framework unless otherwise stated. Indicators with \* are benchmarked vs. national standards

Source: NHS England (SUS and CCG operational plans)

**This dashboard** is being used to monitor and inform continuous improvement programmes across our STP.

Focus is on a more coherent system strategy with place-based delivery focusing on person and place rather than organisation and condition.

It is well understood that projected growth and demand is unsustainable. People are already having poor experiences of health and care, including waiting a long time to be referred for treatment, long waits in A&E departments and the pressure on community and mental health services is mounting.





## Annex 3 – supplementary information about our STP

### 1. **Whitchurch Integrated Health Hub.**

Project manager appointed, funded from OPE monies secured through a successful Shropshire Council bid. The general concept is of a joined-up development that incorporates a primary care centre, community hub and retirement living.

- The need to develop multi-use spaces that could be used by a range of providers and the incorporation of new technologies that will assist with delivering a better range of services than those that currently exist whilst at the same time reducing the cost of delivery has been identified.
- The co-location of modern, high quality GP services within an Enhanced Primary Care setting, linked to the Shropshire Care Closer to Home project, will enable the delivery of a much wider range of integrated services, delivered across a range of health professionals, allowing the delivery of an increasing proportion of services from primary care and community services, in a joined-up way.
- The model locates the GPs with a core Locality Team including district nurses, care co-ordinators, allied health professionals, social care and matrons.
- This project will allow the practices to explore and implement the option of ‘social prescribing’ and alternative therapies that compliment more traditional methods.
- Using the Community Hub as a setting for voluntary services their work will help reduce loneliness, raise the levels of general well-being, encourage fitness activity, facilitate support groups for long term conditions, provide information and sign-posting which all lead to reduced demand on the mainstream health services.
- The inclusion of step up/down facilities, (Adult Social Care led), within the Extra Care, will allow better and faster management of early intervention and/or discharge through to an individual’s home.





## Annex 3 – supplementary information about our STP

### 2. Shawbirch Primary Care Centre

New build project to accommodate anticipated rise in patient population resulting from significant housing development in the area and to provide additional space for out of hospital services as well as enhanced general medical services to the wider population (both across the locality and the CCG as a whole).

- Practice current premises is at full capacity currently with anticipated rise of ~5,000 patients over the next five years.
- Estimated build cost will be around £4.5m. Funded by a combination of STP capital funding and GP funding.
- Most critically the proposal will facilitate improved patient access and support and enable interventions to reduce unplanned emergency admissions. As part of the project, the practice aims to work with other NHS providers (eg Physio First). This will be a significant benefit for patients particularly in reducing travel times to hospital
- The project is deliverable from a site, planning and legal perspective, and will ensure that the practice has a well-designed, modern healthcare facility which meets all the standards required and wherever possible exceeds them. Particular attention has been given to future expansion and flexibility to ensure that the building can adapt as the requirements of health care change.



## Annex 4: STP Estates Directory

### Joint Local Estates Forum & One Public Estate Delivery Groups Membership

Becky Jones, Estates Strategic Adviser, CHP

Caroline Reid-Smith, OPE Programme Manager, Shropshire Council

Maggie Durrant, Programme Manager, Shropshire, Telford & Wrekin Sustainability & Transformation Partnership

Paul Gilmore, Finance Lead, Shropshire, Telford & Wrekin Sustainability & Transformation Partnership

Amanda Alamanos, Primary Care Lead - Shropshire & Telford, NHS England

Tim Smith, Head of Business Enterprise & Commercial Services, Shropshire Council

Darren Francis, Telford & Wrekin CCG,

Martin Foster, Associate Director of Estates, SaTH – (David Thomas, SaTH, John Ellis-Tipton, SaTH, Kate Shaw, SaTH)

Robert Graves, Director of Facilities MPFT, Cliff Jones, MPFT

Sam Tilley, Director of Corporate Affairs, Shropshire CCG,

Steve Ellis, Primary Care Lead Shropshire CCG

Tom Brettell, Better Care Fund Manager, Shropshire CCG

Julie Thornby, Director of Corporate Affairs, Shropshire Community Health Trust

Nick Huband, Associate Director Estates & Facilities RJA, (Mike Bowen, RJA, Phil Davis, RJA)

Richard Dickson, Provider Engagement Programme Lead, DH

Heather Pitchford, NHSE, Elaine Rodgers, NHSE

Carl Hewson, Local Engagement Manager/Regional Advisor, Cabinet Office

Jayne Traverse, Regional Programme Manager, OPE

Phil Brenner, Director PJB Associates UK Ltd (Project Manager-Whitchurch)

Andrew Harding, Strategic Valuation Consultant, Place Partnership (Ian Evans-Fisher, Tracey McIntyre)

Charles Hill, Chief Superintendent, West Mercia Police

Simon Lewis, Head of Estates, West Midlands Ambulance Service

Andy Johnson, Deputy Chief Officer, Shropshire Fire Service


Steve Law, Strategic Asset Manager, Shropshire Council

Paul Partridge, Director of Finance, Shrewsbury Colleges Group

David Cookson, Deputy Head of Service, Probation Service

Dawn Toy, Service Delivery Manager - Regeneration and Investment, Telford & Wrekin Council

## Board of Directors' Meeting 11<sup>th</sup> November 2021

<b>Agenda item</b>	xxx/21			
<b>Report</b>	Estates Plan			
<b>Executive Lead</b>	Executive Director of Finance			
	<b>Link to strategic pillar:</b>		<b>Link to CQC domain:</b>	
	Our patients and community	√	Safe	√
	Our people		Effective	√
	Our service delivery	√	Caring	
	Our partners		Responsive	
	Our governance		Well Led	
	<b>Report recommendations:</b>		<b>Link to BAF / risk:</b>	
	For assurance		BAF 5 / BAF 6	
	For decision / approval	√	<b>Link to risk register:</b>	
	For review / discussion		1075	
	For noting			
	For information			
	For consent			
<b>Presented to:</b>	SaTH Leadership Committee – Transformational 16.9.21 Finance and Performance Assurance Committee 28.9.21 – recommended for approval			
<b>Dependent upon</b> (if applicable):	Completion of options appraisal for 5 year capital programme prioritisation exercise currently underway with the support of HTP team.			
<b>Executive summary:</b>	<p>The Estates Plan is subject to agreement of the 5 year strategic capital programme of works linked to agreed operational and strategic priorities and subject to approval of HTP SOC option. There is also ongoing work around the clinical services strategy that is being finalised while considering expediting a number NHSI for bids against regional allocation in 21/22 and 22/23. In conjunction with this work a Trust-wide review of space utilisation, focusing on zoning and clinical adjacencies has now been completed and will inform future decisions around occupancy.</p> <p>The Board of Directors are asked to note the contents of the paper and approve the Estates Plan as it is currently presented, noting that this is subject to change.</p>			
<b>Appendices</b>	Appendix 1: Draft Estates Plan			
<b>Lead Executive:</b>				

## **1.0 Introduction**

A review of the strategic 5-year capital programme is now progressing in line with capacity planning and alignment and subject to approval of HTP SOC option. Further review would be required to the Estates Plan. This “domino” effect will provide an integrated and joined up approach to estates developments aligning with the future approved HTP SOC solution and the capital programme.

## **2.0 Estates Plan Contents**

The Estates Plan covers the following areas of estate planning and performance. It is important to note that often the focus is on new capital schemes but it is essential that we also focus on the critical issue of a safe and effective environment through addressing the important issue of backlog maintenance.

### **2.1 Total Backlog Liability / 5- Year Backlog Programme (breakdown below)**

Backlog reported in ERIC 19/20 (Estates Return Information Collection) is approximately £55M. The total gross backlog liability covering the next five years is estimated at £96m. The Estates backlog survey is refreshed yearly to ensure that the latest condition information is captured. The backlog survey for FY20/21 is now complete and updated ERIC submission has been made. The current backlog position is shown graphically at RSH on slide 7 (along with current planned projects to address the critical areas on slides 8/9). The PRH position is shown slide 15 (with the current planned programme on slide 16).

The total 5-year backlog programme funding availability over the coming five years is estimated at £25m approximately. This equates to £5m/yr investment in estates backlog depending on CRL and central funding for Critical Infrastructure. The Trust successfully bid for Critical infrastructure funding of £5.6m FY20/21 the works for which is being successfully delivered.

An estimated investment of £1.5m will be required to address need to replace SSD autoclaves is included in the Estates backlog programme and will be spread over a 3 years.

Ventilation upgrades will continue to be a focus over the coming 5 years to address areas of high risk. A ventilation survey is underway to cover patient areas on both sites. It has become apparent that over the years rooms have had their purpose changed without involving Estates and subsequently may not be compliant with HTMs/HBNs etc in term of air changes p/min. An estimated £1.2m/yr investment on ventilation Air Handling Units (AHUs) is planned to ensure compliance.

Continued investment in steam main repairs and calorifiers will be required with £0.4-0.5m earmarked per annum.

Investment in the Building Management System (BMS) will be required in FY21/22 and is estimated at £0.6m. This is required due to the obsolescence of the existing system due to parts unavailability and the need to shift to an open protocol system. This will provide an intelligent system that links to other systems as well as heating and security ventilation.

Electrical infrastructure replacements include UPS / IPS (Uninterrupted Power Supply batteries) equating to £0.3m/yr. Additionally investment in nurse call systems

(£0.1m/yr) will be needed as wards have changed designation of rooms and some areas are not linked or audible, which clearly presents patient risk.

A total of £0.3m/yr has been earmarked to address fire compliance; £0.15m for alarms and detectors with another £0.15m for compartmentation. Roughly £0.15m has been earmarked for asbestos removal focussing on debris and areas with potential deterioration.

A separate £0.5m has been identified in FY 21/22 for subway duct structural work and asbestos removal.

Building fabric investment in floors (£0.15m/yr), roof replacements (£0.35m/yr) and windows replacements (£0.1m/yr) are also planned.

Slides 24 and 25 show the detail around the current five year capital plan, subject to approval.

## 2.2 5-Year Strategic Project Plan

A large number of capital schemes will be delivered by the end of 20/21, which is far in excess of any investment in recent years. A total of **£22.65m of centrally funded investment** across **FY 20/21 (£10m)** and **FY 21/22 (£12.65m)** is being delivered. These are covered in slides 10 and 19-23 and are as follows:

1. Modular SDEC (RSH) £3m
2. Ward 36 (PAU PRH) £2m
3. Fracture Clinic (RSH) £1.75m
4. SAU(RSH) £1.7m
5. SAU Office Accommodation £0.9m
6. MRI-CT(RSH) £3.5m
7. Modular Offices – Ironbridge Suite (PRH) £0.5m – Ironbridge Suite
8. A&E Refurbishment £9.3m

All projects identified above are now complete apart from A&E Refurbishment £9.3m.

### 2021/22

**RSH A&E refurbishment** commenced in April 21 and is being phased, with main clinical space delivered by Dec 21 and project fully complete by March 22. These timings have been agreed with NHSI.

**RSH MRI/CT** ground works commenced in March 21 and was completed in August 21.

Work has also been completed to fit-out the **Ironbridge Suite** at PRH which is a new 60-desk office modular located adjacent to the pre-existing Mallings Health modular.

The **Mallings Health** building and land is in the process of being transferred to the Trust from NHS Property Services via a **zero cost** asset transfer process. The PRH land housing the rear car park and helipad is also being legally transferred from NHS Property Services following an uncompleted Transfer in 2013/14 when the Women & Children's centre transferred from RSH to PRH.

Proposals for a developer-funded new two-storey **commercial front entrance at PRH** are currently being worked-up. This development would house retail offerings and waiting space for patients and staff and potentially create additional capacity on the second floor by re-providing the Education Centre which is located within a ward

template. It would also demonstrate our continued investment in the Princess Royal Hospital.

Estates have successfully completed and handed over **Ophthalmology department (Cataract Suite) in Ward 20** and **W18 fire compartmentation** works in the Copthorne building was complete in April 21.

Bids against NHSI capital allocations to create additional capacity in 21/22 are in development. Currently this includes providing **modular ward(s) at RSH, and the PRH Renal Dialysis Unit moving off-site** to create a 20-bedded ward, with the **PRH Cardio-respiratory service moving to an on-site modular building to release the 10-bedded en-suite Apley Ward** to use as an isolation /infectious diseases ward. We are currently awaiting feedback form the centre.

HTP SOC proposals are still being processed and for this purpose the Estates Plan cannot be finalised until this work is completed and aligned with the current site review of clinical adjacencies and space maximisation. Clinical service plans will be revisited and Strategic Projects programme will adapt to the services plan as it is developed.

Options that are being investigated within estates for RSH and PRH are shown on slides 26 and 27 respectively, but are subject to the finalisation of the five year capital plan.

## 2.3 Sustainability

The Trust, along with all NHS organisations, commits to delivering the NHS plan of a 'Net Zero Carbon Health Service' by 2040. The Trust will adopt the Net Zero Carbon Standard when it is released. In order to deliver the aspirations of the health services estates nationally, the Trust will need to '**Green Plan**' and '**Heat Decarbonisation Plan**', both of which are currently being progressed. This will include construction standards, energy, waste and transport. The Trust has a multi-professional Good Corporate Citizen Group that has been in place for many years, led by the Director of Corporate Services.

The Estates department has already been investing in sustainable technologies where possible as part of backlog investment and on occasion via central funded grants. To date there has been considerable investment in **LED lighting, building management systems (BMS) controls, steam calorifiers, motor controls as well as u-value building fabric improvements including window replacements.** Helpfully energy consumption savings have been identified as a CIP where there is an element of investing to save. In order to deliver higher carbon reductions investment a new energy centre will be required and is subject to Salix PSDS funding (Public Sector Decarbonisation Scheme) application is being developed.

With reduced reliance on fossil fuels, additional electrical power capacity will be required to both sites to offset carbon base energy generation. Estates are working closely with system partners to deliver the sustainability aspirations for the STW STP. A business case to introduce a revenue-neutral electrical vehicles charging points as now been approved. It is recognised that "plug-in" vehicles now represent 10% of all new car sales.

Details of the Trust's sustainability agenda can be found on slides 29-33 of the Plan.

## 2.4 Model Hospital

Slides 35-37 cover the Trust's performance in terms of Estates and Facilities Costs per metre squared.



Estates and Facilities performs generally well in Model Hospital with the exception of critical infrastructure risk (backlog maintenance) and hard facilities management (FM) costs including waste. Due to issues with the national waste contracts cessation, SaTH has incurred significant extra costs due to the temporary waste contract implemented by NHSI, however a new clinical waste contract has been awarded from April 2021 so these figures will significantly reduce.

### Space Management

Slide 36 and 37 refers to the amount of empty and under-utilised space at SATH, which is higher compared to our peers. This has been largely as a result of works underway in the Copthorne building and empty RSH residence blocks which will be updated with next model hospital information output.

A number of areas of accommodations are expected to come into play over the next five years.

In FY 21/22 **145m<sup>2</sup> of Mytton Oak** will be vacated when the MLU moves back into Copthorne W18. This could be considered as alternative accommodation for Therapy Services which are currently located on the William Farr site as their current accommodation is not satisfactory. This will be dependent on a wider review of ongoing service provision.

In addition the **Faculty of Health Building and Learning Centre** on the RSH site lease will end in FY 24/25 meaning this building could be used for other services, although it is likely that Staffordshire University will wish to extend the Lease to provide nurse training on-site. Currently they pay a peppercorn rent and should the lease be re-negotiated a commercial rent will be set. The services SLA is also being reviewed currently as it does not meet current costs incurred by SaTH.

There is a business case being developed for Phase 2 which involves moving the Renal Dialysis Unit across to Ward 35 at RSH.

The **old nurse residence** at the back of the RSH site continues to be under used. Estates have brought some of these areas back into use due to urgent need for office space during COVID-19. The Trust is also paying a **200% council tax premium** on these empty building of around **£60k pa**.

## **2.5 Compliance**

Slides 38-41 cover Estates compliance, which previously has been very poor largely due to gaps in the estates compliance structure as well as having a lack of compliance reporting framework. This is now gradually improving since approval was given for additional compliance resources (APs) and the setup of compliance reporting with the different estates disciplines (elect/vent/water /decon/fire/asbestos/PSSR/ lifts/med gas). The estates structure still suffers from lack of CP roles, for which a business case for five Band 5s has been submitted. This would be revenue neutral as there would be a concomitant reduction in external contractors who currently provide services. Estates also has an aging workforce and the Directorate is working closely with the Trust's Apprenticeship Lead to maximise support available from the national Apprenticeship Levy in 2021/22.

Estates statutory and mandatory maintenance (PPM) has **averaged 64%**. Estates are targeting increase to **80% by December 2021**. (One year ago it was under 40%). This means that planned maintenance is delayed, increasing the risk of failure. It should be noted that PPM delivery is inversely proportionate to reactive maintenance due to limited resources, i.e. if there is an increase in reactive requests PPMs are adversely affected.

Estates led the **PAM (Premises Assurance Model) audit** in 2020. Overall **PAM compliance** achieved was **65%** with the **target** that this increases to **80% by December 2021** due to improved efficiencies and the investment in some key estates infrastructure.

The appointment of an estates compliance manager has significantly improved compliance reporting and monitoring and provided assurance around policy and procedure updates.

## 2.6 ICS / STP Estates Group

Slides 42-46 cover the wider system co-ordination and the work being led by the ICS/ STP Estates forum. The SaTH Estates department has been engaging with the ICS system partners to ensure alignment of system capital plans and better work collaboratively. While the system's meetings were paused due to COVID-19 pandemic they have now recommenced.

The SaTH Estates Lead (Associate Director of Estates) will be taking a lead role in organising and supporting ICS Estates Group to ensure that the necessary estates work is managed and supported by all stakeholders.

**The Cavell Centre** is one of a number of community hubs proposed to house such activities and SaTH is working closely with partners as options are being developed.

## 3.0 Risks and actions

Risk	Action	Lead
1. Lack of alignment with HTP	Once HTP SOC option is approved, co-ordination of 5 year programme will be required	WN – AD Estates & Hospital Site Transformation / HTP Programme Dir
2. Scarce NHS capital	Ensure viable VFM options are included in business case and bid submissions	WN – AD Estates & Hospital Site Transformation / AEM – Strategic Capital Programme Manager Nigel Lee - CFO
3. Estates capacity to undertake projects	Ensure forward planning of estates resources and reporting structures with regular delivery updates over 12-24 months period.	WN – AD Estates & HTP Transformation
4. Under-invested compliance structure eg CPs	12 months forward planning of contractor(s) needs to be included in budget setting	WN – Estates & Hpt Transformation PP – Estates Finance Lead
5. Zero Carbon NHS by 2040	Commission 'Green Plan' and 'Zero Carbon Plan' and define roadmap to zero carbon at SaTH. Work with system partners to ensure sufficient power in the grid to enable the zero carbon transformation	WN – Estates & Hpt Transformation TH – Sustainability Lead
6. Energy Centre Contract	Energy centre contract coming to end. The contract will need to be extended before the construction of the energy centre. New energy centre will need to be designed according to the site decarbonisation plans.	WN – Estates & Hpt Transformation TH – Sustainability Lead

## 4.0 Conclusion

The Estates Plan is partially dependent on HTP programme of works and will therefore be updated as HTP SOC and OBC approvals come through.

The Board of Directors are asked to note the contents of the paper and approve the Estates Plan as it is currently presented, noting that this is subject to change.

**Helen Troalen**  
**Executive Director of Finance**  
**October 2021**

# DRAFT Estates 5 Year Plan

## The Shrewsbury and Telford Hospital NHS Trust



# Contents

## 1. Executive Summary

## 2. Where are we now?

### A. Royal Shrewsbury Hospital

- Existing Site
- Age Profile
- Backlog Maintenance
- Parking
- Backlog

### B. Princess Royal Hospital

- Existing Site
- Age Profile
- Backlog Maintenance
- Parking
- Backlog

## 3. Interim Position

### Capital Urgent Capacity Schemes

- Royal Shrewsbury Hospital

- Princess Royal Hospital

## 4. 5-Year Capital Programme

- 5-Year Backlog Programme
- **5-Year Strategic Capital Programme**

## 5. Sustainability

## 6. Community

## 7. Model Hospital Review

## 8. Space Management

## 9. Compliance

## 10. STP Estates Strategy July 2019

## 11. Next Steps

# 1. Executive summary

This Estates Plan sets out a high level overview of the current estate as at Dec 2020 and charts the direction of travel for a notional 5 year period leading up to expected HTP transformation. It is focussed on backlog required in this period required for the estates fabric to be kept during the 5 year period. As well as capital backlog investments, the plan also takes into account current known service developments and aspirations not within scope of HTP.

## Trust Strategic Direction

The strategic direction is driven by the perspective that the health and care system needs to change in order to meet the needs of our communities and the wider population. As such the Estate will also need to change and adapt but, given the nature and scale of property assets, the challenge becomes extremely complex due to both timescales and required synergy with the future approved HTP solution.

Given the extended timescales taken to realise building and development programmes, it is essential that consideration is given to the strategic risks and opportunities over this period. There are many competing and complex factors which will impact on the effectiveness of this Plan, however there are a number of specific aspects which this Plan will seek to address:

- 1- Reduction in overall Backlog and reducing risk over time using risk based methodology
- 2- Enabling and prioritisation for future
- 3- Urgent and current operational and clinical priorities

The core objective is always to deliver and operate an Estate that is safe, sustainable and fit for purpose to meet the changing needs of patients. The financial constraints within which the NHS must operate. However this heightens the importance of ensuring the use of a robust and transparent system for risk-based decision making and investment prioritisation.

In developing the direction for the future of the estate, it is likely that the following parameters will be foremost:

- Issues of safety and compliance have been prioritised according to the level of risk to patients, staff and the continued delivery of clinical services.
- Revenue budgets will remain flat in real terms, and will be expected to flex in line with increases or reductions to clinical activity in response to STP/ Integrated Care Systems.
- Internally generated capital investment which is limited will focus on investment programmes that are risk based projects.

One of the most significant challenges facing the Estate both historically, and in going forward, is ensuring an appropriate balance of centrally funded investment on new developments as well as funding required for maintaining the existing estate. Both issues carry significant risk if they are not funded appropriately and it is a significant challenge to ensure and identify the right allocation of capital resources. The strategic risk register plays an important part in this aspect, identifying the specific issues that the Trust faces from a service/operational delivery perspective and their relative priority as well as backlog risk carried by the Trust.



## 2. Where are we now

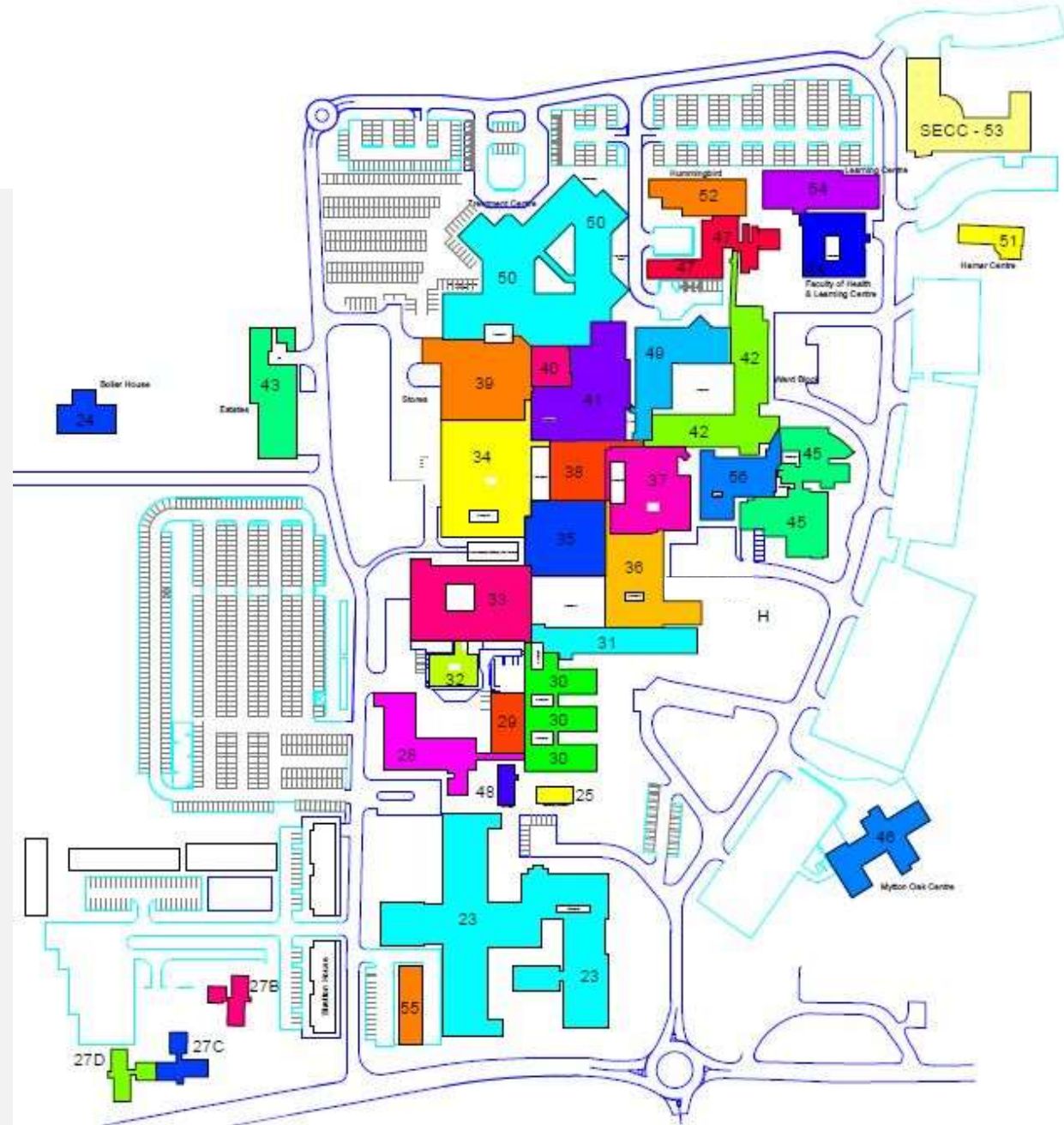
### A. Royal Shrewsbury Hospital





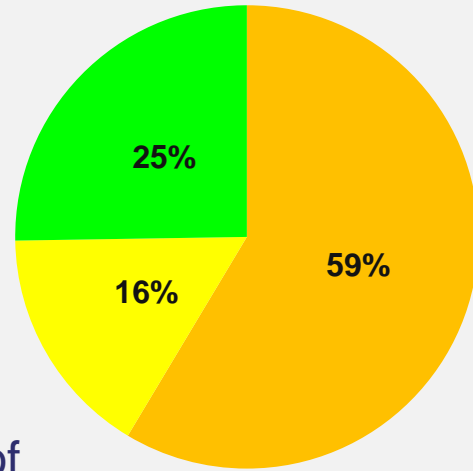
## 2. Where are we now

<b>Block 23</b>	<b>Copthorne Building/Medical Engineering/Eye Department</b>
<b>Block 24</b>	Boiler House
<b>Block 25</b>	Maternity Generator
<b>Block 27</b>	Residencies
<b>Block 28</b>	Pathology
<b>Block 29</b>	Mortuary
<b>Block 30</b>	Outpatients Department
<b>Block 31</b>	OPD Entrance & Medical Records L0 – Trust HD L1 – Admin L2
<b>Block 32</b>	Aseptic Suite
<b>Block 33</b>	Pharmacy/Gym L0 – Ward32/Fertility L1
<b>Block 34</b>	Catering
<b>Block 35</b>	X-Ray
<b>Block 36</b>	A&E
<b>Block 37</b>	Head & Neck
<b>Block 38</b>	ITU/HDU
<b>Block 39</b>	Stores
<b>Block 40</b>	Sterile Services
<b>Block 41</b>	Theatres
<b>Block 42</b>	Ward Block
<b>Block 43</b>	Estates
<b>Block 44</b>	Faculty of Health
<b>Block 45</b>	Radiotherapy
<b>Block 46</b>	Mytton Oak House
<b>Block 47</b>	Renal
<b>Block 48</b>	Elizabeth House
<b>Block 49</b>	Ward Block Extension
<b>Block 50</b>	Treatment Centre
<b>Block 51</b>	Hamar Centre
<b>Block 52</b>	Hummingbird
<b>Block 54</b>	The Learning Centre
<b>Block 55</b>	Daisy Chain Nursery
<b>Block 56</b>	Cancer Treatment Centre



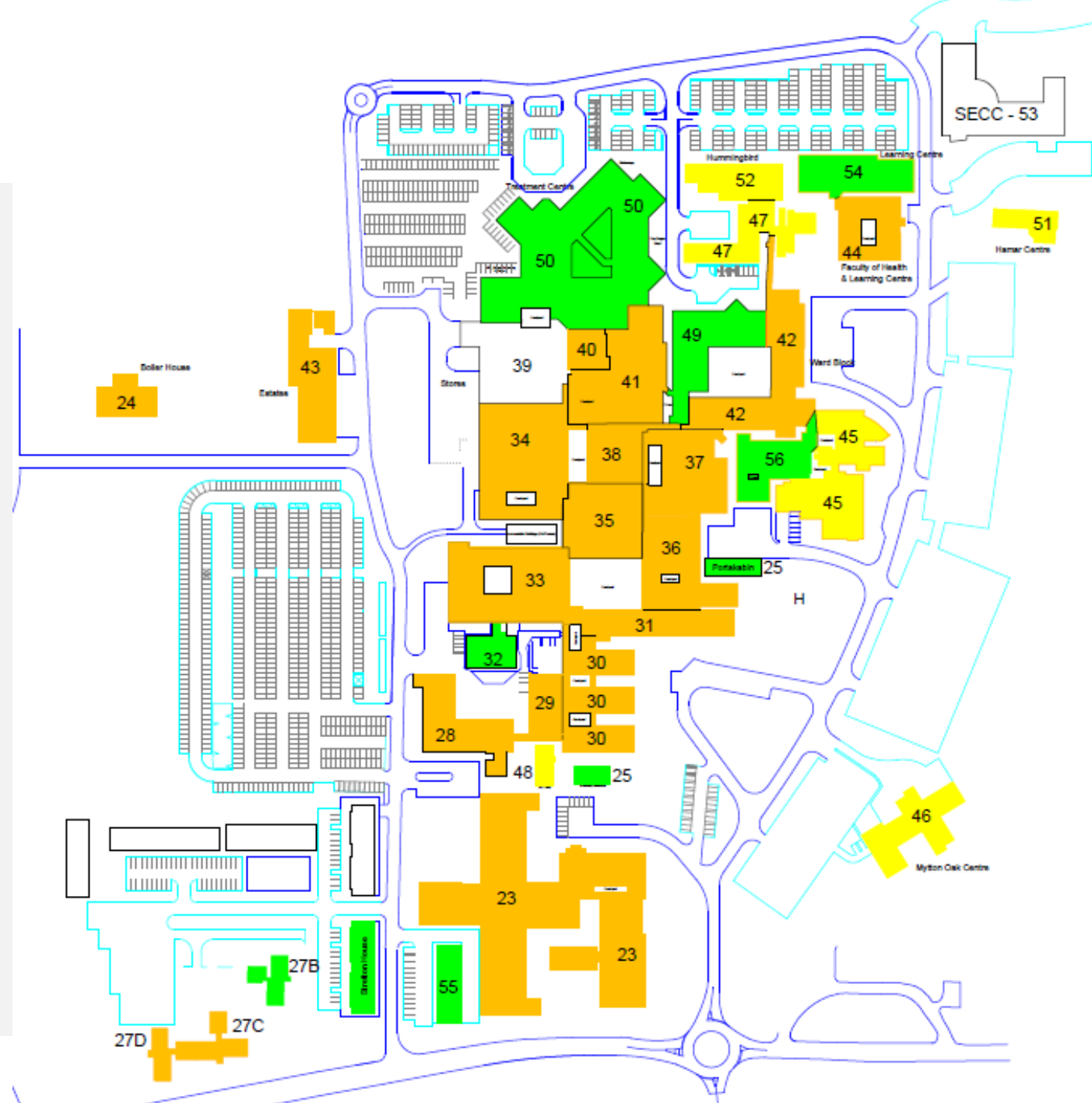
## 2. Where are we now

### A. Royal Shrewsbury Hospital Age Profile



At RSH the oldest part of site was built 1960 – 1980 and represents 59% of the total building area.

- 1960 - 1980
- 1980 - 2000
- 2000 - 2020

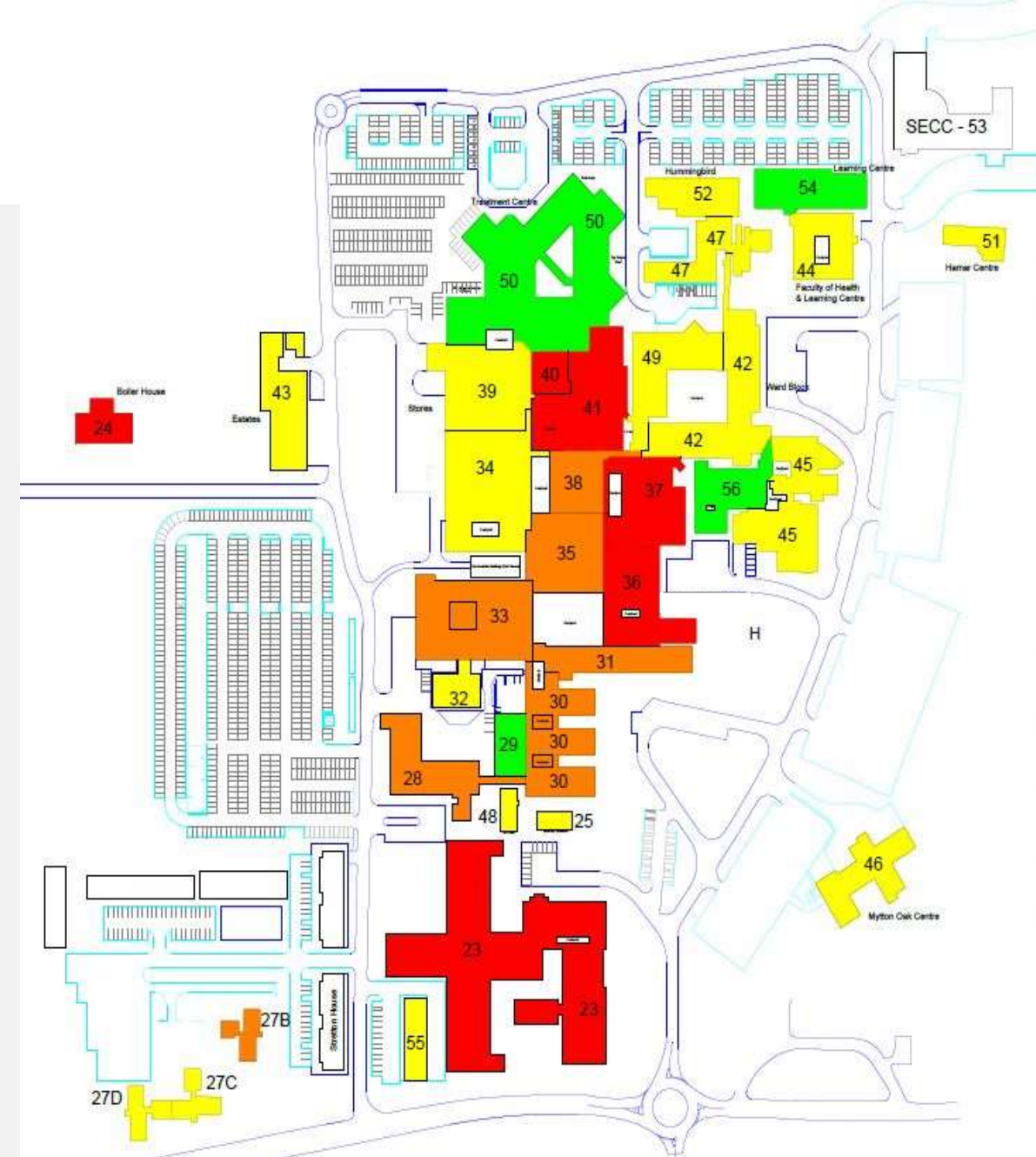


# 2. Where are we now

## A.Royal Shrewsbury Hospital

### Backlog Maintenance

Cost / m.sq.	Block no.	Block Name	Sum of Backlog Costs	
£0 - £100	Block 50	Treatment Centre	£628,994.98	
	Block 54	Learning Centre	£37,044.54	
	Block 29	Mortuary	£54,662.62	
	Block 56	Cancer Treatment Centre	£82,758.72	
£100 - £500	Block 49	Ward Block Extension	£263,211.14	
	Block 45	Radiotherapy and Chemo	£375,920.01	
	Block 52	Hummingbird Centre	£111,062.81	
	Block 43	Estates	£192,624.82	
	Block 55	Daisy Chain Nursery	£75,711.81	
	Block 44	Faculty of Health	£397,375.03	
	Block 47	Renal	£197,062.58	
	Block 32	Aseptic Suite	£171,687.82	
	Block 46	Mytton Oak House	£268,419.68	
	Block 48	Elizabeth House (Phlebotomy & Shropdoc)	£43,342.76	
	Block 42	Ward Block	£2,821,833.62	
	Block 27	Residences Block 3(C)	£357,709.65	
	Block 51	Hamar Centre	£136,936.03	
	Block 34	Catering	£1,407,550.30	
	Block 39	Stores	£495,721.52	
	Block 27	Residences Block 4(D)	£356,944.74	
	£500 - £1000	Block 27	Residences Block 2(B)	£364,802.18
		Block 35	X Ray	£773,222.89
Block 33		Pharmacy, EPAS, Fert etc.	£2,274,740.14	
Block 30		Outpatients Dept	£1,413,913.10	
Block 28		Path Lab	£1,301,871.50	
Block 31		Admin	£1,558,994.37	
Block 38		TU	£667,706.35	
£1000 - £5000	Block 40	Sterile Services	£461,994.05	
	Block 36	A&E	£1,701,581.17	
	Block 24	Boiler House and Waste	£726,810.68	
	Block 41	Theatres	£2,890,623.46	
	Block 23	Copthorne Building	£13,952,468.18	
	Block 37	Emergency Care	£2,640,054.42	





# 2. Where are we now

## A. Royal Shrewsbury Hospital

### FY 20/21 Backlog Programme

There after the Trust will look to invest £3-4M / annum on backlog

#### Note:

There is no commitment on spend for FY 21/22 from projects commenced in FY 20/21. Where projects are extending to FY 21/22 they are additional phases and subject to confirmation of capital plan

Capital Project	FY 20/21 Spend
S120 - RSH BL Drainage Improvements	£836
S122 - RSH BL Asbestos	£335,447
S125 - RSH BL Nurse Call Systems	£6,520
S129 - RSH BL Theatre Lights	£99,382
S133 - RSH BL Ward Kitchen Refurbishments	£25,150
RSH Ward 23 Cancer AHU	£61,419
S111 - RSH BL Distribution Boards	£73,655
S112 - RSH BL Bedside Light Replacement	£96,732
S114 - RSH BL ITU AHU	£294,799
S114 - Ward 29 AHU	£49,806
S126 - RSH BL Roofing	£261,298
S121 - RSH BL Fire Improvements	£540,826
E6 - Subway Duct - RSH (C188)	£15,640
EF - CIR - Estates Backlog - Ward 18 Fire Compartmentation	£406,175
S124 - RSH BL Road Surfacing	£340,115
S127 - RSH BL Window Improvements	£271,921
S128 - RSH BL Flooring	£161,712
S105-S109 - RSH BL Calorifiers ...1	£341,374
S131 - BMS RSH - Phase 1	£501,641
S130 - Replacement RO,	£43,348
RSH S132 ITU/HDU BL	£34,616
S101 - RSH BL Steam Condense	£59,726
<b>Total</b>	<b>£4,022,139</b>

Royal Shrewsbury Hospital Mytton Oak Road Shrewsbury Shropshire, SY3 8XQ	Gross Floor Area	61,400m <sup>2</sup>	Backlog (Year 0) Summary	£s	Site Location & Description  Royal Shrewsbury Hospital is a medium sized acute hospital located to a sloping site on the Western edge of Shrewsbury town centre. Buildings to the site are predominately of concrete frame construction and built circa 1970 with numerous additions built circa 2005 which include the Treatment Centre and the Ward Block Extension.
	Net Usable Area	49,120m <sup>2</sup>	Low Risk	£753,177	
	Building Year	1970-2010	Moderate Risk	£14,715,983	
	Backlog (Year 0)	£31,354,653	Significant Risk	£12,131,455	
Survey Date	August to September 2015 Review: May 2021	Budget (Impending) - Years 1-5	High Risk	£3,734,039	
		Total Cost (Exc. On Costs)	Total	£31,354,653	



Backlog (Year 0) Works

Total remedial work required for the BUILDING, M&E, STATUTORY & FIRE Elements:

Building	£21,359,793
M&E	£9,597,819
Statutory Compliance	£62,320
Fire Safety	£334,721
<b>Backlog (Year 0) Total Cost</b>	<b>£31,354,653</b>

Budget (Impending) - Years 1 - 5 Works

Total remedial work likely to be required within a 5 year period for the BUILDING, M&E, STATUTORY & FIRE Elements:

Building	£1,739,897
M&E	£4,568,657
Statutory Compliance	£0
Fire Safety	£161,237
<b>Budget (Impending) Total Cost</b>	<b>£6,469,791</b>

**Combined Total Costs - Backlog & Budget** £37,824,444  
*Excludes Function Costs*

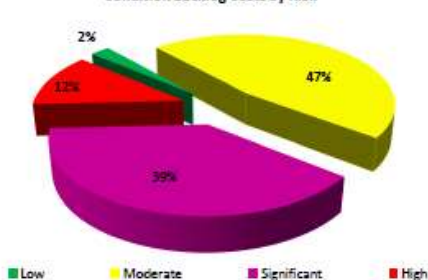
**Combined Total Costs (Including On Costs)** £59,384,377

Figure above includes on-costs: Fees, VAT, Builder Preliminaries and Optimism Bias Contingencies.

Cost Breakdown by Facet

Facet 1 Physical Condition	£37,266,166
Facet 2 Functional Suitability	£0
Facet 3 Space Utilisation	£0
Facet 4 Quality	£0
Facet 5 Statutory Compliance	£558,278
Facet 6 Environmental Management	£0

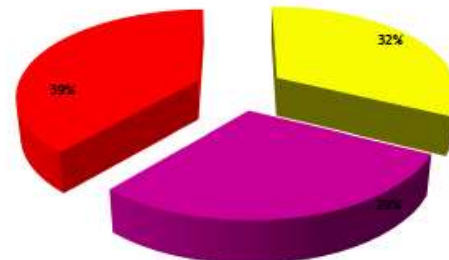
Condition Backlog Costs by Risk



Block Code	Block Name	GIA	Condition & Statutory			Facet Grades & Costs						Overall Grade		
			Backlog Costs (2021)	Budget Costs (2022-2026)	Total Cost	Facet 1 Condition Grade	Facet 2 Function Grade	Facet 3 Space Utilisation	Facet 4 Quality Grade	Facet 5 Statutory Compliance	Facet 6 Environmental Management			
RSH03	Menarthy	4000	£9,954,649	£697,808	£10,652,458	£16,724,359	C	C	Underused	D	D	D	D	C
RSH04	Boiler House	1100	£523,757	£221,223	£744,981	£1,169,620	C	C	Fully Used	B	D	Inc	Inc	C
RSH05	Grounds & Ancillary Buildings	2000	£4,464,724	£247,728	£4,712,452	£7,398,549	B	B	Underused	C	B	Inc	Inc	B
RSH07B	Blocks Adjacent to Staff Residential	750	£327,996	£45,926	£373,922	£587,058	D	D	Underused	D	D	Inc	Inc	D
RSH07C	Blocks Adjacent to Staff Residential	750	£345,133	£21,519	£366,652	£575,644	D	D	Underused	D	D	Inc	Inc	D
RSH07D	Blocks Adjacent to Staff Residential	750	£354,444	£11,424	£365,868	£574,413	D	D	Empty	D	D	Inc	Inc	D
RSH08	Pathology	2400	£1,238,069	£96,349	£1,334,418	£2,095,097	C	D	Overcrowded	D	D	Inc	Inc	D
RSH09	Mortuary	750	£39,243	£16,786	£56,029	£87,966	B	B	Fully Used	B	B	Inc	Inc	B
RSH00	Out Patient Department	3000	£871,937	£238,656	£1,110,593	£1,743,631	C	D	Fully Used	C	D	Inc	Inc	D
RSH01	Administration	3000	£600,202	£464,315	£1,064,517	£1,671,292	C	C	Overcrowded	C	D	Inc	Inc	C
RSH02	Pharmacy	800	£168,249	£2,503	£170,753	£268,081	B	B	Fully Used	B	B	Inc	Inc	B
RSH03	WDS1, WDS2, Fertility & EPAS	4000	£1,905,711	£168,848	£2,074,558	£3,257,056	C	D	Overcrowded	D	D	Inc	Inc	D
RSH04	Catering	2000	£837,109	£605,630	£1,442,739	£2,265,100	D	C	Underused	D	C	Inc	Inc	D
RSH05	X-Ray	1500	£508,581	£112,605	£621,187	£975,263	C	D	Overcrowded	D	D	Inc	Inc	C
RSH06	A&E	1500	£950,960	£169,087	£1,120,047	£1,758,474	C	D	Overcrowded	C	D	Inc	Inc	C
RSH07	Head & Neck	1150	£1,751,105	£175,407	£1,926,512	£3,024,623	C	D	Overcrowded	C	D	Inc	Inc	D
RSH08	LTU	750	£318,918	£66,300	£385,218	£604,792	C	D	Overcrowded	C	D	Inc	Inc	D
RSH09	Stores	2150	£472,538	£35,576	£508,115	£797,740	D	C	Fully Used	C	D	Inc	Inc	D
RSH00	Starline Services (SSD)	400	£427,846	£0	£427,846	£671,718	D	D	Underused	C	D	Inc	Inc	D
RSH01	Theatres	1600	£1,621,221	£1,050,711	£2,671,932	£4,194,933	D	D	Fully Used	D	D	Inc	Inc	D
RSH02	Ward Block	8000	£2,439,477	£374,490	£2,813,967	£4,417,928	C	C	Fully Used	C	C	Inc	Inc	C
RSH03	Estates Department	800	£167,197	£30,243	£197,440	£309,981	C	B	Fully Used	B	C	Inc	Inc	C
RSH04	Faculty of Health	2000	£247,797	£159,513	£407,309	£639,476	C	C	Underused	C	C	Inc	Inc	C
RSH05	Radio Therapy & Chemo	3000	£247,911	£137,407	£385,318	£604,949	B	B	Fully Used	B	B	Inc	Inc	B
RSH06	Mytton Oval Centre	1500	£120,185	£154,945	£275,130	£431,954	B	B	Underused	B	C	Inc	Inc	B
RSH07	Renal Unit	1000	£50,178	£151,812	£201,989	£317,123	B	B	Fully Used	B	B	Inc	Inc	B
RSH08	Philabotomy / SheopDoc - Elizabeth House	200	£18,393	£26,033	£44,426	£69,749	B	C	Overcrowded	C	B	Inc	Inc	B
RSH09	Ward Block Extension	3000	£132,981	£136,811	£269,791	£423,573	B	C	Fully Used	B	B	Inc	Inc	B
RSH00	Treatment Centre	4750	£102,993	£541,727	£644,720	£1,012,210	B	B	Fully Used	B	B	Inc	Inc	B
RSH01	Harrier Centre	500	£65,691	£74,669	£140,359	£220,364	B	B	Fully Used	B	B	Inc	Inc	B
RSH02	Hummingbird Centre	750	£28,047	£85,792	£113,839	£178,728	B	B	Fully Used	B	B	Inc	Inc	B
RSH04	Learning Centre	1000	£22,849	£14,076	£36,925	£57,972	B	B	Fully Used	B	B	Inc	Inc	B
RSH05	Dairy Chain Nursery	550	£19,993	£57,612	£77,605	£121,839	B	B	Fully Used	B	B	Inc	Inc	B
RSH06	Cancer Treatment Centre	2000	£8,568	£76,259	£84,828	£133,179	B	B	Fully Used	B	B	Inc	Inc	B
	<b>TOTAL</b>	<b>61,400</b>	<b>£31,354,653</b>	<b>£6,469,791</b>	<b>£37,824,445</b>	<b>£59,384,378</b>	-	-	-	-	-	-	-	-

Breakdown of Overall Grades based on GIA

- A - Good. Performing as intended.
- B - Satisfactory. Performing as intended, minor deterioration.
- C - Poor. Exhibiting defects and/or not operating as intended.
- D - Bad. Life expired and/or serious risk of imminent failure.



Facet Key

- Physical Condition:**
- A - Good. Performing as intended.
  - B - Satisfactory. Performing as intended, minor deterioration.
  - C - Poor. Exhibiting defects and/or not operating as intended.
  - D - Bad. Life expired and/or serious risk of imminent failure.
- Quality**
- A - A facility of excellent quality.
  - B - A facility requiring general maintenance investment only.
  - C - A less than acceptable facility requiring major capital investment or replacement.
  - D - A very poor facility requiring major capital investment or replacement.
- Functional Suitability**
- A - Very satisfactory, no change needed.
  - B - Satisfactory, minor change needed.
  - C - Not satisfactory, major change needed.
  - D - Unacceptable in its present condition.
- Statutory Compliance**
- A - Complies with all relevant standards and relevant guidance.
  - B - Action required to comply with relevant guidance and statutory requirements.
  - C - Building with known contravention of one or more standards.
  - D - Building areas which are dangerously below 'B'.



# Risk Based Estates Backlog Condition Methodology

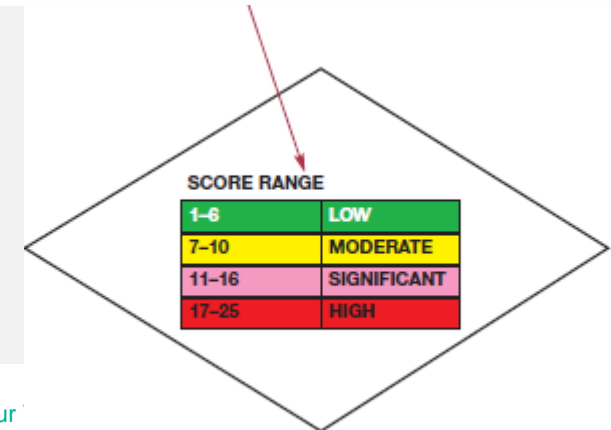
There are two parts to estates backlog assessment.

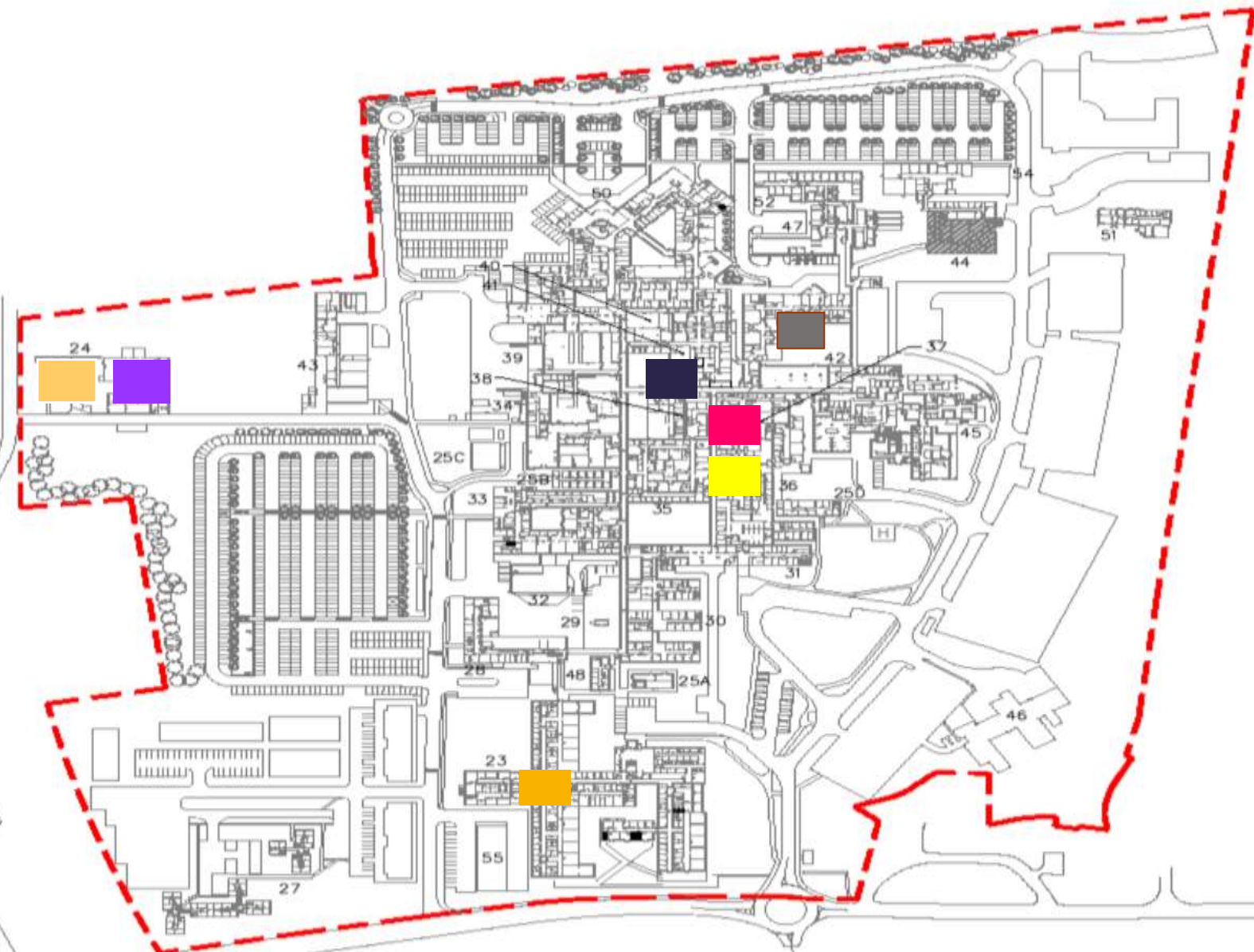
1- Estates backlog surveys allocate a condition ranking for each sub-element relating to physical condition and compliance with mandatory fire safety requirements and statutory safety legislation, as appropriate. Where a particular sub-element (for example fire doors) is assessed on the basis of its physical condition and compliance with fire safety and/or statutory legislation, separate rankings should be assigned for physical condition, fire safety etc.

2- Sub-elements below condition B together with sub-elements in condition B(C) should be risk assessed in order to identify high risk factors in the estate that need to be addressed urgently and those that can be programmed into your estate investment planning process over a longer period. (See Chapter 6 for guidance on how you should record risk.)

TABLE 3.1: RANKINGS FOR PHYSICAL CONDITION

The physical condition of each sub-element should be categorised as follows:	
<b>A</b>	as new and can be expected to perform adequately to its full normal life
<b>B</b>	sound, operationally safe and exhibits only minor deterioration
<b>B(C)†</b>	currently as B but will fall below B within five years
<b>C</b>	operational but major repair* or replacement is currently needed to bring up to condition B
<b>D</b>	operationally unsound and in imminent danger of breakdown**
<b>X</b>	supplementary rating added to C or D to indicate that it is impossible to improve without replacement





Capital Projects	Type	FY 20/21 Potential Spend
RSH BL Subway duct	Building	£700,000
RSH BL Fire Improvements (incl. doors, AFD & compartments)	Fire	£300,000
RSH BL Other Electrical	Electrical	£210,000
RSH BL Asbestos (survey 100K + removals)	Asbestos	£250,000
Replacement of Main Condense lines + Return Unit	Mechanical	£100,000
RSH BL Road Surfacing	Roadworks	£140,000
RSH BL Switchgear	Electrical	£120,000
RSH BL Distribution Boards - Fixed Wire Testing	Electrical	£120,000
RSH BL Flooring	Flooring	£150,000
BMS RSH - Phase 1	BMS	£1,000,000
RSH BL Roofing	Roofing	£200,000
RSH BL Nurse Call Systems	Electrical	£300,000
RSH BL Theatre Lights	Theatre Lights	£100,000
Theatre ITU / HDU Doors	Fire	£80,000
RSH BL Bedside light replacement	Electrical	£50,000
RSH BL ITU AHU	AHU	£250,000
Block 23 - Ward 18 Fire Compartmentation	Fire	£ 500,000
RSH Colorifiers B31, B33,B47	Colorifiers	£350,000
RSH BL Water tank relining B23	Building	£ 49,000
RSH BL Window Improvements Block 23	Windows	£300,000
Replacement RO Boiler House	Mechanical	£50,000
RSH Ward 23 Cancer AHU	AHU	£250,000
Kitchens Both Sites	Kitchens	£300,000
VIE plant	Mechanical	£ 100,000

# Royal Shrewsbury Hospital

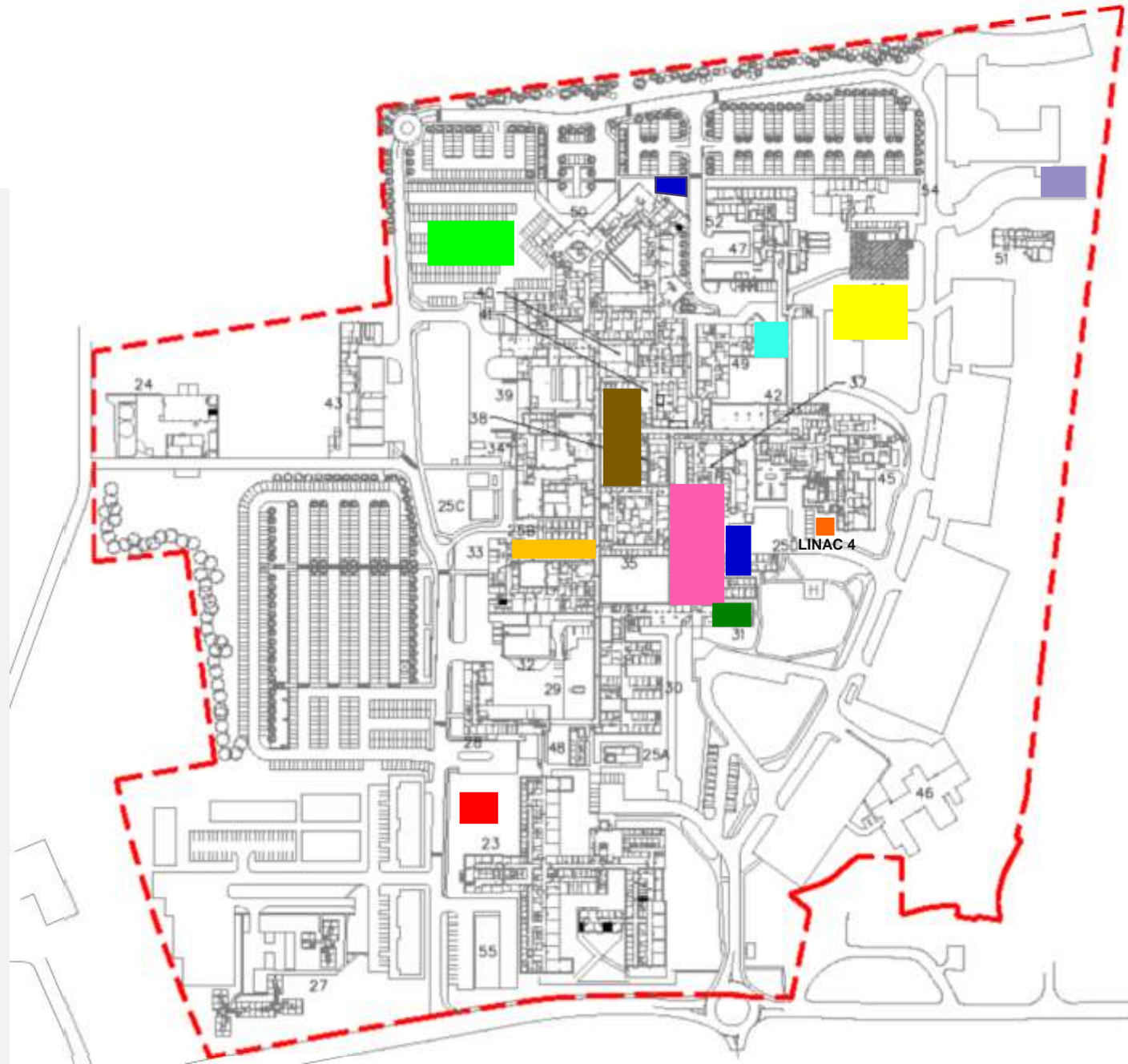
## Capital Schemes

- **Funded:**

- A&E Internal Refurb
- Diagnostics (MRI – CT – US – ENDO)
- Fracture Clinic Relocation
- Same Day Emergency Care (SDEC) - Complete
- Med. Records Refurb (SAU relocation) - Complete
- Althea Unit
- SAU Clinical Refurb

- **Aspirational:**

- CCU Modular
- Modular Wards
- Linac Bunker 4
- ITU/ICU Expansion
- Vanguard Modular





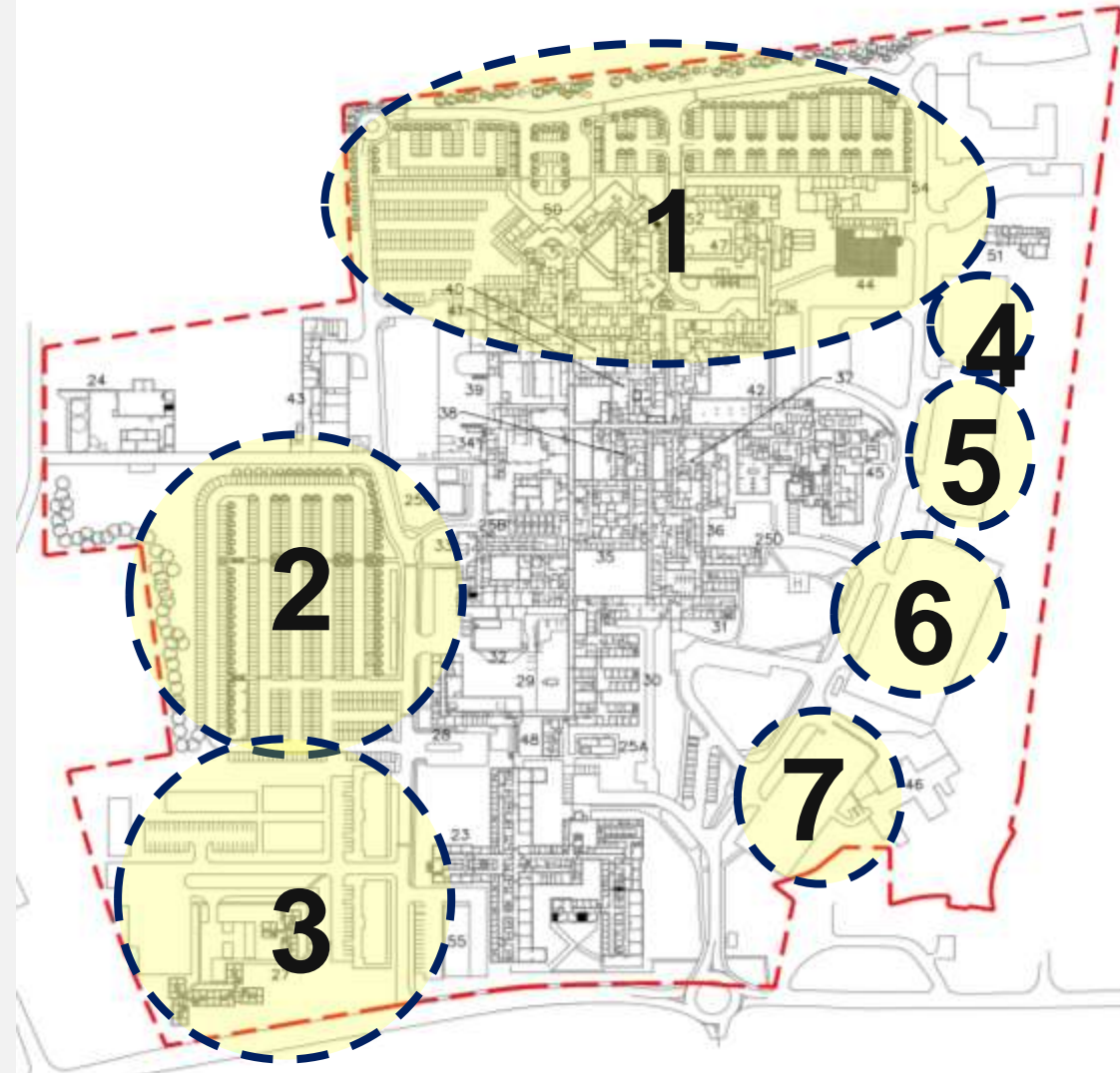
# 2. Where are we now

## A. Royal Shrewsbury Hospital

### Parking

Area	Staff Parking	Patient Parking
1	438	
2	550	
3		50
4	69	
5		104
6		170
7		80
<b>Total</b>	<b>1057</b>	<b>404</b>
<b>Grand Total</b>		<b>1461</b>

Note: Impact assessment of working from home on staff parking and virtual outpatients on visitor parking will need to be commissioned. Consideration being given for additional parking.



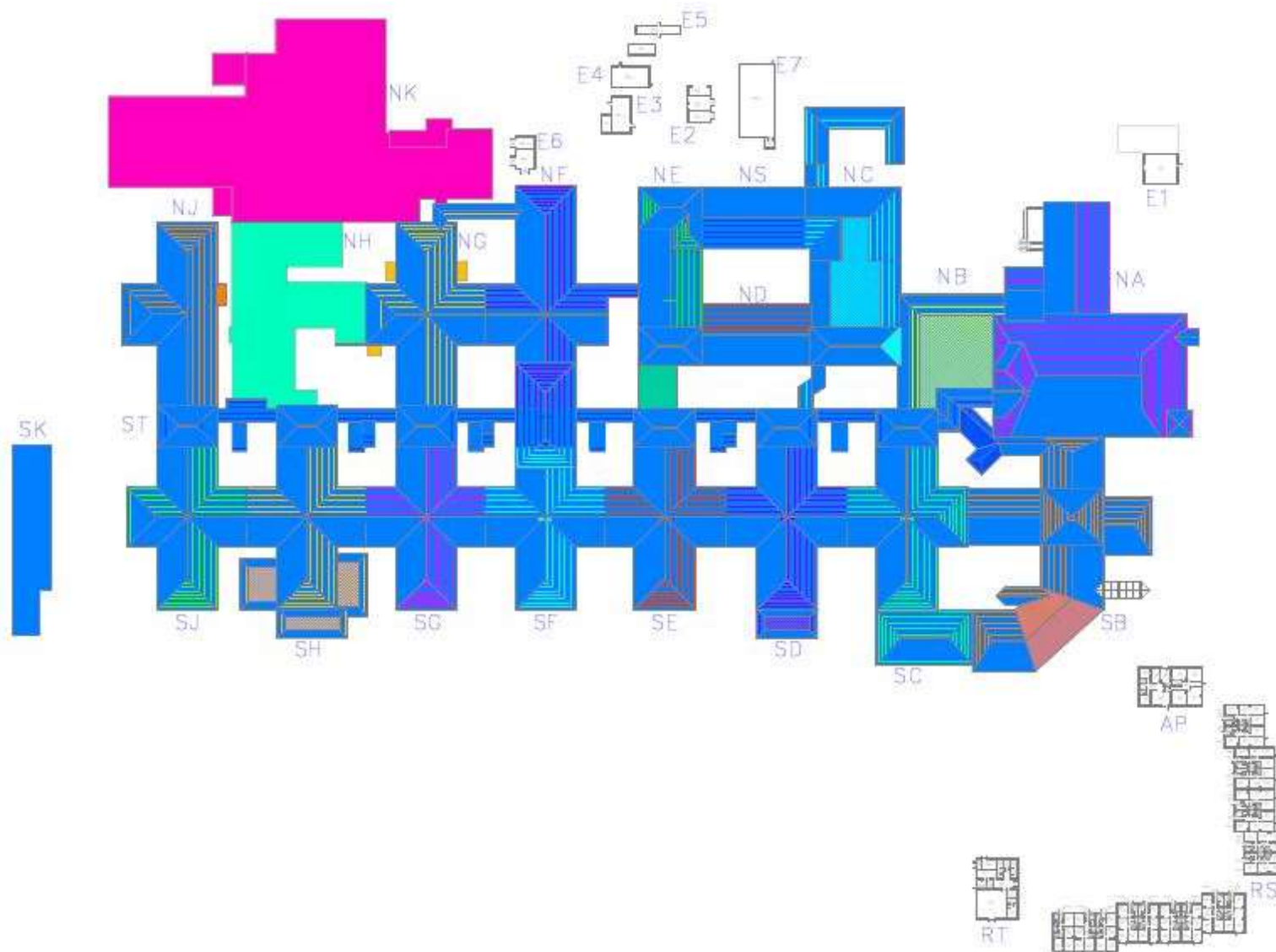
## 2. Where are we now

### B. Princess Royal Hospital





# 2. Where are we now



PRHE6- Block External	W&C HV Switch Room & Water Pumping Station
PRHE2- Block External	Medical Gases
PRHE4- Block External	Generator House No.4
PRHNG- Block NG	Ward 12/14 & 19
PRHNH- Block NH	Children's Outpatients
PRHNK- Block NK	Ward 18 & Wards 21 to 24
PRHSK- Block SK	Ophthalmology
PRHAP- Block AP	Apley Clinic
PRHE1- Block External	Pump House
PRHNA- Block NA	Boiler House/Ward 36 & Endoscopy/Maternity Outpatient Scan
PRHNB- Block NB	Loading Bay/Sub Station 1&2
PRHNC- Block NC	Estates/MES/Stores & Catering
PRHND- Block ND	Pharmacy/Admin Hub
PRHNL- Block NL	Wrekin Midwife Led Unit
PRHNJ- Block NJ	GP X RAY/Fracture Clinic and Plaster Room
PRHNS- Block NS	Mortuary/Path Lab/Admin Hub
PRHRS- Block RS	Residences
PRHRT- Block RT	Old Doctors Mess
PRHSB- Block SB	Paul Brown/Wards 15 & 16
PRHSD- Block SD	Main Entrance/Education
PRHSE- Block SE	Outpatients/Ward 4 & Renal
PRHSH- Block SH	A&E/Wards 08 & 09/Head and Neck
PRHNE- Block NE	Admin Hub/Path Lab
PRHNF- Block NF	Apley Ward/AMU & Theatres 1 to 5
PRHSC- Block SC	Rehabilitant/Education
PRHSF- Block SF	Outpatients/Dental/ITU & HDU
PRHSG- Block SG	X Ray/Wards 06 & 07/CCU
PRHSJ- Block SJ	Day Ward/Theatres 6,7 & 8/Wards 10 & 11
PRHE3- Block External	Generator House No.3
PRHST- Block ST	Street
Site	
PRHE6- Block External	W&C HV Switch Room & Water Pumping Station
PRHE2- Block External	Medical Gases

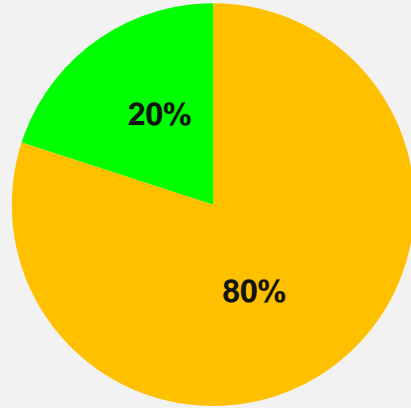


# 2. Where are we now

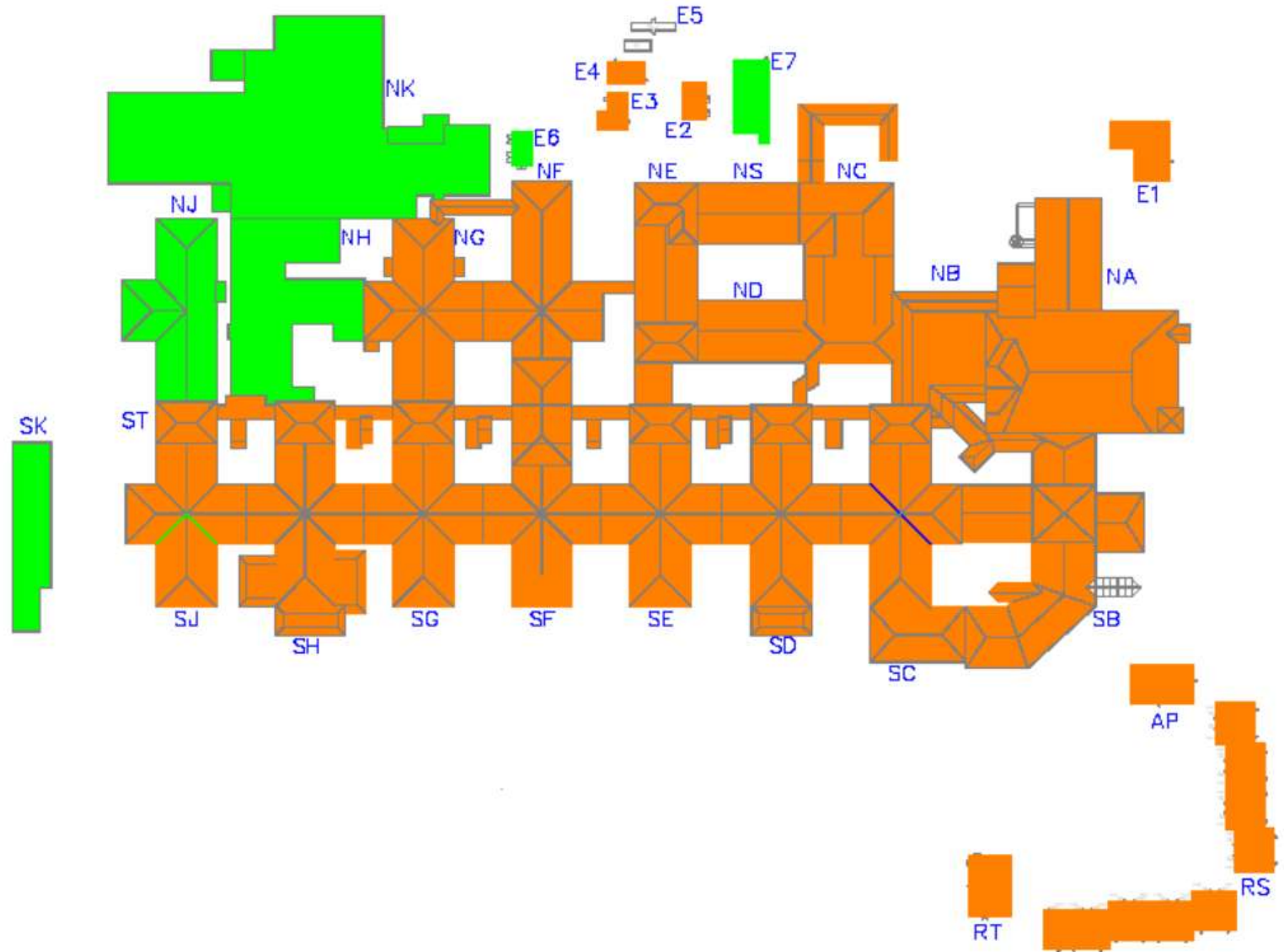
## B. Princess Royal Hospital

### Age Profile

At PRH the oldest part of site was built 1980 – 2000 and represents 80% of the total building area



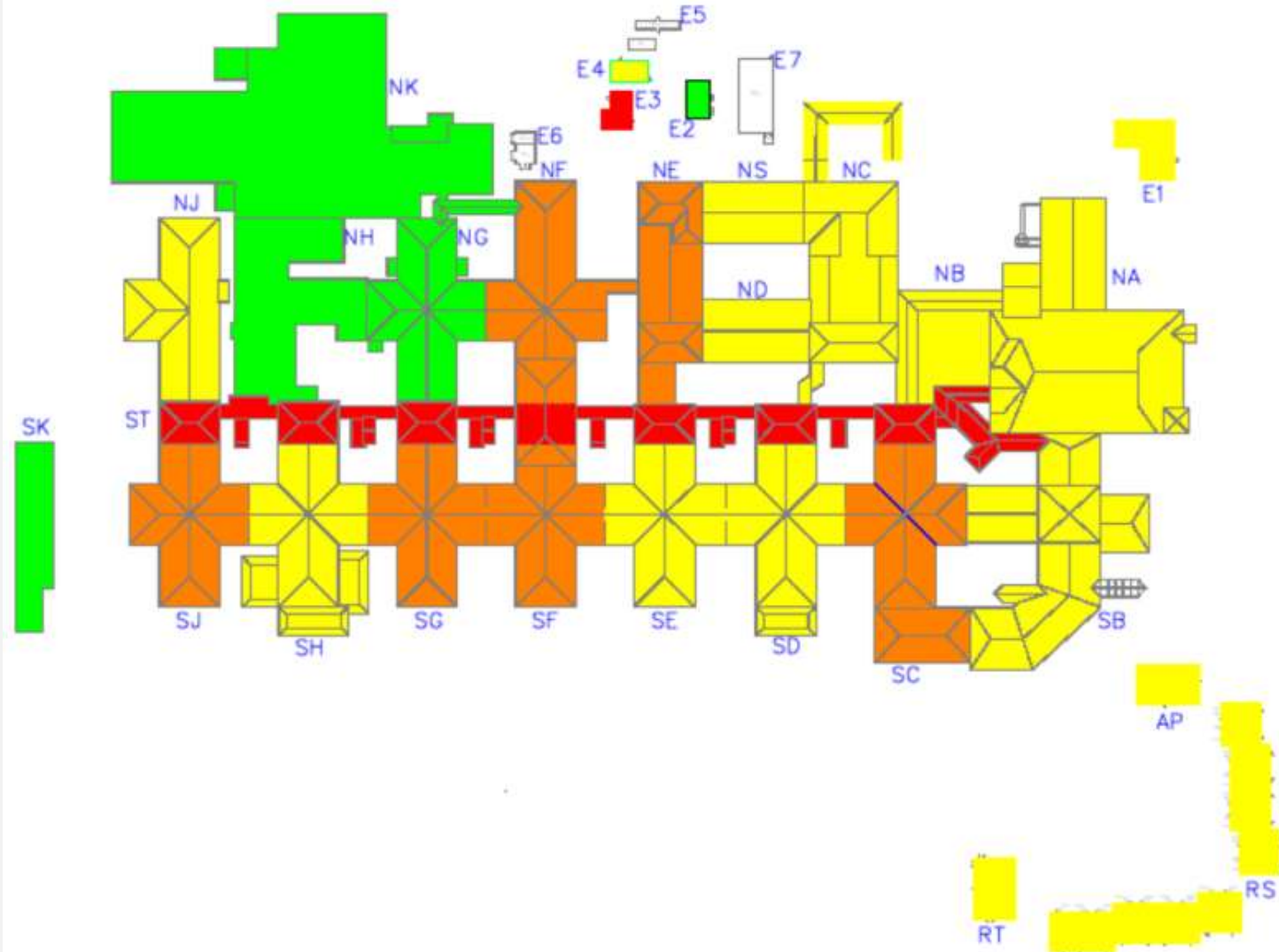
- 1980 - 2000
- 2000 - 2020



# 2. Where are we now

## A.Princess Royal Hospital Backlog Maintenance

Cost / m.sq.	Block Code	Block Name	Sum of Costs
£0 - £100	PRHE6- Block External	W&C HV Switch Room & Water Pumping Station	£1,502.75
	PRHE2- Block External	Medical Gases	£1,669.97
	PRHE4- Block External	Generator House No.4	£5,031.08
	PRHNG- Block NG	Ward 12/14 & 19	£110,954.73
	PRHNH- Block NH	Children's Outpatients	£53,040.00
	PRHNK- Block NK	Ward 18 & Wards 21 to 24	£186,169.03
	1PRHSK- Block SK	Ophthalmology	£24,306.65
£100 - £500	PRHAP- Block AP	Apley Clinic	£81,777.12
	PRHE1- Block External	Pump House	£19,970.49
	PRHNA- Block NA	Boiler House/Wrekin Maternity & Endoscopy	£948,490.17
	PRHNB- Block NB	Loading Bay/Sub Station 1&2	£375,552.74
	PRHNC- Block NC	Estates/MES/Stores & Catering	£1,552,617.74
	PRHND- Block ND	Pharmacy/Admin Hub	£336,023.30
	PRHNJ- Block NJ	GP X RAY/Fracture Clinic and Plaster Room	£219,810.00
	PRHNS- Block NS	Mortuary/Path Lab/Admin Hub	£442,027.02
	PRHRS- Block RS	Residences	£697,912.92
	PRHRT- Block RT	Doctors Mess	£80,201.91
	PRHSB- Block SB	Paul Brown/Wards 15 & 16	£863,125.76
	PRHSD- Block SD	Main Entrance/Education	£570,700.57
	PRHSE- Block SE	Outpatients/Ward 4 & Renal	£987,162.79
	PRHSH- Block SH	A&E/Wards 08 & 09/Head and Neck	£1,180,986.46
	£500 - £1000	PRHNE- Block NE	Admin Hub/Path Lab
PRHNF- Block NF		Apley Ward/AMU & Theatres 1 to 5	£1,912,541.85
PRHSC- Block SC		Rehabilitant/Education	£1,636,198.01
PRHSF- Block SF		Outpatients/Dental/ITU & HDU	£1,212,477.27
PRHSG- Block SG		X Ray/Wards 06 & 07/CCU	£1,332,494.19
£1000 - £1500	PRHSJ- Block SJ	Day Ward/Theatres 6,7 & 8/Wards 10 & 11	£1,470,703.50
	PRHE3- Block External	Generator House No.3	£82,264.29
	PRHST- Block ST	Street (Electrical, Vents, Heating, Aircon etc.)	£2,769,307.72
	Site	Pipe Work, Generators, Nurse Call, Carparks etc.	£2,053,976.36



## 2. Where are we now

### B. Princess Royal Hospital

#### FY 20/21 Backlog Programme

Thereafter the Trust will look to invest £1.5-2.5M per annum

#### Note:

There is no commitment on spend for FY 21/22 from projects commenced in FY 20/21. Where projects are extending to FY 21/22 they are additional phases and subject to confirmation of capital plan

Capital Project	FY 20/21 Spend
T120 - PRH BL Drainage Improvements	£104,115
T125 - PRH BL Nurse Call Systems	£37,444
T129 - PRH BL Theatre Lights	£98,230
T130 - PRH BL Generators (NI)	£11,274
T131 - PRH BL UPS/IPS (NI)	£578,598
T133 - PRH BL Ward Kitchen Refurbishments	£56,360
T102 - PRH W&C Plate Pack Controls	£31,553
T103 - PRH W&C Heating system	£33,304
T105 - PRH BL W&C Plate Pack Refurbishments	£48,925
T114 - PRH BL AHU	£391,416
T126 - PRH BL Roofing	£117,203
T121 - PRH BL Fire Improvements	£5,662
T124 - PRH BL Road Surfacing	£157,132
T127 - PRH BL Window Improvements	£75,104
T128 - PRH BL Flooring	£60,144
T106 - PRH BL Path Lab Lift	£12,133
T104 - PRH RO Pump House	£9,408
T123 - PRH BL Legionella	£84,270
T132 - PRH BL Shower Repairs (NI)	£93,983
T107 - PRH BL BMS Upgrade/Enabling	£34,396
<b>Total</b>	<b>£2,040,656</b>



Princess Royal Hospital		Gross Floor Area (m <sup>2</sup> )	£2,081	Backlog (Year 0) Summary	£s	Site Location & Description The Princess Royal Hospital is a medium sized acute hospital located to a relatively flat site on the edge of Telford town centre. The hospital is primarily a single concrete framed structure built in the late 1980s to a 'Nucleus' design format, the site is largely as built with the main exception being the modern Wrekin MLU Block built circa 2015 to the North of the Site.
Apley Castle		Net Usable Area (m <sup>2</sup> )	49,665	Low Risk	£195,059	
Telford		Building Year	1980-2015	Moderate Risk	£4,725,532	
TF1 6TF		Backlog (Year 0)	£16,506,488	Significant Risk	£30,194,803	
V2		Budget (Impending) - Year 1-5	£6,862,825	High Risk	£1,441,120	
Survey Date	October 2015	Total Cost (Exc. On Costs)	£23,369,313	Risk Adj Backlog	£16,506,487	



**Backlog (Year 0) Works**

Total remedial work required for the BUILDING, M&E, STATUTORY & FIRE Elements:

Building	£6,549,567
M&E	£9,431,783
Statutory Compliance	£77,174
Fire Safety	£447,964
<b>Backlog Total Cost</b>	<b>£16,506,488</b>

**Budget (Impending) - Years 1 - 5**

Total remedial work likely to be required within a 5 year period for the BUILDING, M&E, STATUTORY & FIRE Elements:

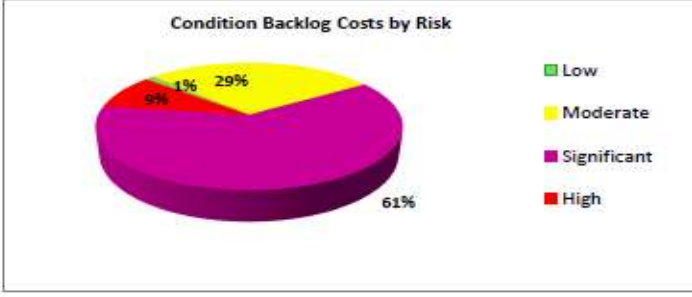
Building	£1,590,744
M&E	£5,272,081
Fire Safety	£0
<b>Future Planned Total Cost</b>	<b>£6,862,825</b>

<b>Combined Total Costs - Backlog &amp; Budget</b>	<b>£23,369,313</b>
<b>Combined Total Costs (Including On Costs)</b>	<b>£36,689,821</b>

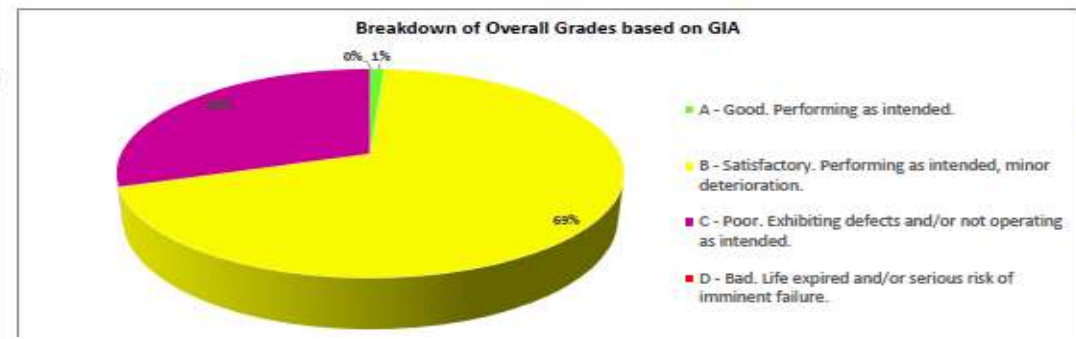
Figure above includes on-costs: Fees, VAT, Builder Preliminaries and Optimism Bias Contingencies.

**Cost Breakdown by Facet**

Facet 1 Physical Condition	£22,844,175
Facet 2 Functional Suitability	£0
Facet 3 Space Utilisation	£0
Facet 4 Quality	£0
Facet 5 Statutory Compliance	£525,138
Facet 6 Environmental Management	£0



Block Code	Block Name	BIA	Costs				Facet Grades						Overall Grade
			Backlog Costs	Budget Costs	Total Cost	Total Cost (Inc On-Costs)	Facet 1 Condition Grade	Facet 2 Function Grade	Facet 3 Space Utilisation	Facet 4 Quality Grade	Facet 5 Statutory Compliance Grade	Facet 6 Environmental Management	
000	Site	NA	£1,331,228	£723,572	£2,054,800	£3,228,035	B	N/A	N/A	N/A	N/A	D	C
0000	Whole Site	NA	£364,750	£0	£364,750	£886,658	N/A	N/A	N/A	N/A	N/A	Inc	N/A
AP	Apley Clinic, PRHAP	170	£48,476	£39,545	£88,021	£131,600	B(C)	B	Fully Used	B	B(C)	Inc	B
External	Generator House No 3, PRHE3	63	£94,571	£0	£94,571	£148,478	B	N/A	N/A	N/A	B	Inc	B
External	Generator House No 4, PRHE4	55	£46,157	£0	£46,157	£72,466	B	N/A	N/A	N/A	B	Inc	B
External	Medical Gases, PRHE2	58	£1,712	£0	£1,712	£2,687	B	N/A	N/A	N/A	B	Inc	B
External	Pump House, PRHE1	73	£19,213	£1,257	£20,470	£32,138	B(C)	N/A	N/A	N/A	B	Inc	B
External	WSC HV Switch Room & Water Pumping Station, PRHE6	44	£1,540	£0	£1,540	£2,418	B	N/A	N/A	N/A	B	Inc	B
NA	Boiler House & Endoscopy, PRHNA	3690	£948,783	£280,536	£329,319	£1,459,031	B	B	Fully Used	B	B(C)	Inc	B
NB	Loading Bay/Sub Station 1 & 2, PRHNB	1047	£308,694	£76,248	£384,942	£604,358	B(C)	N/A	N/A	N/A	B	Inc	B
NC	Estates/MES/Stores & Catering, PRHNC	3269	£1,345,739	£445,694	£1,591,433	£2,408,599	B	B	Fully Used	B	B	Inc	B
ND	Pharmacy/Admin Hub, PRHND	1394	£259,916	£54,508	£314,424	£540,745	B(C)	C	Overcrowded	B	B	Inc	C
NE	Admin Hub/Path Lab, PRHNE	2542	£717,345	£421,151	£1,138,496	£1,787,324	C	B	Fully Used	B	B	Inc	B
NF	Apley Ward/AMU & Theatres 1 to 5, PRHNF	3442	£1,026,959	£935,396	£1,962,355	£3,077,758	C	C	Fully Used	B	B	Inc	C
NG	Wards 12/14 & 19, PRHNG	3105	£44,378	£69,450	£113,828	£178,554	B	B	Fully Used	B	B	Inc	B
NH	Children's Outpatients, PRHNH	1339	£0	£54,268	£54,268	£85,355	B	B	Fully Used	B	B	Inc	B
NJ	GP X RAY/Fracture Clinic & Plaster Room, PRHNJ	919	£70,049	£155,257	£225,306	£353,729	B	C	Overcrowded	B	B	Inc	B
NK	Ward 18 & Wards 21 to 24, PRH NK	8486	£41,000	£190,823	£231,823	£383,593	A	B	Fully Used	B	B	Inc	B
NL	Wrekin MLU, PRHNL	865	£41,000	£0	£41,000	£64,370	B	B	Fully Used	B	B	Inc	A
NS	Mortuary/Path Lab/Admin Hub, PRHNS	1421	£358,323	£94,735	£453,058	£711,332	B(C)	B	Fully Used	B	B	Inc	C
RS	Residences, PRHRS	1050	£527,804	£187,447	£715,251	£1,123,116	B	B	Fully Used	B	B	Inc	B
RT	Block RT - Doctors Mess, PRHRT	167	£57,363	£24,844	£82,207	£125,865	B(C)	B	Underused	B	B	Inc	B
SB	Paul Brown/ Wards 15 & 16, PRHSB	3330	£318,346	£255,785	£774,131	£1,211,909	B	B	Fully Used	B	B	Inc	B
SC	Rehabilitation/ Education, PRHSC	3955	£1,391,670	£485,233	£1,876,903	£2,633,052	B(C)	B	Fully Used	B	B	Inc	B
SD	Main Entrance/ Education, PRHSD	3123	£308,287	£276,681	£584,968	£928,400	B	B	Fully Used	B	B	Inc	B
SE	Outpatients/ Ward 4 & Renal, PRHSE	3050	£699,088	£312,754	£1,011,842	£1,588,392	B(C)	B	Fully Used	B	B	Inc	B
SF	Outpatients/Dental/TU & HDU, PRHSF	2908	£903,406	£341,382	£1,344,788	£1,951,179	C	B	Fully Used	B	B	Inc	C
SG	X Ray/Wards 06 & 07/CCU, PRHSG	2979	£1,066,815	£298,992	£1,365,807	£2,144,316	C	C	Overcrowded	B	B	Inc	C
SH	A&E/ Wards 08 & 09/Head & Neck, PRHSH	3602	£827,477	£383,054	£1,210,531	£1,900,302	C	B	Fully Used	B	B	Inc	C
SJ	Day Ward/Theatres 6,7 & 8/Wards 10 & 11, PRHSJ	2997	£1,209,467	£298,004	£1,507,471	£2,366,739	C	C	Overcrowded	B	B	Inc	C
SK	Ophthalmology, PRHSK	457	£24,914	£0	£24,914	£39,115	B	B	Fully Used	B	B	Inc	B
ST	Street, PRHST	4505	£2,410,209	£428,331	£2,838,540	£4,456,508	B(C)	B	Fully Used	B	B	Inc	B
<b>TOTAL</b>		<b>62,081</b>	<b>£16,506,488</b>	<b>£6,862,827</b>	<b>£23,369,314</b>	<b>£36,689,823</b>							



**Facet Key**

**Physical Condition:**  
 A - Good. Performing as intended.  
 B - Satisfactory. Performing as intended, minor deterioration.  
 C - Poor. Exhibiting defects and/or not operating as intended.  
 D - Bad. Life expired and/or serious risk of imminent failure.

**Quality**  
 A - A facility of excellent quality.  
 B - A facility requiring general maintenance investment only.  
 C - A less than acceptable facility requiring major capital investment or replacement.  
 D - A very poor facility requiring major capital investment or replacement.

**Functional Suitability**  
 A - Very satisfactory, no change needed.  
 B - Satisfactory, minor change needed.  
 C - Not satisfactory, major change needed.  
 D - Unacceptable in its present condition.

**Statutory Compliance**  
 A - Complies with all relevant standards and relevant guidance.  
 B - Action required to comply with relevant guidance and statutory requirements.

# PRH Backlog Figures June 21

# 2. Where are we now

## B. Princess Royal Hospital

### Parking

Area	Staff Parking	Patient Parking
1a		212
1b	154	
2	350	
3	28	
4	57	
5	68	
6		376
7	35	
<b>Total</b>	<b>692</b>	<b>588</b>
<b>Grand total</b>		<b>1280</b>

Note: Impact assessment of working from home on staff parking and virtual outpatients on visitor parking will need to be commissioned. Consideration being given for new MSCP.







Capital Projects	Type	FY 20/21 Spend
PRH BL Roofing	Roofing	£100,000
Kitchens Both Sites	Kitchens	£100,000
PRH BL Theatre Lights	Theatre Lights	£100,000
PRH BL Fire Improvements	Fire	£100,000
PRH Shower wards	Building	£100,000
PRH BL Flooring	Flooring	£100,000
PRH BL Road Surfacing	Roadworks	£100,000
PRH BL Window Improvements	Windows	£50,000
PRH BL Drainage Improvements	Building	£50,000
Car park / Road Surface	Roadworks	£100,000
PRH Legionella/Wash hand basins (Clinical areas)	Water	£100,000
PRH AHU HDU / ITU	AHU	£400,000
PRH BL W&C Plate Pack Controls	Mechanical	£56,000
PRH BL W&C Plate Pack Refurbishments	Mechanical	£56,000
PRH AHU Womens and Childrens (DC)	AHU	£50,000
PRH BL W&C Chiller Units	Mechanical	£32,000
BMS Upgrade software + W&C BMS control	BMS	£25,000
PRH BL W&C Heating System	Mechanical	£42,000
PRH BL RO Pump House	Mechanical	£84,000
PRH BL Path Lab Lift	Electrical	£11,000
VIE plant	Mechanical	£100,000
PRH Theatre UPS / IPS	Electrical	£500,000



# 3. Interim Position

Royal Shrewsbury Hospital

Same Day Emergency Care (SDEC)

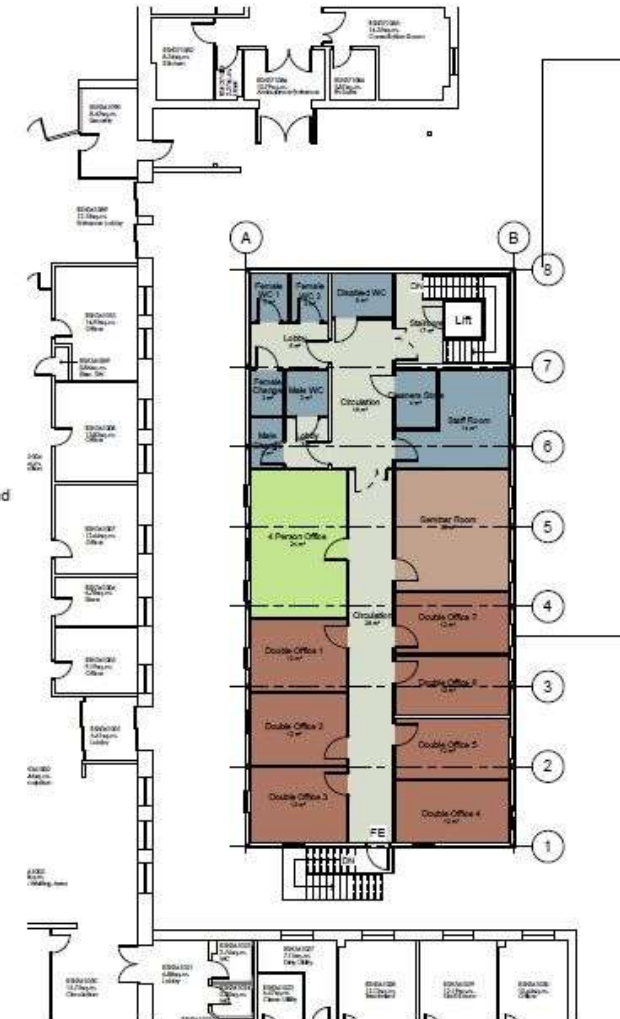
Completed 2020



1 Level 0, GA SDEC Plan  
1:100

By Department Legend

- Circulation
- Clinical Space
- Clinical Support Spaces
- Entrance Facilities
- Plant
- Staff Support Facilities



2 Level 1, Relocated Office Accommodation Plan  
1:100

By Department

- 2 Person Office
- 4 Person Office
- Circulation
- Sanitary Room
- Staff Support Facilities

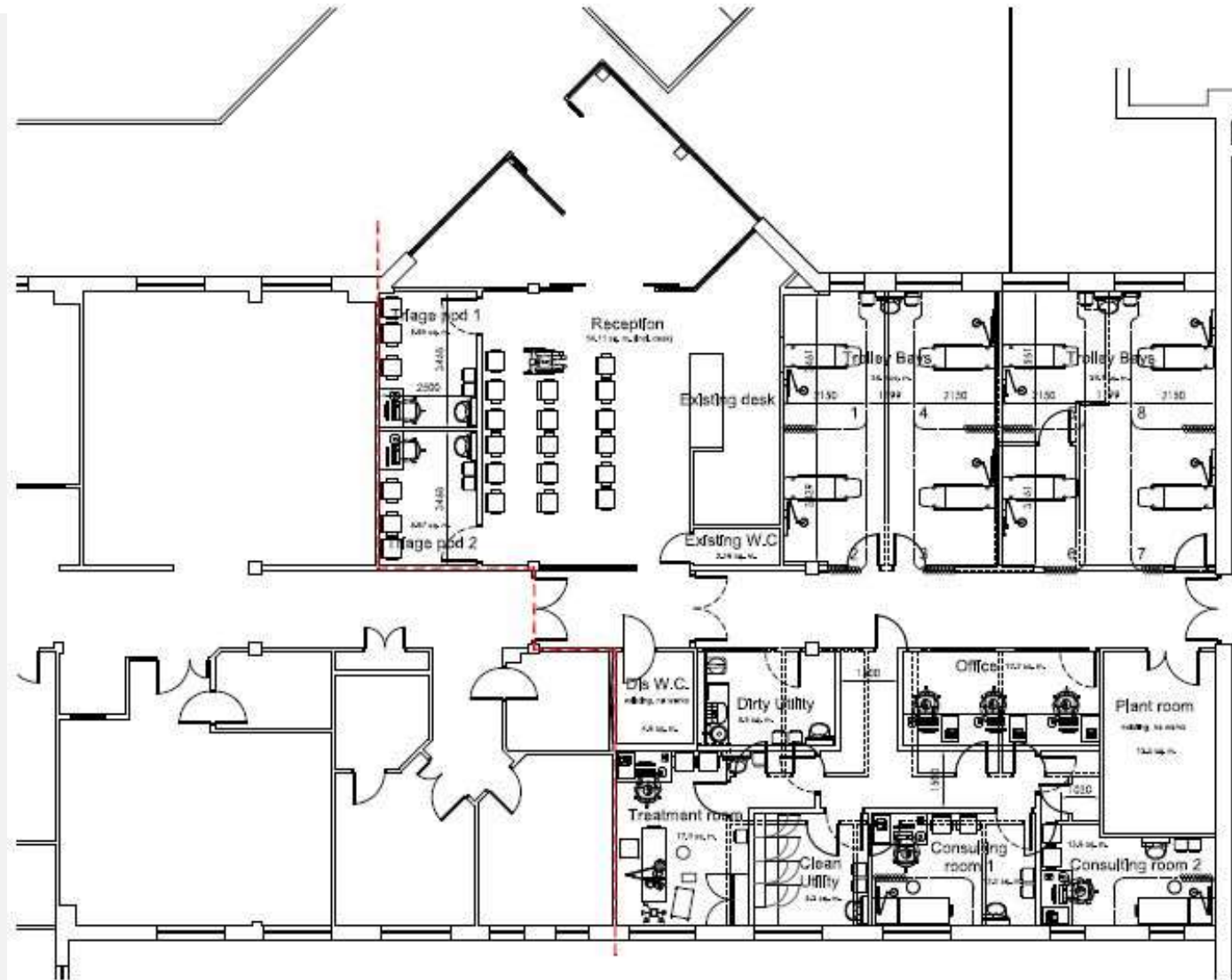


# 3. Interim Position

Royal Shrewsbury Hospital

SAU Clinical Refurbishment

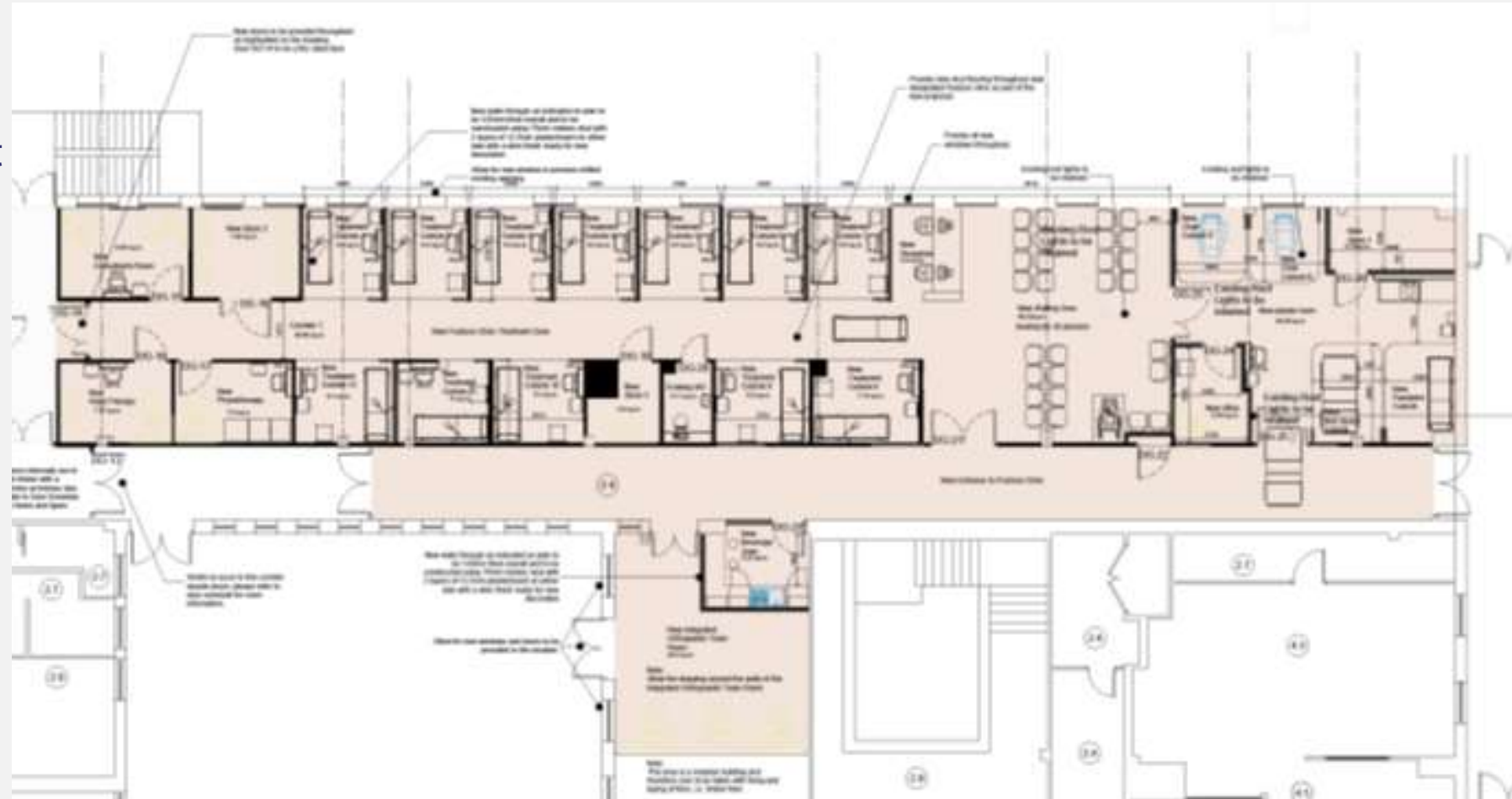
Completed 2021



# 3. Interim Position

Royal Shrewsbury Hospital

Fracture Clinic Refurbishment  
Completed 2021

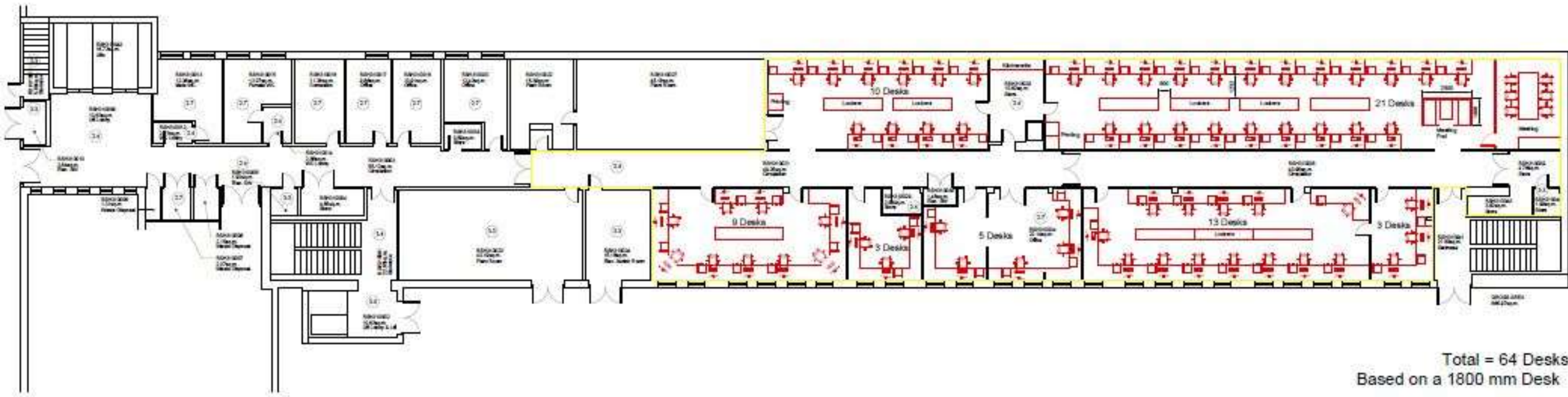




# 3. Interim Position

## Royal Shrewsbury Hospital

Medical Records Refurbishment for SAU – Completed 2020



Total = 64 Desks  
Based on a 1800 mm Desk



# 4. Backlog 5 Year Programme Both Sites

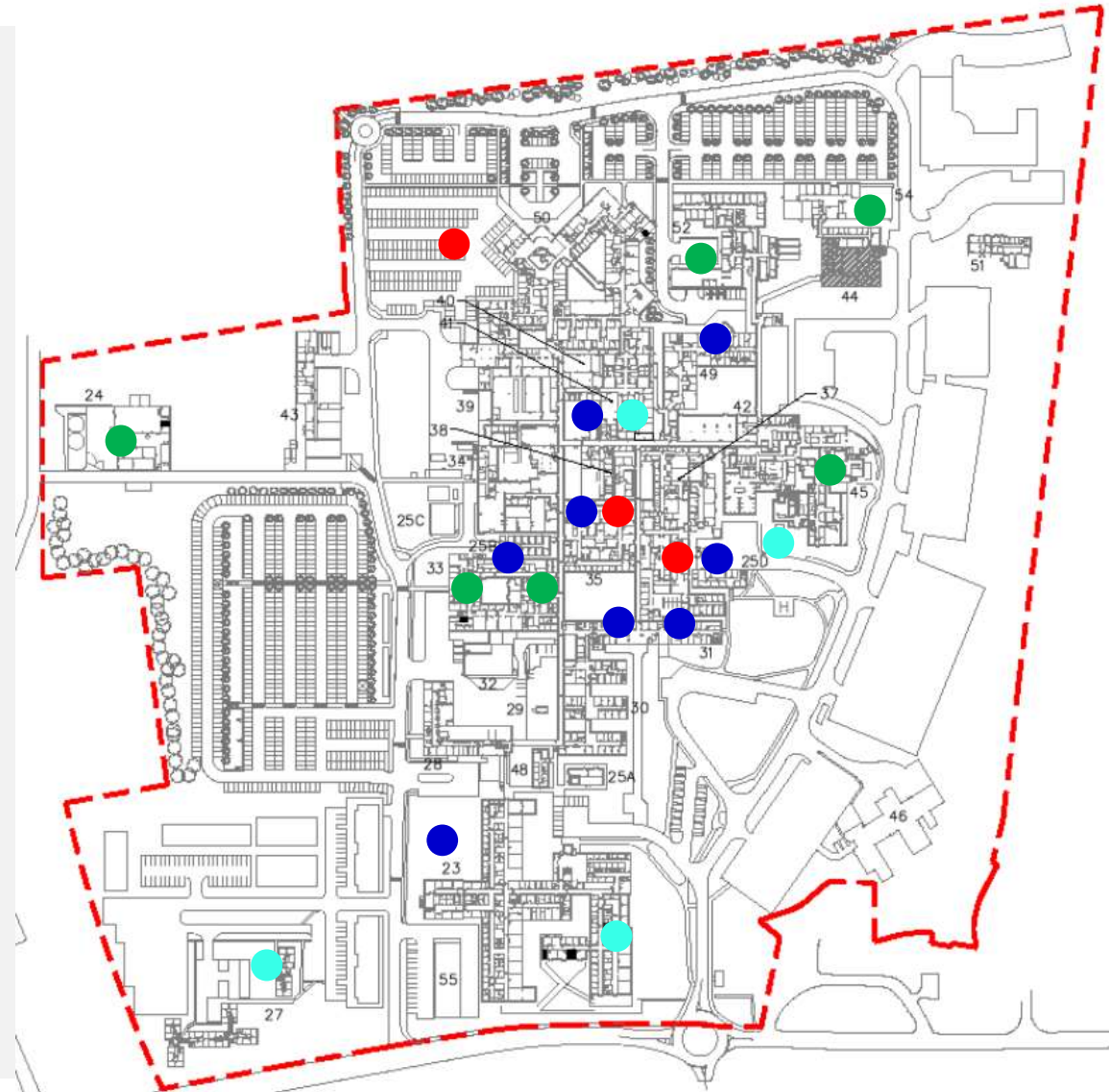
Carry Over Excluding UPS / BMS schemes					£ 500,000				
Building									
Fire									
		Alarms			£ 150,000	£ 150,000	£ 150,000	£ 150,000	£ 150,000
		Doors / Dampers / Compartmentation			£ 150,000	£ 300,000	£ 300,000	£ 300,000	£ 300,000
Asbestos									
		Survey			£ 50,000	£ 35,000	£ 35,000	£ 35,000	£ 35,000
		Removals			£ 60,000	£ 60,000	£ 60,000	£ 60,000	£ 60,000
		Ducts			£ 50,000	£ 50,000	£ 50,000	£ 50,000	£ 50,000
Drainage					£ 40,000	£ 40,000	£ 40,000	£ 40,000	£ 40,000
Roofs					£ 50,000	£ 350,000	£ 350,000	£ 350,000	£ 350,000
Flooring					£ 50,000	£ 150,000	£ 150,000	£ 150,000	£ 150,000
Roads					£ 50,000	£ 50,000	£ 100,000	£ 100,000	£ 100,000
Kitchens						£ 50,000	£ 50,000	£ 50,000	£ 50,000
Windows						£ 100,000	£ 100,000	£ 50,000	£ 50,000
Mechanical									
AHUs					£ 1,200,000	£ 1,200,000	£ 1,200,000	£ 1,200,000	£ 1,200,000
Heating						£ 100,000	£ 100,000	£ 100,000	£ 100,000
Calorifiers / Plate Heat Packs					£ 200,000	£ 400,000	£ 400,000	£ 200,000	£ 200,000
BMS				£ 500,000	£ 600,000				
BMS Controls						£ 80,000	£ 80,000	£ 80,000	£ 80,000
Tube System					£ 50,000	£ 150,000	£ 50,000	£ 50,000	£ 50,000
Water / Legionella (PRH - RA Deadleg removal)					£ 100,000	£ 50,000	£ 50,000	£ 50,000	£ 50,000
Sanitary Compliance					£ 50,000	£ 50,000	£ 150,000	£ 80,000	£ 80,000
Other Mechanical						£ 50,000	£ 50,000	£ 50,000	£ 50,000
Braithwaite Water Tanks					£ 60,000	£ 60,000	£ 60,000	£ 60,000	£ 60,000
Concrete Water Lagoons						£ 60,000	£ 60,000	£ 60,000	£ 60,000
Medical Gas Infrastructure - excluding requirements for a new ring main					£ 50,000	£ 50,000	£ 50,000	£ 50,000	£ 50,000
Medical Gas Pendants in Theatres					£ 50,000	£ 50,000	£ 50,000	£ 50,000	£ 50,000
Main Water In-comer					£ 100,000				
R32 Gas Replacement					£ 20,000	£ 80,000	£ 80,000	£ 80,000	£ 80,000
Steam Main Infrastructure Repairs					£ 100,000	£ 150,000	£ 150,000	£ 50,000	£ 50,000

# 4. Backlog 5 Year Programme Both Sites

Electrical										
	DBs / Switchboards					£ 75,000	£ 200,000	£ 200,000	£ 300,000	£ 200,000
	Crossbonding - Earthing					£ 50,000	£ 300,000	£ 300,000	£ 300,000	
	UPS / IPS Installations					£ 500,000	£ 300,000	£ 300,000	£ 300,000	£ 300,000
	Theatre Lights / Upgrades							£ 150,000	£ 150,000	£ 150,000
	Lifts					£ 50,000	£ 180,000	£ 180,000		
	Nurse Call					£ 100,000	£ 100,000	£ 100,000	£ 100,000	£ 100,000
	Subway Ducts					£ 500,000	£ 735,000			
	Body Fridges - PRH					£ 53,000				
SSD	Autoclaves- Queensway					£ 100,000	£ 300,000	£ 600,000	£ 500,000	
Queensway Engineering Infrastructure						£ 50,000				
					£ 500,000	£ 5,208,000	£ 5,980,000	£ 5,745,000	£ 5,145,000	£ 4,245,000
Excluding VAT						£ 4,340,000	£ 4,983,333	£ 4,787,500	£ 4,287,500	£ 3,537,500
VAT @ 20%						£ 868,000	£ 996,667	£ 957,500	£ 857,500	£ 707,500
Vat Reclaim @ 50%						£ 434,000	£ 498,333	£ 478,750	£ 428,750	£ 353,750
<b>Outturn</b>						<b>£ 4,774,000</b>	<b>£ 5,481,667</b>	<b>£ 5,266,250</b>	<b>£ 4,716,250</b>	<b>£ 3,891,250</b>

# 4. RSH – 5 YEAR CAPITAL PROGRAMME

Key	Year	Schemes	Cost £(000)
20/21		A&E SDEC	£3,026
		Fracture Clinic	£1,224
		SAU Clinical	£880
		Admin Corridor	£560
		Exec Offices	£180
		A&E Enabling Works	£580
		MRI/CT Pod	£2,100
		DSU	£240.5
		Bioquell/ Redrooms	£124
		Philips Diagnostic Equipment Roll out	£2350
		Staff Rooms	£220
21/22		A&E Refurbishment	£8,300
		Philips Diagnostic Equipment Roll out	£1070
		New CT Radiology	£600
22/23		*32 Bed Modular Ward	£7100
		Linac Bunker	£4,000
		ITU/HDU/Theatre Recovery	£9,800
		W16 Training Centre into Mytton Oak	£2,250
23/24		Nurses Accommodation	£150
		Energy Centres	£7500
		Darrt Relocation (W18) / Refurbishment	£500
		PAU Refurbishment	£150
		Renal Refurbishment	£1,100
		Refurbishment of Therapies areas	£1,000
		New Therapies Centre (Faculty of Health)	£2,400



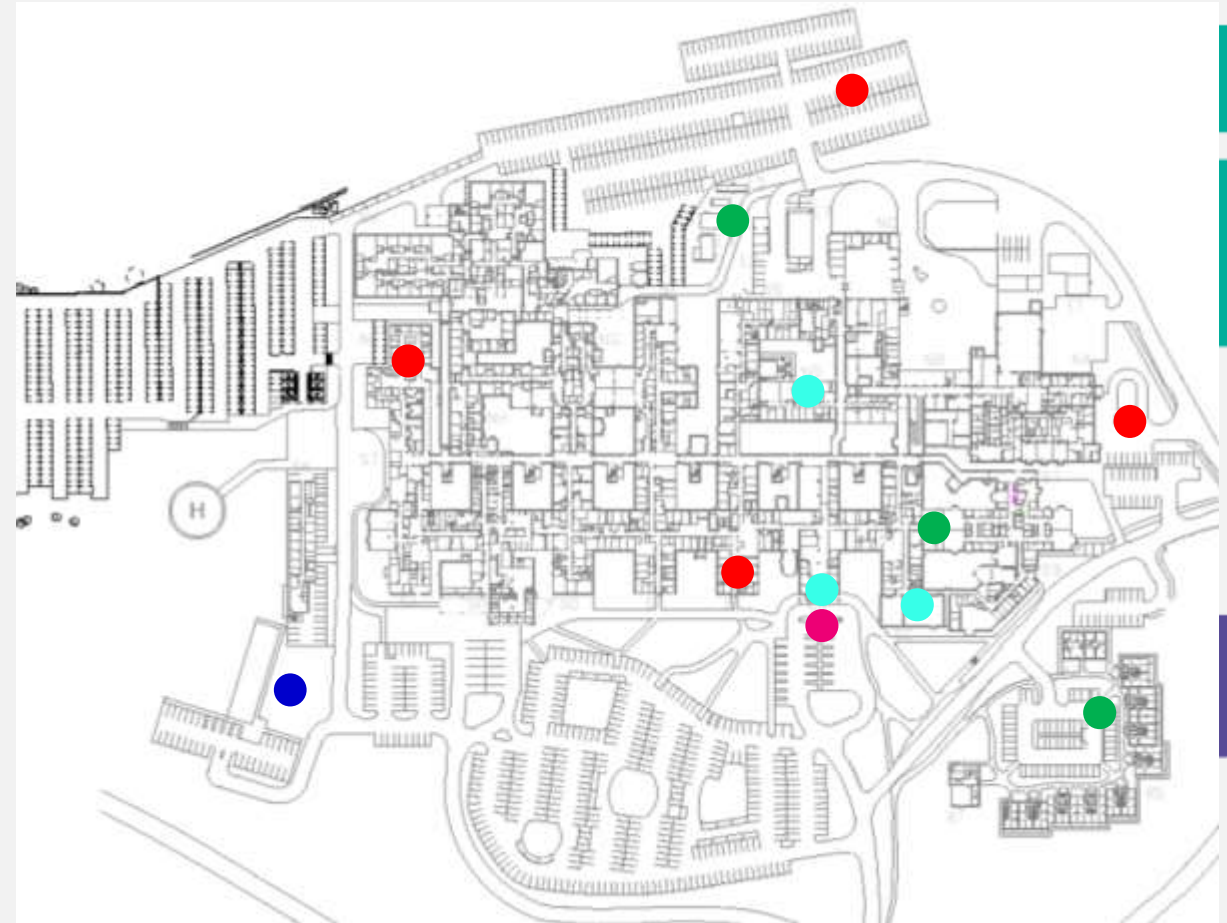
RSH - Total Cost and Additional Beds Created	
5yr Total Capital Cost	£60,025



# 4. PRH – 5 YEAR CAPITAL PROGRAMME

Key	Year	Schemes	Cost £(000)
Blue	20/21	DSU	£240.5
		Bioquell/ Redrooms	£124
		Philips Diagnostic Equipment Roll out	£2350
		Staff Rooms	£220
		Modular Office	£680
Red	21/22	Philips Diagnostic Equipment Roll out	£1070
		New CT Radiology	£600
		*Single Deck Car Park	£1,600
		*Renal Off Site	£4,500
		*Renal Refurbishment	£500
		*Cardio Respiratory Modular	£3,000
Cyan	22/23	Main Entrance (commercial Development)	£5,000
		New Admin Office Hub	£2,000
		Education Centre Relocation/Refurbishment	£2,000
		Admin Hub Refurbishment	£1,000
		Old Medical Records Area	£250
Green	23/24	Energy Centres	£7500
		Refurbishment of Paul Brown Building	£1,500
Pink	24/25	New Main Entrance (Commercial Development)	£5,000

PRH - Total Cost and Additional Beds Created	
5yr Total Capital Cost	£35,564





# 4. Projects: Aspirational 5-Year Programme

**RSH A&E refurbishment** will commence in April 21 and will be phased, with main clinical space delivered by Dec 21 and project fully complete by March 22. These timings have been agreed with NHSI

**RSH MRI/CT** ground works commence in March 21 and is due for completion and occupation in June 21.

In addition to the above, work is underway to erect the **Ironbridge Suite** at PRH which is a new 60-desk office modular adjacent to the pre-existing Malling Health modular.

The **Malling Health** building and land is in the process of being transferred to the Trust from NHS Property Services via a **zero cost** asset transfer process. The PRH land housing the rear car park and helipad is also being legally transferred from NHS Property Services following an uncompleted Transfer in 2013/14, when the Women & Children's centre transferred from RSH to PRH.

Proposals for a developer-funded new two-storey **commercial front entrance at PRH** are currently being worked-up. This development would house retail offerings and waiting space for patients and staff and potentially create additional capacity on the second floor by re-providing the Education Centre which is located within a ward template. It would also provide assurance to local residents that there is continued investment in their local hospital.

In addition to the above estates have successfully completed and handed over **Ophthalmology department (Cataract Suite) in Ward 20** and **W18 fire compartmentation** works in the **Copthorne building will be completed in April 2021**.

Bids against NHSI capital allocations to create additional capacity in 21/22 are in development. Currently this includes providing **Modular ward(s) at RSH, and PRH Renal Dialysis Unit moving off-site** to create a 20-bedded ward, with the **PRH Cardio-respiratory service moving to an on-site modular building to release the 10-bedded en-suite Apley Ward** to use as an isolation /infectious diseases ward. We are currently awaiting feedback from the centre.

HTP SOC proposals are still being progressed. For this purpose the Estates Plan may change dependent on the outcome of the approval process and aligned with the current site review of clinical adjacencies and in light of space maximisation. Clinical service plans will be revisited and Strategic Projects programme will adapt to the services plan as it is developed. Other physical capacity projects currently being considered are

## Critical Care

- Ensure sufficient capacity

## Renal Satalite

## Diagnostics

- Linac RSH / CT RSH / Remote Diagnostics

## Therapies

- Attend anywhere

## Outpatients

- Maximising Outpatient Utilisation
- Use of community provision

# 5. Sustainability

## Sustainability Programme of Works

Projects being explored

- Energy Centre
- Infrastructure and Energy
- LED lighting
- BMS Controls
- Steam calorifier to PHX conversion (and controls)
- Steam trap replacement
- BMS (either standalone or bureau controlled)
- LED lighting (but not external)
- Cavity wall insulation
  - PRH original building, residences, old Doc's Mess
  - RSH School of Health, Hamar, Hummingbird, Mytton Oak Building, old Lingen Davis.
- Motor replacement – with high efficiency replacements (could include pump replacement)
- Motor controls – VSDs
- Ventilation – fan / motor replacement
- Boiler replacement – any gas boilers in outlying buildings (to be replaced with condensing / combi boilers)
- Energy efficient industrial catering ovens
- Offsite generation



## Delivering a 'Net Zero' National Health Service



# 5. Sustainability

The Trust is committed to achieving the NHS Plan “Delivering a Net Zero National Health Service” (NHE&I October 2020) to be carbon net-zero by 2040 for our direct emissions, and by 2045 for those that we can influence. We will adopt the Net Zero Carbon Hospital Standard when this is released. The Plan encompasses all of the NHS activities, and this Estates Plan focuses on the elements that are directly related to estates. In order to achieve the required standard, a SaTH ‘Green Plan’ and ‘Heat Decarbonisation Plan’ will need to be developed. Procurement of this piece of work is being progressed.

Across the NHS, Estates activities account for approximately 15% of carbon emissions, therefore we will be taking local approaches to minimise this, including:

# 5. Sustainability

## 1. Construction

- a. Our approach will be to minimise new construction by firstly re-using existing buildings where suitable and economically viable, and secondly, by maximising occupancy in terms of density and time periods. The latter is a metric within Model Hospital.
- b. Where new construction is required, on larger schemes, we will adopt BREEAM Methodology to assess the lifetime environment impacts of products. To minimise waste and spoilage during construction, we will use off-site manufacture where possible. A similar approach will be taken to building services, with an emphasis on standardised components and assemblies so as to reduce stock holdings.
- c. Our new buildings will be designed to be resilient to the effects of climate change.

# 5. Sustainability

## 2. Energy usage

- a. We will be replacing, upgrading and extending our Building Management Systems to ensure that they continue to perform optimally. The systems will be checked at regular intervals to ensure that they are correctly programmed to match occupancy.
- b. We have undertaken a Trust-wide programme of LED lighting installation and all new buildings and refurbished areas will include this or any subsequent lighting technology. Light-level and occupancy sensors will be installed where appropriate.
- c. Much of our estate is single glazed with metal-framed windows (without thermal breaks). These will be upgraded over time. Walls and roofs will receive thermal improvement as and when the opportunity arises.
- d. Our energy centres currently generate steam, this being a legacy of now-past requirements. We are actively looking to de-steam our sites and at the same time, to install low-carbon technology. We already has Combined Heat and Power Plants – and we are looking to the next tier of technology, including opportunities around solar, heat pumps and low-carbon electricity.
- e. Our IT equipment already includes automatic power-down and we will consider heat recovery from server rooms as part of our major hospital redevelopment.
- f. We already deploy low-flow showerheads. We will consider other devices to prevent water wastage where these do not compromise safety or cleanliness.



# 5. Sustainability

## 3. Waste

- a. We already undertake a degree of waste segregation to ensure legal compliance but there are opportunities for further segregation, subject to adequate storage space being made available. Future plans will have to accommodate additional space to enable additional segregation. We are also looking at ward-level opportunities, so as to achieve a greater degree of segregation at the point of production.
- b. As technology develops, techniques such as a pyrolysis will be investigated for on-site treatment of our waste.

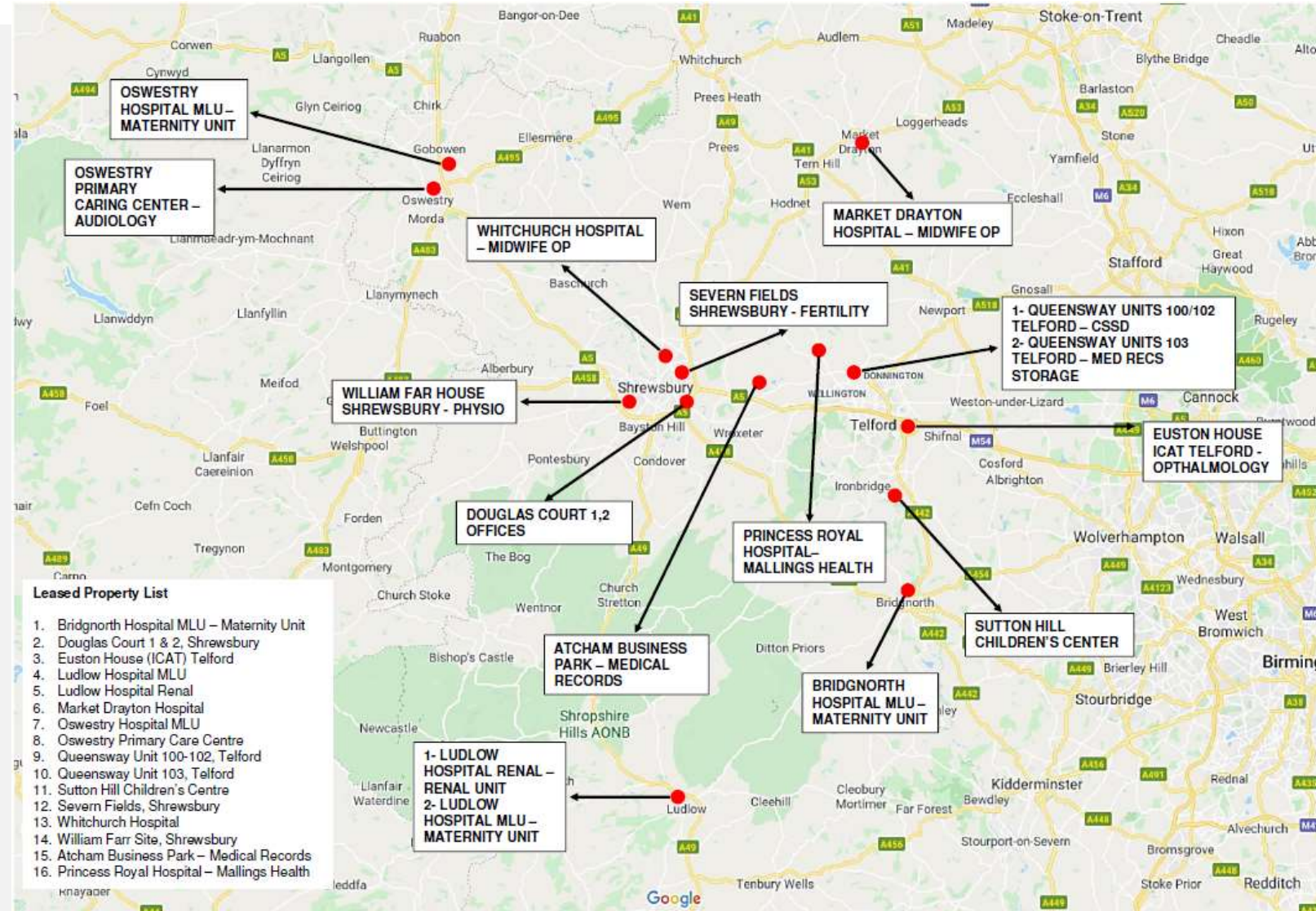
## 4. Transport

- a. The NHS moves large amounts of commodities, people and waste. We will work closely with our Estates suppliers to reduce the number of delivery vehicles coming to site, and furthermore, we will encourage the use of alternative-fuelled vehicles so as to minimise emissions.
- b. We are exploring the installation of electric vehicle charging points on both sites as well as electrifying our fleet.
- c. Whilst outside the remit of this Estates Plan, we will encourage the use of alternative modes of transport for our staff and visitors – be that by bus, walking or cycling, We will provide secure and well-lit cycle parking facilities. Our parking charging will reward staff that either car share or reduce use of the car.

# 6. Community

## SATH LEASED PROPERTY MAP 2019/2020

- Vacating Douglas court being explored
- Vacating Euston House
- Identify better VFM options
- Malling Health: on PRH Site but currently leased from NHS Property services – pending land transfer business case)
- Review required for all leases property to ensure they are suitable in terms of location, size and are VFM.
- NHS PS are investigating options to relocate our Therapies services at William Farr to an alternative location.



**Leased Property List**

1. Bridgnorth Hospital MLU – Maternity Unit
2. Douglas Court 1 & 2, Shrewsbury
3. Euston House (ICAT) Telford
4. Ludlow Hospital MLU
5. Ludlow Hospital Renal
6. Market Drayton Hospital
7. Oswestry Hospital MLU
8. Oswestry Primary Care Centre
9. Queensway Unit 100-102, Telford
10. Queensway Unit 103, Telford
11. Sutton Hill Children's Centre
12. Severn Fields, Shrewsbury
13. Whitchurch Hospital
14. William Farr Site, Shrewsbury
15. Atcham Business Park – Medical Records
16. Princess Royal Hospital – Malling Health

# 7. Model Hospital

## Estates and Property Maintenance Cost (£ per m2)

S01\_08 Estates and Property Maintenance /

S02\_02 Areas – Occupied Floor Area

Definition encompasses:

All estates and property maintenance costs include:

- estates and property management revenue and costs relating to trust's capital programme;
- equipment maintenance relating to the built environment;
- backlog maintenance monitoring,
- implementing and managing associated investment – fire safety and health & safety compliance relating to the built environment
- only revenue costs are included and capital compliance expenditure is excluded.

**Trust £34**

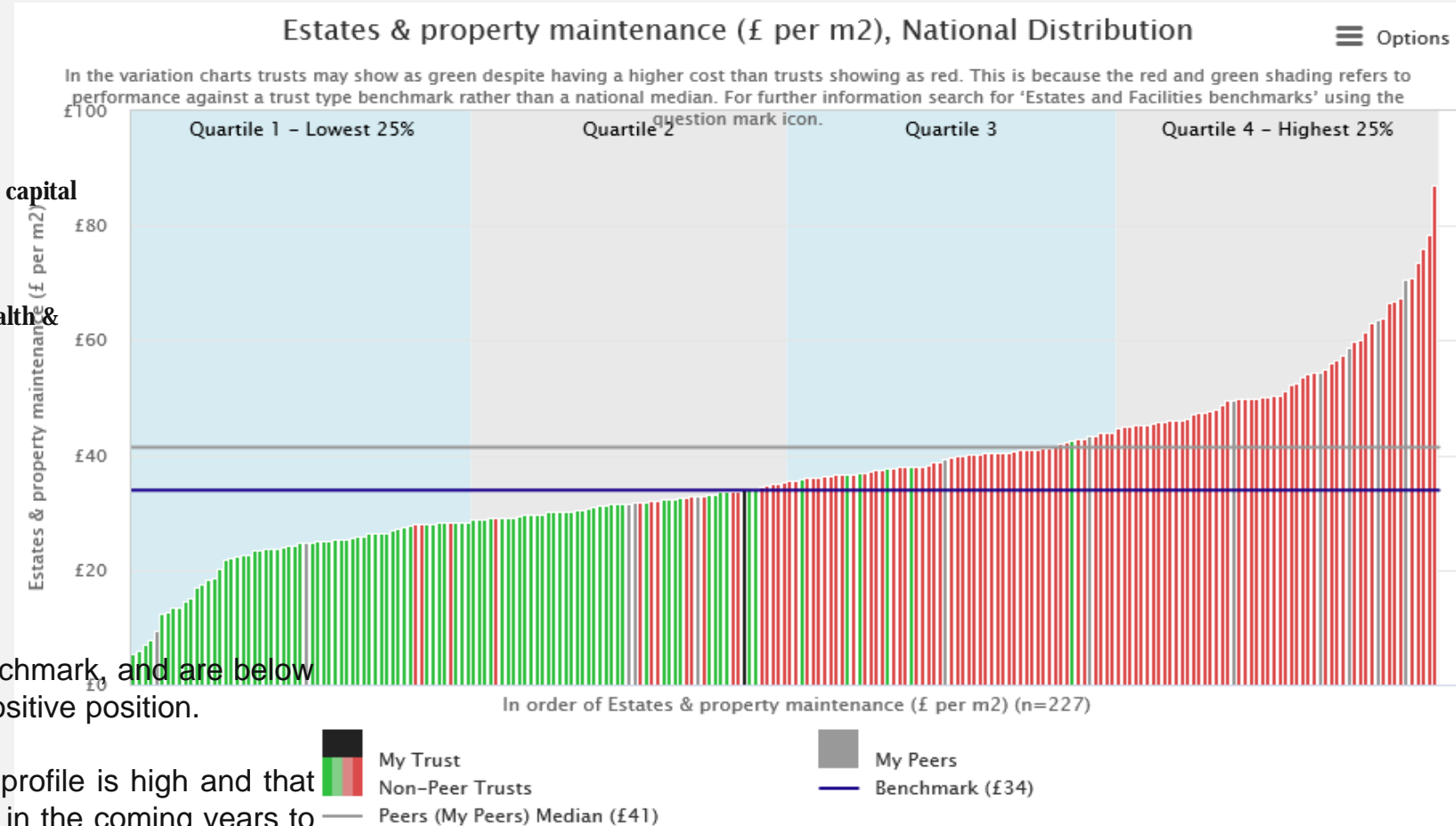
MH Peer £36 (SaTH Peer £41)

Benchmark £34

Commentary:

Estates and Property Maintenance costs are at the benchmark, and are below the MH and SaTH peer group mean. All of which, is a positive position.

It must be noted that data shows that the estates age profile is high and that additional apprentices and B3/B4 posts will be required in the coming years to ensure maintaining of high levels of statutory maintenance compliance (HTMs). Estates have delivered PPM compliance at 65% on average during 2020.









# 7. Model Hospital – Space Utilisation

Management of non-clinical space at SaTH space is below national targets (30.9%) and peer median (32.5%)

However empty space and under utilised space is high. This is as a result of ongoing works in the Copthorne building which when completed will improve metrics on Empty Space % and Amount of Under-Utilised Space %.

The Trust has no private patient space.

The Trust has commissioned a re-survey of all space on the estates MICAD system to ensure it is valid. A Trust wide adjacencies exercise has also been commissioned.

Space usage				
<b>Amount of non-clinical space (%)</b>				
Data period	Trust value	Peer median	Benchmark value	
2018/19	25.7%	32.5%	30.9%	
<b>Amount of empty space (%)</b>				
Data period	Trust value	Peer median	Benchmark value	
2018/19	1.8%	0.9%	1.1%	
<b>Amount of under-utilised space (%)</b>				
Data period	Trust value	Peer median	Benchmark value	
2018/19	1.3%	0.7%	1.0%	
<b>Private patient space (%)</b>				
Data period	Trust value	Peer median	Benchmark value	
2018/19	0.00%	0.00%	0.00%	

# 8. Model Hospital Space Management

The 'Accommodation Control Group' (ACG) has responsibility for management and allocation of space throughout the organisation. The remit of the ACG is:

- Space Management
- Space Utilisation (room and desk booking)
- Outpatient space management

The impact of Attend Anywhere on space management will be considered at ACG.

The group has instructed an Adjacencies review across the sites to inform the group when prioritising space across. A survey of all space usage is also underway to ensure MICAD space data accuracy. The ACG will explore ways of working on hot-desking provision and measuring utilisation.

Room and desk booking functions are now available via the Estates MICAD system. Any user group may request the addition of their space to the system for booking.

Space booking across STP / ICS is being explored via the Local Estates Forum (LEF)

## Space Availability

In FY 21/22 **145m<sup>2</sup> of Mytton Oak** will be vacated when the MLU moves back into Copthorne W18. This could be considered as alternative accommodation for Therapy Services which are currently located on the William Farr site but the accommodation is not satisfactory. However this will be dependent on a wider review of ongoing service provision.

In addition the **Faculty of Health Building and Learning Centre** on the RSH site lease will end in FY 24/25 which could be used for other services, although it is likely that Staffordshire University will wish to extend the Lease to provide nurse training on-site. Currently they pay a peppercorn rent and should the Lease be re-negotiated a commercial rent will be set. The Services SLA is also being reviewed currently as it does not meet current costs incurred by SaTH.

The 6 inpatient real beds transferred to ward 35 Copthorne in March 2021, as Phase 1. There is a Business Case for Phase 2 which involves moving the Renal Dialysis Unit across to Ward 35, however this has not yet been approved

The **old nurse residence** at the back of the RSH site continues to be under used. Estates have brought some of these areas back into use due to urgent need for office space during COVID-19. The Trust is also paying a **200% council tax premium** on these empty building of around **£60k pa**.



# 9. Compliance – Statutory and Mandatory PPMs

Current status of compliance for 2020 (Dec 2020 all sites);

## PPM's

Electrical 64.4%

Water 59.5%

Medical Gases 64%

Fire Safety 74.9%

HVAC 65.1%

PSSR 49.9

Statutory PPM's 59.6%

Mandatory PPM's 51.5%

Routine PPM's 34.7%

Where we want to be by year end

## • PPM's

- At least 90% for statutory and mandatory PPMs
- At least 80% average completed by Dec 2021

Main issues;

- PPM's cancelled due to pandemic
- Lack of resource due to shielding
- Restricted access to some areas due to COVID-19

*It should be noted that PPM and reactive maintenance are inversely proportionate in that if we see an increase in the number of reactive maintenance requests there is a reduction on PPM compliance due to limited resources.*

# 9. Compliance: PAM (Premises Assurance Model)

## Current status of PAM;

Electrical 37.5%

Water 37.5%

Medical Gases 25%

Fire Safety 62.5%

HVAC 25%

PSSR 25%

Decontamination 25%

Asbestos 87.5%

Overall PAM compliance  
64.5%

## Where we want to be by year end 2021

- At least 90% compliant by year end

## Main issues;

- Missing resources (AP & CP)
- Missing policies (R&R & TOR)
- Missing BCP

# 9. Compliance: Policies In Progress

Policy Description	Current Status	Progress
Decontamination Policy	Version 1.4 DRAFT	In Progress
RSH Medical Gas Pipeline Systems Policy 201306-converted	Version 2.1 DRAFT	In Progress
HS Management of Ventilation Systems Policy	Version 1 DRAFT	Ready to submit to February HSSF meeting
HS22 Control and Management of Legionella v5.5 (KT last edit 27 Nov 19)	Version 5.5 DRAFT	In Progress
FS00 Fire Safety Policy (reviewed Jan 21)	Version 2 APPROVED	N/A
HS19 Electrical Safety & Lighting Policy V4.4	Version 4.4 DRAFT	Submitted to February HSSF meeting
HS Passenger and Goods Lift Management Policy V1 DRAFT	Version 1 DRAFT	Submitted] to February HSSF meeting
SATH (DRAFT) Pressure Systems Safety Policy	Version 1 DRAFT	Ready to submit to February HSSF meeting
Permit to Work Policy	Version 2	Under review by Estates
Estates Business Continuity Plan	Version 1	Under review by Estates

# 9. Compliance: Upcoming Legislation Changes for 2021

None that affect the way Estates operates

Only changes known are due to Brexit or COVID-19 and are related to employment law change.

New ventilation HTM 03-01 now issued.

Estates Zero Carbon Standards – will impact future estate designs

Progress on System Green Plans will be fundamental

# 10. STP Estates Strategy – Approved July 2019

- **Whitchurch Paul's Moss Site – Local Health Hub**
  - Community Hub incorporating health care facilities as part of a combined housing, extra-care and community hub facility promoting care closer to home.
- **Oswestry Health Centre**
  - Space sharing initiative between SCHAT and MPFT
- **Shawbirch**
  - ETTTF funded new build to provide extended working hours and modern primary care estate
- **Shifnal**
  - New build ETTTF funded to support delivery of PCNs
- **Tannery Riverside**
  - New build supporting Primary Care at Scale, funding through Shropshire Council and CCG revenue. Colocation with University Halls.
- **Midwife Led Units Reconfiguration**
  - Introduction of hubs across the county



# 10. STP Estates Strategy – July 2019

## Disposals

Site Details				Sharing	Delivery			Receipts	Housing
Plot Name	Org.	Plot Address (no. of sites)	Plot area (Ha)	Data sensitive?	Disposal Status	Disposal Year	Declared Surplus	Estimated sale receipt (£000)	Housing Units No.
Land and demountable building forming ex-Malling Health Centre, Telford Hospital	NHS Property Services	Princess Royal Hospital site, Apley Castle, Apley, Telford TF1 6TF	1	Yes	Opportunity – Possible disposal up to March 2020	2019 - 20	No	N/K	40
Land between Malling Health Centre site and Severn Hospice, Telford Hospital.	DHSC	Princess Royal Hospital site, Apley Castle; Apley, Telford TF1 6TF	0.7979	No	Opportunity - Possible disposal from April 2025 and beyond	2025+	2024	200	0
Old accommodation blocks 2 – 4	Shrewsbury and Telford Trust	Royal Shrewsbury Hospital, Mytton Oak, Shrewsbury SY3 8XQ	0.7919	No	Opportunity - Possible disposal up to March 2025	2024-25	c2016	1,162	65

# 10. STP Estates Strategy – Approved at July 2019 - Disposals

Site Details				Sharing	Delivery			Receipts	Housing
Plot Name	Org.	Plot Address (no. of sites)	Plot area (Ha)	Data sensitive?	Disposal Status	Disposal Year	Declared Surplus	Estimated sale receipt (£000)	Housing Units No.
Land adjacent to Racecourse Lane, adjoining old accommodation blocks referred to above (adjacent to Malling Health)	DHSC	Princess Royal Hospital site, Apley Castle; Apley, Telford TF1 6TF	0.7	Yes	Opportunity - Possible disposal from April 2025 and beyond	2025+	2004	350	25
Land opposite front entrance, across road	Robert Jones, Agnes Hunt	RJAH Orthopaedic Hospital, Gobowen, Shropshire, SY10 7AG	0.16	No	Opportunity – Possible disposal up to March 2025	2024-25	March 2019	180	8
Land at back of site, inclusive of sports field	Robert Jones, Agnes Hunt	RJAH Orthopaedic Hospital, Gobowen, Shropshire, SY10 7AG	2.34	No	Opportunity – Possible disposal up to March 2025	2024-25	March 2019	500	40

# 10. STP Estates Strategy – July 2019

## Headline Focus Areas

- Development and adoption of one space booking system across the STP
- Integrated care hubs
- Integration of back office functions across the system
- Integrated Business Support Unit



# 11. Next Steps

## ICS Estates Function

The ICS Estates Group are working more closely and are working up proposals for:

- Supporting big 6 Ticket Items
- Joint estates procurement
- Capital prioritisation for backlog and strategic projects
- System wide space booking system
- System wide compliance framework

## SaTH Operational Estates

- Continue to implement compliance structure and framework providing board assurance
- Succession planning and reduction of estates age profile through the bringing in of apprentices
- 5 year estates operational plans being developed

# 11. STP Big 6 Ticket Items

The ICS has identified Big 6 Ticket items for development. Many of these will need significant estates input and support. These are as follows:

- **Hospital Transformation Programme**
  - Draft SOC proposals submitted for approval
- **Local care and alternatives to hospital admissions**
  - Scope and estates implications are being developed
- **Outpatient Transformation**
  - Scope and estates implications currently being developed
- **MSK Transformation**
  - Scoping to go into Hollinswood House in Telford
- **Workforce Transformation**
  - No estates implications envisaged
- **Integrated place based commissioning**
  - No estates Implications envisaged



# HTP Change Control Process

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## 1.0 Purpose

This Change Control Procedure sets out how 'Changes' will be monitored and controlled. That is proposed, accepted or rejected, authorised and instructed. It will govern Changes to the development of briefing information in determining the scope of the Hospital Transformation Programme at Shrewsbury & Telford Hospital NHS Trust throughout the Pre-Construction period post-Version 4 endorsement of the Departmental Schedule of Accommodation – i.e. Contract Changes to Project Scope, Programme and/or Cost for:

- The addition, omission or substitution of any work specified in the Briefing Documents.
- The alteration of the kind or standard of any of the materials or goods to be used;
- Timelines for approvals and acceptance will be as the Master Programme

The Key is determining what constitutes change, is it technically generated affecting the scope of the HTP Programme or is it changing operational or clinical narratives, consideration through the change control group will determine if the proposed change will impact Time, Cost or Quality of the HTP Programme.

## 2.0 Change Control Procedure

The Change Control Procedure encompasses five activities:



The process addresses the following activities:

- Identification, issue and recording of Change Proposals;
- Preparation and submission of the impact of the change on time and cost
- Evaluation of the Change Proposal, including reviewing the supporting documentation.
- Acceptance and rejection of Change Proposals;
- Tracking the status of Change Proposals; and
- Instructing 'Authorised' Changes.

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## 3.0 Proposed Changes

Either the HTP Operational team / SRO or the Technical Design Team may propose a Change.

### 3.1 Change Proposals by Trust

All proposed changes will be submitted to the HTP change control group for decision. All changes will be collated onto the master change control log owned and maintained by the HTP PMO, any accepted technical changes will require the change control request to be issued to the Estates workstream Lead who will disseminate to the Lead Consultant, Principal Designer and the Quantity Surveyor to include within the revised scope the Change Proposal will be dated and will contain the authorising signatory to change the scope of the programme.

All Change Proposals are to be submitted, in writing, using agreed Pro Formas.

### 3.2 Delegated Authority

The HTP SRO and Trust Board can authorise change up to a £500,000. Any change above delegated limits will need to be reported and agreed by the HTP change control group in accordance with HTP and Trust governance.

Alongside this any change that may have an impact on fire, infection control, IT or estates / future maintenance would also need to be signed off by the relevant specialist within the Trust prior to instruction should the change be accepted.

All timescales for approval must be in line with the HTP Master Programme.

### 3.3 Change Proposals by Design Team / Advisor

The Design Team / Technical Advisors shall submit to the Trust Estates workstream Lead (change proformas will also be copied to the Lead Consultant and the Cost Manager) to ascertain time, cost, quality impact. The proforma will be logged onto the master change control register with the PMO and decisions made via the HTP Change control group.

All Technical Change Proposals are to be submitted, in writing, to the Estates Workstream lead using agreed change control Pro Formas.

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## 4.0 Change Quotation / Estimate Procedure

### 4.1 Trust's Change Proposals

If the Trust or HTP Clinical team member proposes a Change, that will affect the design, the key team member will issue a proposed instruction to the Estates workstream lead to review with the technical team, a Change Event will be recorded onto the master change control register as per the timescales agreed within the process and the results discussed with the change control group to ascertain if the change is to be accepted or rejected.

### 4.2 Design Team / Advisor Change Proposals

If the Design Team / advisor proposes a Change by the issue of a Change Proposal, they shall also submit a change control pro forma to the PMO to be recorded onto the master change control register and submit the change control Proposal to the Estates workstream lead to ascertain time, cost and quality impacts, that can then be assessed by the change control group to make an informed decision.

### 4.3 Proposed changes

Proposed changes shall indicate how the Additional Cost or the Reduction in Costs is calculated by showing, separately, the amounts attributable to:

1. Additional Cost of resulting from the Change;
2. Reduction in Cost resulting from the Change;
3. Amount of any direct loss and/or expense directly consequential upon the Change;

The change control form shall further provide a detailed breakdown showing how the Additional Cost or the Reduction in Costs is estimated

In addition, the Change control shall give details of any effect of the Change Proposal on the Completion Date for the whole, or any Section, of the Master Programme and provide information in support of any proposed alteration to such Dates.

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## 4.4 Last Date for Acceptance

The last date on which the proposed change can be accepted by the Project, and Instructed by the Estates workstream lead, is to be stated on the change control form by the Proposer. The change control group will also agree the timescales for the completion of the change.

## 5.0 Change Evaluation Procedure

On receipt of a Trust's proposed change on the agreed proforma that affects the technical elements of the programme, the estates workstream lead will instruct the relevant Design Team members to review and provide comment on the technical aspects of the HTP proposal; and instruct the Cost Manager to verify that the cost proposals are acceptable within a 7 day period.

Both the Design Team members and the Cost Manager are to submit their conclusions and recommendations back to the estates team lead to inform the change control group and to seek a decision in relation to the proposed change within the 7 day period to enable the change to be implemented or rejected.

The Estates workstream lead will collate and summarise the conclusions and recommendations of the group in relation to the proposed technical change.

All changes will be captured on the PMO Master change control register for governance purposes.

## 6.0 Change Authorisation Procedure

A 'Change Authorisation' is initiated by the change control group providing, the change control form which will outline:

1. Summary of the Change Proposal;
2. Summary of the effects of the Change Proposal on the Contract – in terms of both cost and programme;
3. Comments on the Change Quotation / Estimate;
4. Recommendation as to whether the Project should accept or reject the Change Quotation / Estimate;
5. Highlight the 'Last Date for Acceptance of Quotation / Estimate' by the Trust.

The change control group will meet fortnightly to review proposed changes through the HTP PMO Change control process.



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The members of the group consist of:

SRO

Clinical Director HTP

Technical Director HTP

Capital and ICS Lead HTP

Clinical Lead HTP

Clinical Lead HTP

Technical & Estates Workstream Lead

Programme Manager HTP

All proposed changes should be assessed by the change control group within 14 days of the proposed change, the change status is updated on the PMO Master change register (Held with the PMO) once the change control group has reached a decision regarding the proposed change. All supporting documents are then kept for governance purposes and issued to the Estates workstream lead to capture within the technical scope for the HTP programme, if the change impacts time, cost or quality of the HTP Programme.

Following the group's decision, the Trust SRO will review the 'Change Authorisation' request and endorse or reject the group's decision by completing the appropriate part of the 'Change Authorisation' request.

For 'Accepted' Change Proposals and if technical in nature the Estates workstream lead will draft and issue an Instruction to the Design Team, the HTP PMO will update the master change control register to record when the group decision was made.

For 'Rejected' Change Proposals, if technical in nature the Estates workstream lead will inform the Design Team and the HTP PMO Master change control register will be updated to record the group's decision.

## **7.0 Change Proposal Tracking and Records**

The PMO will maintain the Master change control register which captures all changes across all workstreams.

The Master Change Control Register is a live Project Document and will be maintained by the PMO throughout the Design Stage through to Practical Completion.

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5. Highlight the 'Last Date for Acceptance of Quotation / Estimate' by the Trust.

The change control group will meet fortnightly to review proposed changes through the HTP PMO Change control process.

The members of the group consist of:

Matthew Neal – SRO

Meinir Williams – Clinical Director HTP

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Mark Peat – Technical Director HTP  
Will Nabih – Capital and ICS Lead HTP  
Andrew Tapp – Clinical Lead HTP  
Ed Rysdale – Clinical Lead HTP  
Adam Ellis-Morgan – Technical & Estates Workstream Lead  
Sharon Stuart – Programme Manager HTP

All proposed changes should be assessed by the change control group within 14 days of the proposed change, the change status is updated on the PMO Master change register (Held with the PMO) once the change control group has reached a decision regarding the proposed change. All supporting documents are then kept for governance purposes and issued to the Estates workstream lead to capture within the technical scope for the HTP programme, if the change impacts time, cost or quality of the HTP Programme.

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Our Ref: NM/CAT

6 June 2023

Dr Catriona McMahon  
Chair  
Shrewsbury and Telford Hospital NHS Trust  
Trust Headquarters  
Royal Shrewsbury Hospital  
SHREWSBURY  
SY3 8XQ

Dear Catriona

**Letter of Support to the Board of SATH in relation to the Outline Business Case (OBC) for the Hospitals Transformation Programme**

The NHS STW Board (referred to as 'the Board') met on Wednesday, 31 May 2023 to consider the HTP OBC presented by your team. Please extend my thanks, on behalf of the Board, to those involved in developing the Strategic Outline Case (SOC) into the comprehensive OBC it is today. It is clear that many of the areas that required further development at the SOC stage have progressed significantly.

Many thanks too for your team's work with the ICB and wider executive during this time to ensure that we strengthen connections into the overall System strategy. As a Board (that has representatives from all system partners) we will not lose sight of the critical interdependencies between the HTP and our Local Care Transformation Programme (LCTP), for example the particular commitment in our modelling assumptions for 151 beds worth of activity in secondary care to be taken into a community setting through admission avoidance, length of stay reduction and provision of virtual wards.

More broadly, the activity, finance and workforce assumptions that underpin the OBC (for both SATH and other providers) are recognised by System partners. We believe these assumptions to be reasonable in the context of what we know now about growth in allocations and funding. These will continue to be clearly articulated in our medium to long term strategy and plans with elements of this work already captured in the 23/24 system operating plan that was recently submitted to NHSE. The System continues to be committed to mitigating growth in demand for acute services through preventative interventions, adopting clinical innovation and new pathways and shifting activity closer to home where appropriate and possible.

We recognise that there continues to be a need to balance the complexities of competing stakeholder priorities, ambitions and objectives. We know that this is also set in a context of capital funding constraint which must also be taken into consideration.

The Board note that the case states a preference for shortlisted options 2<sup>1</sup> to 4 with options 0 and 1 being discounted as they are not tenable in the long term. We support this view on the

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<sup>1</sup> 0 Business as Usual; 1 Additional BAU Comparator; 2 Core DMBC (do minimum); 3 Core DMBC + key estates risks; 4 Core DMBC + key estates risks + integration.

basis that to do nothing or take minimal action will not resolve the estate and workforce issues presented; will not support our system ambitions over time and does not meet the requirements of the model that the previous commissioner (CCGs) consulted on.

The Board support the view of the OBC that option 2, “Core DMBC (do minimum)” is the only option that currently achieves an appropriate balance between overall net benefits and capital affordability given the current context that we are operating in. We are in the process of refreshing our System Estates Strategy and confirm that HTP will remain one of its core components. We are also content that this option will deliver the core objectives and ambitions that were consulted on in 2018 and signed off by the CCG Governing Bodies and have received external legal advice that confirms this to be the case.

The Board also note that there are other capital programme dependencies that will support and enhance the model described in the OBC. As an example, the PRH elective hub which is due to receive its first patients this Summer and supports the new clinical model of PRH becoming a site specialising in Planned Care. Further, we acknowledge that the Trust is keen to pursue other additional sources of funding for future years such that, over time, it can seek to address other key estates risks that have been identified and the ambition for further integration of services. These would still be subject to governance and process, as in place at the relevant time. This is to enable us to make sure that we preserve the strategic ‘fit’ that we have secured to date and also to provide appropriate prioritisation given funding constraints.

We recognise that the document shared with the Board at this stage is a draft and will be subject to a regional and national review process to finalise it. We do not expect this process to result in any material changes to the substance of the case and would expect to be notified if this were to be the case.

Taking the above into account, the Board of NHS Shropshire, Telford and Wrekin can, therefore, confirm its support for the OBC and the preferred option identified.

Having taken the time to read the OBC in full and in listening to our clinicians regarding the current challenges that they face with the current estate limitations, it is clear that progress with this is even more pressing. If we are to deliver on a new model of care whilst having an unremitting focus on improving outcomes for our local population, then we need to implement these changes as soon as is practically possible. The residents of Shropshire, Telford and Wrekin have every right to expect fit for purpose estate and a model of care that aligns to best clinical practice. It is our responsibility to deliver that for our staff and for our residents.

Yours sincerely



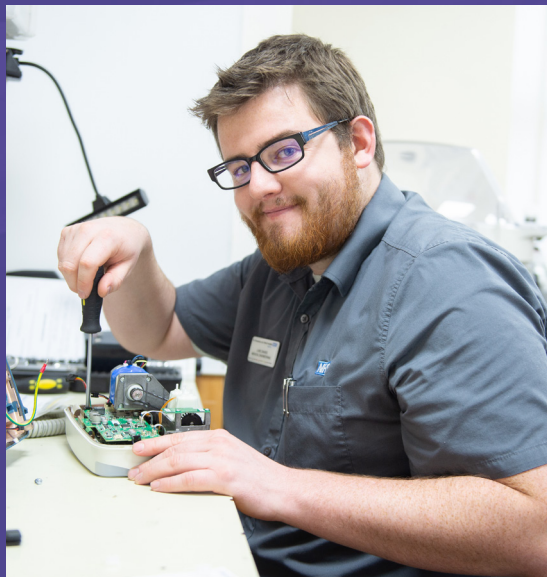
**Sir Neil McKay**  
**ICB Chair**  
**NHS Shropshire, Telford and Wrekin**

cc     Simon Whitehouse  
       Louise Barnett  
       Claire Skidmore  
       Matthew Neal





**Integrated  
Care System**  
Shropshire, Telford and Wrekin



# ECONOMIC APPENDICES



**The Shrewsbury and  
Telford Hospital**  
NHS Trust



The Shrewsbury and  
Telford Hospital  
NHS Trust

# Hospitals Transformation Programme

## Long List Appraisal

9<sup>th</sup> December 2022



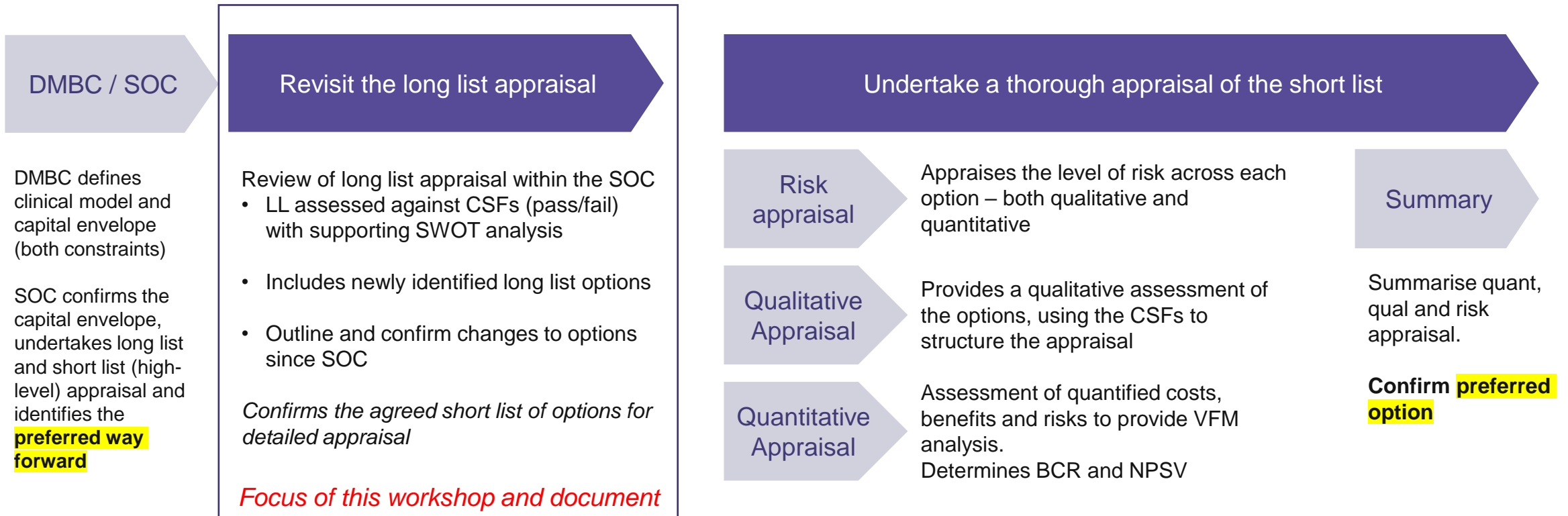
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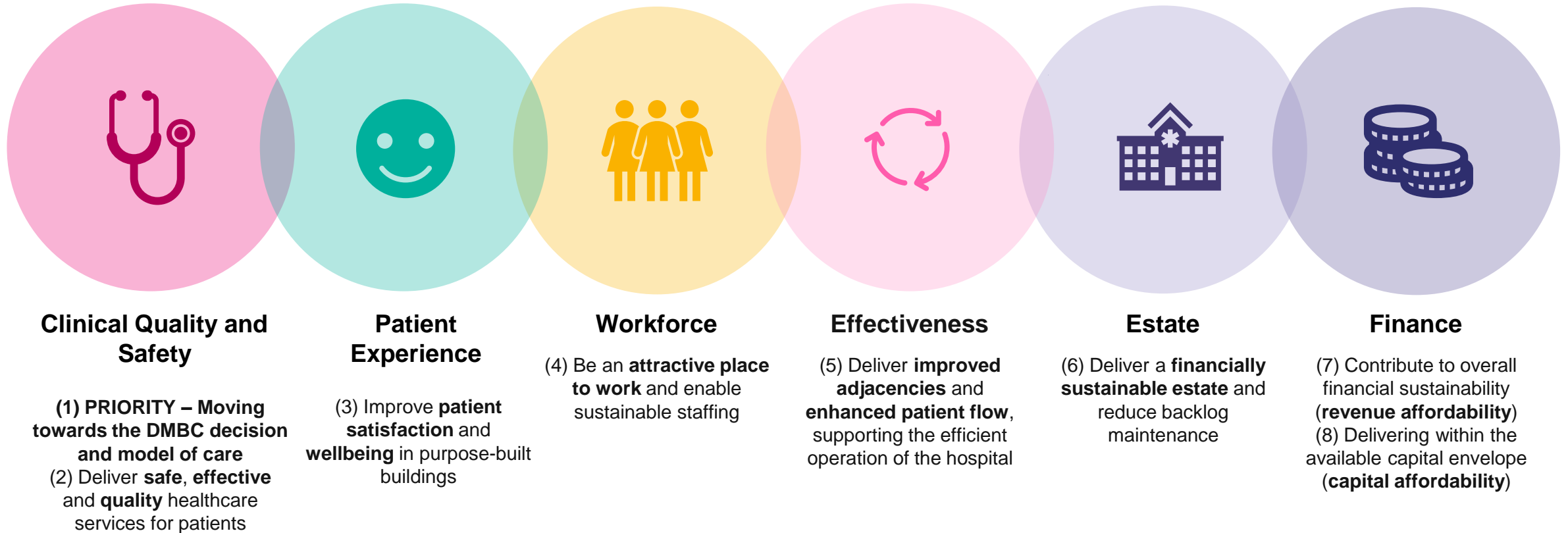
# Appraisal Process

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.



# 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 HMT's five generic drivers for intervention and spend.





# CSFs

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.

The long list options are appraised against the relevant CSFs for each dimension – the short listed options will be appraised against all the CSFs.



# Investment Objectives and CSFs

	Investment Objective	Critical success factor	Description	HMT Category
Qualitative	1. <b>PRIORITY OBJECTIVE</b> Consultation	Clinical model	<ul style="list-style-type: none"> <li>Delivering the core DMBC requirements (defined in DMBC S9.3, and associated capacity) and moving towards the wider 'Future Fit' ambitions</li> </ul>	<i>Strategic fit and business needs</i>
	2. Clinical Quality and Safety	Clinical quality and patient experience	<ul style="list-style-type: none"> <li>Supports required improvement in service and clinical quality and safety</li> </ul>	
	3. Patient Experience		<ul style="list-style-type: none"> <li>Supports required improvement in patient experience</li> </ul>	
	4. Workforce	Workforce	<ul style="list-style-type: none"> <li>Supports required improvement in workforce availability and sustainability</li> </ul>	
	5. Effectiveness	Effectiveness / Access	<ul style="list-style-type: none"> <li>Services must be located to maintain or improve access for local population (patients and staff) and to improve adjacencies and enhance patient flow</li> </ul>	
			Commercial viability	
Quantitative	6. Estate	Build deliverability	<ul style="list-style-type: none"> <li>Makes an appropriate use of existing NHS estate</li> <li>Deliverable by target year of opening</li> <li>Site locations must be able to deliver the required footprint and capacity</li> <li>Supported by commissioners and the system</li> </ul>	<i>Potential achievability</i>
	7. Finance	Value for money	<ul style="list-style-type: none"> <li>Net present social value and benefit-cost ratio</li> </ul>	<i>Potential value for money</i>
	8. Finance	Capital affordability	<ul style="list-style-type: none"> <li>Relative capital affordability of the option versus the original allocated capital of c. £312m</li> </ul>	<i>Potential affordability</i>



# Relevant CSFs for each dimension at this stage

Critical success factor	Scope	Service Solution	Service Delivery	Implementation	Funding
Clinical model	•	•	•		
Clinical quality and patient experience	•	•	•		
Workforce	•	•	•		
Effectiveness / Access	•	•	•		
Commercial viability	•	•	•	•	
Build deliverability	•	•	•	•	•
Value for money				•	•
Revenue affordability	<i>NA – for short list appraisal</i>				
Capital affordability					

# Appraisal Definitions

Each Option is appraised against the CSFs. In line with the guidance, options may fail, pass or be preferred against the CSFs.

## Appraisal Definitions:

Appraisal	Definition
<b>Fail</b>	<ul style="list-style-type: none"><li>• Fail a Critical Success Factor – not expected to meet a Critical Success Factor</li><li>• Discounted – not carried forward to short-list appraisal</li></ul>
<b>Pass</b>	<ul style="list-style-type: none"><li>• Pass a Critical Success Factor – is expected to meet a Critical Success Factor</li><li>• Carried forward to short-list appraisal</li></ul>
<b>Preferred</b>	<ul style="list-style-type: none"><li>• Preferred against a Critical Success Factor – is expected to be most favourable against a Critical Success Factor (offer material advantages vs. other options that have passed)</li><li>• Carried forward to short-list appraisal</li></ul>



# Options Framework

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.

This table provides a summary of the Green Book Options Framework:

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.



# Options Updates Since SOC (as per JIC conditions)



SOC short list	OBC scope options (to include extended phasing)	Implications
1. Business-as-usual	0. Business As Usual (no/minimal capex)	A BAU comparator can be developed that captures the revenue implications of maintaining current services and addressing future demand
2. Core DMBC ('Do minimum')	1. Additional Comparator Option (c.£72m capex)	The £72m capex option could be included as another comparator rather than a 'do minimum' if required, as it doesn't meet the priority investment objectives
3. Core DMBC + key estates risks	2. Core DMBC ('Do Minimum')	Suggest that this option is retained as the 'Do Minimum' and that the phasing sensitivities are only considered for the preferred scope
4. Core DMBC + key estates risks + integration	3. Core DMBC + key estates risks	Suggest that the additional phasing sensitivities are not considered for the other do-something options (i.e. those that are not identified as the preferred way forward, to keep narrative simpler / more accessible)
	4. Core DMBC + key estates risks + integration	

# Long List Options – Changes since SOC

Dimension	Option #	Domains and options
Scope	a.	Continue Current Arrangements (comparator)
	b.	Delivering the core DMBC requirements
	c.	Delivering the wider Future Fit ambitions
Service solution	0	Business-as-usual (no/minimal capex)
	1	Additional comparator option (c.72m capex)
	2	Core DMBC requirements ('Do Minimum')
	3	Core DMBC + key estates risks
	4	Core DMBC + key estates risks + integration
Service delivery	i.	Procurement framework
	ii.	Single-stage tender
	iii.	Two-stage tender
Implementation	i.	Phased as per SOC
	ii.	Longer Term phasing
Funding	i.	Internal financing
	ii.	Charitable financing
	iii.	Government PDC via HTP
	iiii.	Private financing

*Added long list option since SOC*

# This creates 122 potential permutations of the Long list



#	Scope	Service solution	Service delivery	Implementation	Funding
1	Continue Current Arrangements (comparator)	Business As Usual (no/ minimal capex)			
2	Continue Current Arrangements (comparator)	Additional comparator (c.72m capex)			
3	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Procurement Framework	Phased as per SOC	Internal financing
4	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Single-stage tender	Phased as per SOC	Internal financing
5	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Two-stage tender	Phased as per SOC	Internal financing
6	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Procurement Framework	Longer Term phasing	Internal financing
7	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Single-stage tender	Longer Term phasing	Internal financing
8	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Two-stage tender	Longer Term phasing	Internal financing
9	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Procurement Framework	Phased as per SOC	Charitable financing
10	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Single-stage tender	Phased as per SOC	Charitable financing
11	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Two-stage tender	Phased as per SOC	Charitable financing
12	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Procurement Framework	Longer Term phasing	Charitable financing
13	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Single-stage tender	Longer Term phasing	Charitable financing
14	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Two-stage tender	Longer Term phasing	Charitable financing
15	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Procurement Framework	Phased as per SOC	Government PDC via HTP

#	Scope	Service solution	Service delivery	Implementation	Funding
16	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Single-stage tender	Phased as per SOC	Government PDC via HTP
17	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Two-stage tender	Phased as per SOC	Government PDC via HTP
18	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Procurement Framework	Longer Term phasing	Government PDC via HTP
19	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Single-stage tender	Longer Term phasing	Government PDC via HTP
20	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Two-stage tender	Longer Term phasing	Government PDC via HTP
21	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Procurement Framework	Phased as per SOC	Private financing
22	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Single-stage tender	Phased as per SOC	Private financing
23	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Two-stage tender	Phased as per SOC	Private financing
24	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Procurement Framework	Longer Term phasing	Private financing
25	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Single-stage tender	Longer Term phasing	Private financing
26	Delivering the core DMBC requirements minimum'	Core DMBC ('Do DMBC requirements minimum')	Two-stage tender	Longer Term phasing	Private financing
27	Delivering the core DMBC requirements minimum'	Core DMBC + key estates risks	Procurement Framework	Phased as per SOC	Internal financing
28	Delivering the core DMBC requirements minimum'	Core DMBC + key estates risks	Single-stage tender	Phased as per SOC	Internal financing

# This creates 122 potential permutations of the Long list

#	Scope	Service solution	Service delivery	Implementation	Funding
29	Delivering the core DMBC requirements	Core DMBC + key estates risks	Two-stage tender	Phased as per SOC	Internal financing
30	Delivering the core DMBC requirements	Core DMBC + key estates risks	Procurement Framework	Longer Term phasing	Internal financing
31	Delivering the core DMBC requirements	Core DMBC + key estates risks	Single-stage tender	Longer Term phasing	Internal financing
32	Delivering the core DMBC requirements	Core DMBC + key estates risks	Two-stage tender	Longer Term phasing	Internal financing
33	Delivering the core DMBC requirements	Core DMBC + key estates risks	Procurement Framework	Phased as per SOC	Charitable financing
34	Delivering the core DMBC requirements	Core DMBC + key estates risks	Single-stage tender	Phased as per SOC	Charitable financing
35	Delivering the core DMBC requirements	Core DMBC + key estates risks	Two-stage tender	Phased as per SOC	Charitable financing
36	Delivering the core DMBC requirements	Core DMBC + key estates risks	Procurement Framework	Longer Term phasing	Charitable financing
37	Delivering the core DMBC requirements	Core DMBC + key estates risks	Single-stage tender	Longer Term phasing	Charitable financing
38	Delivering the core DMBC requirements	Core DMBC + key estates risks	Two-stage tender	Longer Term phasing	Charitable financing
39	Delivering the core DMBC requirements	Core DMBC + key estates risks	Procurement Framework	Phased as per SOC	Government PDC via HTP
40	Delivering the core DMBC requirements	Core DMBC + key estates risks	Single-stage tender	Phased as per SOC	Government PDC via HTP
41	Delivering the core DMBC requirements	Core DMBC + key estates risks	Two-stage tender	Phased as per SOC	Government PDC via HTP
42	Delivering the core DMBC requirements	Core DMBC + key estates risks	Procurement Framework	Longer Term phasing	Government PDC via HTP
43	Delivering the core DMBC requirements	Core DMBC + key estates risks	Single-stage tender	Longer Term phasing	Government PDC via HTP

#	Scope	Service solution	Service delivery	Implementation	Funding
44	Delivering the core DMBC requirements	Core DMBC + key estates risks	Two-stage tender	Longer Term phasing	Government PDC via HTP
45	Delivering the core DMBC requirements	Core DMBC + key estates risks	Procurement Framework	Phased as per SOC	Private financing
46	Delivering the core DMBC requirements	Core DMBC + key estates risks	Single-stage tender	Phased as per SOC	Private financing
47	Delivering the core DMBC requirements	Core DMBC + key estates risks	Two-stage tender	Phased as per SOC	Private financing
48	Delivering the core DMBC requirements	Core DMBC + key estates risks	Procurement Framework	Longer Term phasing	Private financing
49	Delivering the core DMBC requirements	Core DMBC + key estates risks	Single-stage tender	Longer Term phasing	Private financing
50	Delivering the core DMBC requirements	Core DMBC + key estates risks	Two-stage tender	Longer Term phasing	Private financing
51	Delivering the core DMBC requirements	Core DMBC + key estates risks + integration	Procurement Framework	Phased as per SOC	Internal financing
52	Delivering the core DMBC requirements	Core DMBC + key estates risks + integration	Single-stage tender	Phased as per SOC	Internal financing
53	Delivering the core DMBC requirements	Core DMBC + key estates risks + integration	Two-stage tender	Phased as per SOC	Internal financing
54	Delivering the core DMBC requirements	Core DMBC + key estates risks + integration	Procurement Framework	Longer Term phasing	Internal financing

# This creates 122 potential permutations of the Long list

#	Scope	Service solution	Service delivery	Implementation	Funding
55	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Single-stage tender	Longer Term phasing	Internal financing
56	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Two-stage tender	Longer Term phasing	Internal financing
57	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Procurement Framework	Phased as per SOC	Charitable financing
58	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Single-stage tender	Phased as per SOC	Charitable financing
59	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Two-stage tender	Phased as per SOC	Charitable financing
60	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Procurement Framework	Longer Term phasing	Charitable financing
61	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Single-stage tender	Longer Term phasing	Charitable financing
62	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Two-stage tender	Longer Term phasing	Charitable financing
63	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Procurement Framework	Phased as per SOC	Government PDC via HTP
64	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Single-stage tender	Phased as per SOC	Government PDC via HTP
65	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Two-stage tender	Phased as per SOC	Government PDC via HTP
66	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Procurement Framework	Longer Term phasing	Government PDC via HTP
67	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Single-stage tender	Longer Term phasing	Government PDC via HTP
68	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Two-stage tender	Longer Term phasing	Government PDC via HTP
69	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Procurement Framework	Phased as per SOC	Private financing

#	Scope	Service solution	Service delivery	Implementation	Funding
70	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Single-stage tender	Phased as per SOC	Private financing
71	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Two-stage tender	Phased as per SOC	Private financing
72	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Procurement Framework	Longer Term phasing	Private financing
73	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Single-stage tender	Longer Term phasing	Private financing
74	Delivering the core DMBC requirements risks + integration	Core DMBC + key estates	Two-stage tender	Longer Term phasing	Private financing
75	Delivering the core DMBC requirements risks + wider Future Fit ambition	Core DMBC + key estates	Procurement Framework	Phased as per SOC	Internal financing
76	Delivering the core DMBC requirements risks + wider Future Fit ambition	Core DMBC + key estates	Single-stage tender	Phased as per SOC	Internal financing
77	Delivering the core DMBC requirements risks + wider Future Fit ambition	Core DMBC + key estates	Two-stage tender	Phased as per SOC	Internal financing
78	Delivering the core DMBC requirements risks + wider Future Fit ambition	Core DMBC + key estates	Procurement Framework	Longer Term phasing	Internal financing
79	Delivering the core DMBC requirements risks + wider Future Fit ambition	Core DMBC + key estates	Single-stage tender	Longer Term phasing	Internal financing
80	Delivering the core DMBC requirements risks + wider Future Fit ambition	Core DMBC + key estates	Two-stage tender	Longer Term phasing	Internal financing
81	Delivering the core DMBC requirements risks + wider Future Fit ambition	Core DMBC + key estates	Procurement Framework	Phased as per SOC	Charitable financing



# This creates 122 potential permutations of the Long list

#	Scope	Service solution	Service delivery	Implementation	Funding
82	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Single-stage tender	Phased as per SOC	Charitable financing
83	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Two-stage tender	Phased as per SOC	Charitable financing
84	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Procurement Framework	Longer Term phasing	Charitable financing
85	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Single-stage tender	Longer Term phasing	Charitable financing
86	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Two-stage tender	Longer Term phasing	Charitable financing
87	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Procurement Framework	Phased as per SOC	Government PDC via HTP
88	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Single-stage tender	Phased as per SOC	Government PDC via HTP
89	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Two-stage tender	Phased as per SOC	Government PDC via HTP
90	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Procurement Framework	Longer Term phasing	Government PDC via HTP
91	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Single-stage tender	Longer Term phasing	Government PDC via HTP
92	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Two-stage tender	Longer Term phasing	Government PDC via HTP
93	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Procurement Framework	Phased as per SOC	Private financing

#	Scope	Service solution	Service delivery	Implementation	Funding
94	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Single-stage tender	Phased as per SOC	Private financing
95	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Two-stage tender	Phased as per SOC	Private financing
96	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Procurement Framework	Longer Term phasing	Private financing
97	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Single-stage tender	Longer Term phasing	Private financing
98	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks	Two-stage tender	Longer Term phasing	Private financing
99	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Procurement Framework	Phased as per SOC	Internal financing
100	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Single-stage tender	Phased as per SOC	Internal financing
101	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Two-stage tender	Phased as per SOC	Internal financing
102	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Procurement Framework	Longer Term phasing	Internal financing
103	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Single-stage tender	Longer Term phasing	Internal financing
104	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Two-stage tender	Longer Term phasing	Internal financing

# This creates 122 potential permutations of the Long list

#	Scope	Service solution	Service delivery	Implementation	Funding
105	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Procurement Framework	Phased as per SOC	Charitable financing
106	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Single-stage tender	Phased as per SOC	Charitable financing
107	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Two-stage tender	Phased as per SOC	Charitable financing
108	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Procurement Framework	Longer Term phasing	Charitable financing
109	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Single-stage tender	Longer Term phasing	Charitable financing
110	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Two-stage tender	Longer Term phasing	Charitable financing
111	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Procurement Framework	Phased as per SOC	Government PDC via HTP
112	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Single-stage tender	Phased as per SOC	Government PDC via HTP
113	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Two-stage tender	Phased as per SOC	Government PDC via HTP

#	Scope	Service solution	Service delivery	Implementation	Funding
114	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Procurement Framework	Longer Term phasing	Government PDC via HTP
115	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Single-stage tender	Longer Term phasing	Government PDC via HTP
116	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Two-stage tender	Longer Term phasing	Government PDC via HTP
117	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Procurement Framework	Phased as per SOC	Private financing
118	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Single-stage tender	Phased as per SOC	Private financing
119	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Two-stage tender	Phased as per SOC	Private financing
120	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Procurement Framework	Longer Term phasing	Private financing
121	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Single-stage tender	Longer Term phasing	Private financing
122	Delivering the core DMBC requirements + wider Future Fit ambition	Core DMBC + key estates risks + integration	Two-stage tender	Longer Term phasing	Private financing

# Description of the Options - Scope

i.	<b>Continue Current Arrangements (comparators)</b>	Does not deliver any of the requirements of the DMBC and is included for comparative purposes.
ii.	<b>Delivering the core DMBC Requirements</b>	Considers what can be achieved with the allocated capital budget.
iii.	<b>Delivering the wider future fit ambitions</b>	Considers options that progress beyond the core DMBC requirements and progress towards some of the wider Future Fit ambitions.



# SWOT Analysis - Scope

	Continue Current Arrangements (comparator)	Delivering the core DMBC Requirements	Delivering the wider future fit ambitions
Conclusion	Carry forward as BAU	Carry forward	Carry forward - preferred
Rationale	<ul style="list-style-type: none"> <li>Can be delivered in the absence of additional funding being received</li> <li>Used as VFM comparator</li> </ul>	<ul style="list-style-type: none"> <li>In line with the trust's strategic / clinical vision and priorities</li> <li>Delivers the core DMBC requirements</li> </ul>	<ul style="list-style-type: none"> <li>Maximises opportunity for redevelopment</li> <li>Delivers the full Future Fit ambition – expected to deliver optimal VFM</li> </ul>
Strengths	<ul style="list-style-type: none"> <li>Currently within the trusts ability to fund.</li> </ul>	<ul style="list-style-type: none"> <li>Meets all CSFs</li> <li>Delivers new clinical model</li> <li>Improves clinical adjacencies</li> <li>Provides capacity needed for future increases in demand</li> <li>Reduction in waiting times</li> </ul>	<ul style="list-style-type: none"> <li>Meets all CSFs</li> <li>Delivers new clinical model</li> <li>Optimises clinical adjacencies</li> <li>Provides capacity needed for future increases in demand</li> <li>Reduction in waiting times</li> </ul>
Opportunities	<ul style="list-style-type: none"> <li>Not constrained by the consultation – allows for complete change in how care is provided</li> </ul>	<ul style="list-style-type: none"> <li>Lays foundations for further improvements</li> </ul>	<ul style="list-style-type: none"> <li>Allows trust to focus efforts in further improvements</li> </ul>
Weaknesses	<ul style="list-style-type: none"> <li>Fails most CSFs</li> <li>Does not address trust's biggest challenges identified through Future Fit (workforce, clinical, finance etc.)</li> <li>Does not deliver the new clinical model described within Future Fit</li> </ul>	<ul style="list-style-type: none"> <li>Requires external funding</li> <li>Does not address all estates risks and challenges</li> <li>Workforce improvements driven by enhanced physical environment so limited to redeveloped areas</li> </ul>	<ul style="list-style-type: none"> <li>High capital requirement</li> <li>Extension of timelines to deliver</li> <li>Does not address all estates risks and challenges</li> <li>Requires additional funding</li> </ul>
Threats	<ul style="list-style-type: none"> <li>Further growth in demand</li> <li>Current services deteriorate further, leading to service failures</li> </ul>	<ul style="list-style-type: none"> <li>Lack of funding available</li> <li>Continued use of existing ward accommodation in the tower block</li> </ul>	<ul style="list-style-type: none"> <li>Lack of funding available</li> <li>Further increases in inflation</li> </ul>

# Appraisal against CSFs - Scope

Critical Success Factor	Continue current arrangements (comparator)	Delivering the core DMBC requirements	Delivering the wider Future Fit ambition
Clinical Model	Fail	Pass	Preferred
Clinical Quality and Patient Experience	Fail	Pass	Preferred
Workforce	Fail	Pass	Preferred
Effectiveness/ Access	Fail	Pass	Preferred
Commercial Viability	Pass	Pass	Preferred
Build Deliverability	Fail	Pass	Preferred
Value for Money	Not applicable	Not applicable	Not applicable
Revenue Affordability	Not applicable	Not applicable	Not applicable
Capital Affordability	Not applicable	Not applicable	Not applicable
<b>Summary</b>	<b>Carry forward as BAU</b>	<b>Carry forward</b>	<b>Carry forward – preferred</b>
Rationale for conclusion	<p>Does not deliver Future Fit clinical model, and associated improvements to clinical quality and patient experience.</p> <p>Doesn't address workforce challenges.</p> <p>There is no improvement in access and additional capacity requirements are not met.</p>	<p>Passes all relevant CSFs at this stage.</p>	<p>Passes all relevant CSFs at this stage.</p>



# Description of the Options – Service Solutions

Continue Current Arrangements	<b>0</b>	<b>Business As Usual</b>	c. £ minimal	Remaining with the current service configuration (i.e. assuming no additional capital investment over and above the ICB operational planning assumptions) – including additional internal resourcing costs, additional costs for outsourcing components of the care that we currently provide to other NHS/ private providers.
	<b>1</b>	<b>Additional Comparator Option</b>	c. 72m	Continuation of current arrangements, including our baseline annual capital programme over the appraisal period. Annual essential backlog items across both sites. This option also includes funding for additional modular ward capacity to address operational bed pressures due to bed capacity shortfalls and clinical pathway issues.
Delivering the core DMBC requirements	<b>2</b>	<b>Core DMBC ('Do Minimum')</b>	c. 312m	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).
Delivering the wider Future Fit ambitions	<b>3</b>	<b>Core DMBC + key estates risks</b>	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 and reduction in estates risk.
	<b>4</b>	<b>Core DMBC + key estates risks + integration</b>	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 ward accommodation that meets latest standards, outpatient and theatre refurbishment and reduction in significant/high estates risk.



# SWOT Analysis – Service Solutions

	Business As Usual (no/ minimal capex)	Additional comparator option (c.72m capex)	Core DMBC	Core DMBC + estates risks	Core DMBC + estates risks + integration
Conclusion	Carry forward as BAU	Carry forward as Economic Comparator	Carry forward	Carry forward	Carry forward – preferred
Rationale	<ul style="list-style-type: none"> <li>No additional capital investment over and above the ICB operational planning assumptions – requested by JIC</li> <li>Used as VFM comparator</li> </ul>	<ul style="list-style-type: none"> <li>Continuation of current arrangements, with investment in capacity to meet future demand</li> <li>Used as VFM comparator</li> </ul>	<ul style="list-style-type: none"> <li>Minimum investment required to deliver the priority investment objectives (core DMBC requirements)</li> </ul>	<ul style="list-style-type: none"> <li>Provides further progression towards wider Future Fit ambitions.</li> </ul>	<ul style="list-style-type: none"> <li>Delivers full Future Fit ambitions.</li> <li>Seeks to maximise the opportunity for redevelopment and improves overall sustainability</li> </ul>
Strengths	<ul style="list-style-type: none"> <li>Currently within the trusts ability to fund</li> </ul>	<ul style="list-style-type: none"> <li>Less capital investment required</li> </ul>	<ul style="list-style-type: none"> <li>Delivers the consulted clinical model, improving some facilities</li> <li>Affordable – achievable with allocated government funding</li> <li>Delivers some of the planned pathway benefits</li> <li>Provides physical capacity needed for future demand</li> <li>Increases single room provision at RSH</li> </ul>	<ul style="list-style-type: none"> <li>Improves most of the facilities for staff and patients</li> <li>Provides increased single room provision</li> <li>Addresses areas of highest-estate risk</li> </ul>	<ul style="list-style-type: none"> <li>Delivers the core DMBC requirements and most of the wider Future Fit ambition</li> <li>Improves all facilities for staff and patients</li> <li>Optimised clinical adjacencies</li> <li>Provides increased single room provision</li> </ul>
Opportunities	<ul style="list-style-type: none"> <li>Not constrained by the consultation – allows for complete change in how care is provided</li> </ul>	<ul style="list-style-type: none"> <li>Not constrained by the consultation – allows for complete change in how care is provided.</li> </ul>	<ul style="list-style-type: none"> <li>Delivers the consulted clinical model, and provides a foundation for future improvement and investment</li> </ul>	<ul style="list-style-type: none"> <li>Provides stronger foundation for further improvements</li> </ul>	<ul style="list-style-type: none"> <li>Enables significant financial and clinical benefits</li> </ul>
Weaknesses	<ul style="list-style-type: none"> <li>Not aligned to trust's priorities</li> <li>No clinical improvements</li> <li>Does not provide capacity for future service demand, requiring outsourcing of services</li> <li>Does not address trust's biggest challenges identified through Future Fit (workforce, clinical, finance etc.)</li> <li>Does not deliver the new clinical model described within Future Fit</li> </ul>	<ul style="list-style-type: none"> <li>No changes in overall clinical model</li> <li>Doesn't deliver agreed clinical configuration or Future fit outcome - would result in stakeholder challenge</li> <li>No improvement in single rooms and post-COVID-19 separation</li> <li>Doesn't address workforce challenges</li> </ul>	<ul style="list-style-type: none"> <li>Requires the continued use of existing sub-optimal wards</li> <li>Levels 3,4,5 of the ward block is considered to be in condition 'D' – this accounts for 210 beds</li> <li>Limits clinical adjacencies, reducing efficiency, improving opportunity</li> <li>Provides limited increase in single room provision</li> <li>Would result in a significant contrast between buildings</li> </ul>	<ul style="list-style-type: none"> <li>Will not improve quality and experience across the entirety of the estate</li> <li>Phased approach means delivery timelines are extended, increasing costs</li> <li>Lack of redevelopment of Outpatient Department – restricts efficiencies.</li> <li>High capital requirement</li> </ul>	<ul style="list-style-type: none"> <li>High capital requirement – inability to secure funding</li> <li>Provides sub-optimal value for money and affordability</li> </ul>
Threats	<ul style="list-style-type: none"> <li>Further growth in demand</li> <li>Current services continue to deteriorate</li> </ul>	<ul style="list-style-type: none"> <li>Further growth in demand</li> <li>Current services begin to deteriorate</li> </ul>	<ul style="list-style-type: none"> <li>Funding required from DHSC</li> <li>Key estates risks remain</li> <li>Dependent on the progression of the ICS led Local Care Programme, day case hub and energy centre</li> </ul>	<ul style="list-style-type: none"> <li>Lack of funding</li> <li>Further increases in inflation</li> <li>Interdependent on the progression of the day case hub and energy centre</li> </ul>	<ul style="list-style-type: none"> <li>Lack of funding</li> <li>Further increases in inflation</li> <li>Interdependent on the progression of the day case hub and energy centre</li> </ul>

# Appraisal against CSFs - Service Solutions

CSF	Business As Usual	Additional comparator option (c.£72m capex)	Core DMBC ('Do Minimum')	Core DMBC + key estates risks	Core DMBC + key estates risks + integration
Clinical Model	Fail	Fail	Pass	Pass	Preferred
Clinical Quality and Patient Experience	Fail	Fail	Pass	Pass	Preferred
Workforce	Fail	Fail	Pass	Pass	Preferred
Effectiveness	Fail	Fail	Pass	Pass	Preferred
Commercial Viability	Pass	Pass	Pass	Pass	Pass
Build Deliverability	Fail	Fail	Pass	Pass	Pass
Value for money	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Revenue affordability	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Capital affordability	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
<b>Summary</b>	<b>Carry forward as BAU</b>	<b>Carry forward as Additional Comparator</b>	<b>Carry forward</b>	<b>Carry forward – to be explored if further capital became available</b>	<b>Carry forward – preferred – to be explored if further capital became available</b>
<b>Rationale for Conclusion</b>	<p>Does not deliver Future Fit clinical model, and associated improvements to clinical quality and patient experience.</p> <p>Doesn't address workforce challenges.</p> <p>There is no improvement in access and additional capacity requirements are not met.</p>	<p>Does not deliver Future Fit clinical model, and associated improvements to clinical quality and patient experience.</p> <p>Doesn't address workforce challenges.</p> <p>There is no improvement in access and additional capacity requirements are not met.</p>	<p>Passes all relevant CSFs at this stage.</p>	<p>Passes all qualitative CSFs but it is noted that there may be affordability constraints – to be explored in the quantitative appraisal.</p>	<p>Passes all qualitative CSFs</p> <p>Preferred solution at this stage but it is noted that there may be affordability constraints – to be explored in the quantitative appraisal.</p>

# Description of the Options – Service Delivery

i.	<b>Procurement Framework (e.g. CCS/ NHSE ProCure23)</b>	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.
ii.	<b>Single Stage Tender</b>	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.
iii.	<b>Two Stage Tender (with potential novation)</b>	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.

**\*Only these procurement route options are considered due to there being no reason to deviate to explore other options as alignment to NHS guidance is imperative and ProCure23 is advised.**



# Appraisal of the Options – Service Delivery

## Option i: Framework Procurement (including P22, P23, CCS)

<b>Description</b>	This option would utilise a suitable framework to procure the support required. Several frameworks are available and in development. These are considered in more detail in the Commercial Case (Section 3.1.1).
<b>Advantages</b>	<ul style="list-style-type: none"> <li>- Framework Procurement is the primary procurement route in line with NHSE Business Case guidance (unless an alternative route to market can be justified), to appoint Principal Supply Chain Partners (PSCPs)</li> <li>- All potential suppliers are proficient with complex, health-specific design and construction projects</li> <li>- 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.</li> <li>- Likely reduction in the legal and management burden to the Trust</li> <li>- Effective Contract Management and administration is supported by the set of pro-formas</li> <li>- Lower management overheads from dealing with a single contractor</li> <li>- An established price mechanism (Guaranteed Maximum Price)</li> <li>- Variations to contract activities are managed (e.g., increase/decrease in costs via the Compensation Events process) during the works</li> <li>- Training for all project team members to enhance project proficiency and Implementation advisor support, offered in a neutral capacity (free of charge)</li> </ul>
<b>Disadvantages</b>	<p>Limits the number of potential suppliers to those who have prequalified on the chosen framework.</p> <p>Shared risk allocation.</p>
<b>Conclusion</b>	<p>A framework such as P23 or CCS is likely to present the most favourable route.</p> <p>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, as well as understanding the balance of risk between Trust and PSCP will need consideration throughout the procurement process.</p>





# Appraisal of the Options – Service Delivery

## Option ii: Traditional Procurement – Single Stage Tender

<b>Description</b>	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
<b>Advantages</b>	<ul style="list-style-type: none"> <li>- Competitive tender process</li> <li>- Provides maximum flexibility</li> <li>- Opportunities to include modern methods of construction, and repeatable design element from the outset.</li> <li>- Design team is under direct Trust control</li> <li>- Potential continuity of design team from SOC stage</li> </ul>
<b>Disadvantages</b>	<ul style="list-style-type: none"> <li>- More complex to manage; integration and delivery risks remain with the Trust.</li> <li>- Separating the design development and construction process exposes both the contractor and the customer to high levels of risk.</li> <li>- Contract terms and conditions require significant consideration to best manage risks and likely additional costs from legal advisors.</li> <li>- 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.</li> <li>- Significant expense and effort expended by the bidding contractor (with only a small chance of a contract award).</li> <li>- Potential for inflationary pressure as a result of longer timelines</li> </ul>
<b>Conclusion</b>	This option would be a high-risk option but would afford us maximum flexibility and control. However, it is unlikely to be viable as the pool of available contractors is likely to be small.

# Appraisal of the Options – Service Delivery

## Option iii: Design and Build Contract – Two Stage with Potential Novation

<b>Description</b>	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.
<b>Advantages</b>	<ul style="list-style-type: none"> <li>- Value for money demonstrated through competitive tender</li> <li>- Single Point Responsibility for Design &amp; Construction can be achieved</li> <li>- Greater options to manage risk</li> <li>- Pricing Approach can allow Target Price option</li> <li>- Retention of two competing designs can maintain competitive pressure into the agreement of the build contract, maximising value for money</li> </ul>
<b>Disadvantages</b>	<ul style="list-style-type: none"> <li>- Statutory definition of required timescale</li> <li>- Trust will need to manage a complex procurement process and qualify potential bidders</li> <li>- Contract terms and conditions require significant consideration to best manage risks and likely additional costs from legal advisors.</li> <li>- Potential additional cost if commercial strategy is to develop two competing designs</li> </ul>
<b>Conclusion</b>	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. The cost, and time associated with legal advice on contractual terms is also a significant disadvantage.

# SWOT Analysis – Service Delivery

	Continue Current Arrangements	Procurement Framework (including P22, P23, CCS)	Single Stage Tender	Two Stage Tender
Conclusion	Carry forward as BAU	Carry forward – preferred	Discount	Discount
Rationale	<ul style="list-style-type: none"> <li>Can be delivered in absence of additional funding</li> </ul>	<ul style="list-style-type: none"> <li>Utilises best practise as per business case guidance</li> </ul>	<ul style="list-style-type: none"> <li>Maximum flexibility but with maximum risks</li> </ul>	<ul style="list-style-type: none"> <li>Maintains opportunity for flexibility with less risks</li> </ul>
Strengths	<ul style="list-style-type: none"> <li>Minimal / no procurement requirements</li> <li>Can utilise existing Trust procurement approaches through existing estates capital programme</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in legal and management burden to the trust</li> <li>Drives strong value for money and efficiency due to national approach</li> <li>Variations to contract activities are managed during the works</li> <li>Training for all project team members is offered in a neutral capacity</li> <li>Quick and easy access to experienced and proficient partners</li> </ul>	<ul style="list-style-type: none"> <li>Value for money as a result of competitive tender</li> <li>Maximum flexibility</li> <li>Opportunities to include MMC</li> <li>Design team is under direct Trust control</li> <li>Potential continuity of design team from SOC stage</li> </ul>	<ul style="list-style-type: none"> <li>Value for money as a result of competitive tender</li> <li>Single Point responsibility for design and construction can be achieved</li> <li>Greater options to manage risk</li> <li>Pricing Approach can allow target price option</li> <li>Maintaining competitive pressure</li> </ul>
Opportunities	<ul style="list-style-type: none"> <li>Not constrained by the consultation – allows for complete change in how care is provided</li> </ul>	<ul style="list-style-type: none"> <li>Ensures consistency with government policy</li> </ul>	<ul style="list-style-type: none"> <li>Ensures a competitive price can be secured</li> </ul>	<ul style="list-style-type: none"> <li>Some risk is transferred to the contractor</li> </ul>
Weaknesses	<ul style="list-style-type: none"> <li>Will not deliver the required improvements to the estate</li> </ul>	<ul style="list-style-type: none"> <li>Potential suppliers may be locked out of the process if they are not awarded onto the framework from the outset</li> </ul>	<ul style="list-style-type: none"> <li>Complex to manage – integration and delivery risks maintain wit the trust</li> <li>Contractor and customer are exposed to high levels of risk</li> <li>Contract terms and conditions require significant consideration</li> <li>Price will not be known until the design is complete</li> </ul>	<ul style="list-style-type: none"> <li>Trust will need to manage a complex procurement process and quantify potential bidders</li> <li>Potential for additional costs</li> </ul>
Threats	<ul style="list-style-type: none"> <li>Further growth in demand</li> <li>Further increases in inflation</li> </ul>	<ul style="list-style-type: none"> <li>Funding for the HTP is no longer available from the government</li> </ul>	<ul style="list-style-type: none"> <li>Significant expense/ effort by the bidding contractor (with only a small chance of contract award) – potential for lack of bidders as a result</li> </ul>	<ul style="list-style-type: none"> <li>Once a firm is selected for negotiations, competition is lost and this may impact price.</li> </ul>



# Appraisal against CSFs - Service Delivery



Critical Success Factor	Continue Current arrangements	Option i Framework Procurement	Option ii Single Stage Tender	Option iii Two Stage Tender
Clinical model	Not applicable	Not applicable	Not applicable	Not applicable
Clinical quality and patient experience	Not applicable	Not applicable	Not applicable	Not applicable
Workforce	Not applicable	Not applicable	Not applicable	Not applicable
Effectiveness	Not applicable	Not applicable	Not applicable	Not applicable
Commercial Viability	Pass	Preferred	Fail	Pass
Build Deliverability	Fail	Preferred	Pass	Fail
Value for Money	Fail	Preferred	Pass	Pass
Revenue affordability	Not applicable	Not applicable	Not applicable	Not applicable
Capital affordability	Not applicable	Not applicable	Not applicable	Not applicable
Summary	<b>Carry forward as BAU</b>	<b>Carry forward - preferred</b>	<b>Discount</b>	<b>Discount</b>
Rationale for conclusion	Does not deliver desired outcome or necessary additional capacity.	Negotiated rates have already been agreed and contractors are prequalified suggesting build deliverability and commercial viability.	Is not commercially viable as the pool of contractors able to commit to a single stage contract is unlikely to be large enough.  The Trust will need to manage integration and design risks.	A separate two stage competitive tender process is unlikely to be supported by stakeholders due to the cost and time associated with legal advice on contractual terms.

# Description of the Options - Implementation

i.	<b>Phased as per SOC</b>	<p>The solution would be delivered as follows:</p> <p><b>Core DMBC ('Do minimum')</b>: Delivered through a single, core, phase of works</p> <p><b>Delivering the core DMBC requirements and addressing key estates risks</b>: 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</p> <p><b>Delivering the core DMBC requirements, addressing key estates risks and improving health service integration</b>: 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</p>
ii.	<b>Longer term phasing</b>	An extended delivery timeline – likely to involve lengthening delivery timelines by circa 6 months.



# SWOT Analysis - Implementation

	Continue current arrangements	Phased as per SOC	Longer term phasing
Conclusion	Carry forward as BAU	Carry forward – preferred	Discount
Rationale	<ul style="list-style-type: none"> <li>Can be delivered in the absence of additional funding being received</li> </ul>	<ul style="list-style-type: none"> <li>Enables optimisation and prioritisation of the delivery of the clinical model.</li> <li>Minimises operational disruption to maintain clinical activity</li> </ul>	<ul style="list-style-type: none"> <li>Programme phased over an additional 6 months</li> </ul>
Strengths	<ul style="list-style-type: none"> <li>Currently within the Trust's ability to fund</li> </ul>	<ul style="list-style-type: none"> <li>No additional costs associated with delay</li> <li>Reduced risk of a single stage large implementation</li> <li>Brings forward the benefits and capital spend</li> </ul>	<ul style="list-style-type: none"> <li>Reduces risk</li> <li>Allows for potential to raise more capital</li> </ul>
Opportunities	<ul style="list-style-type: none"> <li>Not constrained by the consultation – allows for complete change in how care is provided</li> </ul>	<ul style="list-style-type: none"> <li>Requires no additional changes to planning/ design</li> </ul>	<ul style="list-style-type: none"> <li>Allows more time to raise funds and account for delays</li> </ul>
Weaknesses	<ul style="list-style-type: none"> <li>Does not provide a feasible long term solution to critical estates backlog issues</li> </ul>	<ul style="list-style-type: none"> <li>Plans may not be ready</li> <li>Contractors may not be able to complete the programme on time</li> </ul>	<ul style="list-style-type: none"> <li>Greater logistical ambiguities</li> <li>Increased capital costs</li> <li>Temporary services required for longer</li> <li>Could lead to significant inefficiencies</li> <li>Will not allow for the PCSP to function appropriately during phasing</li> </ul>
Threats	<ul style="list-style-type: none"> <li>Further growth in demand</li> <li>Additional estates backlog issues arise</li> </ul>	<ul style="list-style-type: none"> <li>Delays to approval</li> </ul>	<ul style="list-style-type: none"> <li>Further increases in inflation</li> <li>Additional capital costs can't be added to the funding envelope</li> <li>Lack of support for subsequent phases</li> <li>PSCP unlikely to agree to longer term phasing</li> </ul>

# Appraisal against CSFs - Implementation



Critical success factor	Continue Current Arrangements	Phased as per SOC	Longer term phasing
Clinical model	Not applicable	Not applicable	Not applicable
Clinical quality and patient experience	Not applicable	Not applicable	Not applicable
Workforce	Not applicable	Not applicable	Not applicable
Effectiveness / Access	Not applicable	Not applicable	Not applicable
Commercial viability	Pass	Preferred	Pass
Build deliverability	Fail	Preferred	Fail
Value for money	Fail	Preferred	Pass
Revenue affordability	Not applicable	Not applicable	Not applicable
Capital affordability	Not applicable	Not applicable	Not applicable
<b>Summary</b>	<b>Carry forward as BAU</b>	<b>Carry forward – preferred</b>	<b>Discount</b>
Rationale for conclusion	Does not deliver desired outcome or necessary additional capacity.	Passes all relevant CSFs.	Will lead to increasing costs and inefficiencies – reducing value for money and impacting deliverability.

# Description of the Options - Funding

i.	<b>Internal financing</b>	The programme is funded from the Trust's internally generated capital.
ii.	<b>Charitable financing</b>	Charitable contribution from local charities, donors or other Trusts.
iii.	<b>Government PDC via HTP</b>	The programme is funded by Public Dividend Capital (PDC) - 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.
iii.	<b>Private/ External financing</b>	Funding through an external organisation outside of government.

# SWOT Analysis - Funding

	Continue current arrangements	Internal financing	Charitable financing	Government PDC	Private/ External financing
Conclusion	Carry forward as BAU	Explore contributions	Explore contributions	Carry forward – preferred	Discount
Rationale	<ul style="list-style-type: none"> <li>Appropriate for BAU but not sufficient funding for any of the do-something options</li> </ul>	<ul style="list-style-type: none"> <li>Likely to offer good value for money</li> <li>Will be limited in availability</li> <li>Unlikely to be able to fully fund the scheme</li> </ul>	<ul style="list-style-type: none"> <li>Likely to offer good value for money</li> <li>Will be limited in availability</li> <li>Unlikely to be able to fully fund the scheme</li> </ul>	<ul style="list-style-type: none"> <li>Government PDC is supported by the NHS as the core route to capital</li> </ul>	<ul style="list-style-type: none"> <li>Likely to incur greater costs of capital</li> <li>Not likely to be available for this scheme</li> </ul>
Strengths	<ul style="list-style-type: none"> <li>Currently within the trusts ability to fund</li> </ul>	<ul style="list-style-type: none"> <li>Low cost of capital means that it will be good value for money</li> </ul>	<ul style="list-style-type: none"> <li>Low cost of capital means that it will be good value for money</li> </ul>	<ul style="list-style-type: none"> <li>Preferred approach to fund the development</li> </ul>	<ul style="list-style-type: none"> <li>Can potentially attain higher amounts of capital</li> </ul>
Opportunities	<ul style="list-style-type: none"> <li>Not constrained by the consultation – allows for complete change in how care is provided</li> </ul>	<ul style="list-style-type: none"> <li>Good value for money allows for ability to fund further improvements if available</li> </ul>	<ul style="list-style-type: none"> <li>Good value for money allows for ability to fund further improvements if available</li> </ul>	<ul style="list-style-type: none"> <li>Funding was confirmed as part of the 2018 Wave 3 Sustainability and Transformation Partnership capital budget.</li> </ul>	<ul style="list-style-type: none"> <li>Potential for high amounts of capital that will be able to fund more improvements</li> </ul>
Weaknesses	<ul style="list-style-type: none"> <li>Insufficient funding available for 'Do Something' options</li> </ul>	<ul style="list-style-type: none"> <li>Potentially insufficient funding for 'Do Something' options</li> </ul>	<ul style="list-style-type: none"> <li>Potentially insufficient funding for 'Do Something' options</li> </ul>	<ul style="list-style-type: none"> <li>Allocated Government funding will no longer support the delivery of all of the wider future fit ambitions.</li> </ul>	<ul style="list-style-type: none"> <li>Does not have NHS/ political backlog</li> <li>Likely to deliver poor value for money due to higher cost of capital</li> </ul>
Threats	<ul style="list-style-type: none"> <li>Further growth in demand</li> <li>Further increase in inflation</li> <li>Additional estates backlog issues arise which require additional funding</li> </ul>	<ul style="list-style-type: none"> <li>Further growth in demand</li> <li>Further increase in inflation</li> <li>Additional estates backlog issues arise which require additional funding</li> </ul>	<ul style="list-style-type: none"> <li>Further growth in demand</li> <li>Further increase in inflation</li> <li>Additional estates backlog issues arise which require additional funding</li> </ul>	<ul style="list-style-type: none"> <li>Increases in inflation mean that costs have increased significantly since the capital was estimated – they could increase further</li> </ul>	<ul style="list-style-type: none"> <li>Increased cost of capital due to current economic climate</li> </ul>



# Appraisal against CSFs - Funding

Critical success factor	Continue Current Arrangements	Internal financing	Charitable financing	Government PDC	Private financing
Clinical model	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Clinical quality and patient experience	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Workforce	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Effectiveness / Access	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Commercial viability	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Build deliverability	Fail	Pass	Pass	Preferred	Fail
Value for money	Pass	Pass	Pass	Preferred	Fail
Revenue affordability	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Capital affordability	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Summary	<b>Carry forward as BAU</b>	<b>Explore contributions</b>	<b>Explore contributions</b>	<b>Carry forward - preferred</b>	<b>Discount</b>
Rationale for conclusion	Does not deliver desired outcome or necessary additional capacity.	Passes all relevant CSFs at this stage but is unlikely to be available.	Passes all relevant CSFs at this stage but is unlikely to be available.	Passes all relevant CSFs.	Higher cost of capital results in low value for money.



# Long List to Short List

Domains and options	Summary of Assessment
<b>Scope</b>	
Continue Current Arrangements (comparator)	Carried Forward –Comparators
Delivering the core DMBC requirements	Short-listed
Delivering the wider Future Fit ambitions	Short-listed
<b>Service Solution</b>	
Business As Usual (no/minimal capex)	Carried Forward – BAU
Additional comparator option (c.72m capex)	Carried Forward – Additional Comparator
Core DMBC requirements ('Do Minimum')	Short-listed
Core DMBC + key estates risks	Short-listed
Core DMBC + key estates risks + integration	Short-listed
<b>Service Delivery</b>	
Procurement Framework	Short-listed
Single-stage tender	Discounted
Two-stage tender	Discounted
<b>Implementation</b>	
Phased as per SOC	Short-listed
Longer Term phasing	Discounted
<b>Funding</b>	
Internal financing	Explore if available
Charitable financing	Explore if available
Government PDC	Short-listed
Private financing	Discounted



# Long List to Short List

Dimension	Options				
1. Scope	Continue current arrangements	Delivering the core DMBC Requirements		Delivering the wider Future Fit ambitions	
2. Service solution		Additional Comparator Option	Core DMBC	Core DMBC + key estates risks	Core DMBC + key estates risks + integration
3. Service delivery		Framework Procurement	Single Stage Tender		Two Stage Tender
4. Service implementation		Phased as per SOC		Longer term phasing	
5. Funding		Internal financing	Charitable financing	Government PDC	Private Financing

Preferred
Carry forward
Discounted

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.

# Short List

0	<b>Business As Usual</b>	c. £ minimal	Remaining with the current service configuration (i.e. assuming no additional capital investment over and above the ICB operational planning assumptions) – including additional internal resourcing costs, additional costs for outsourcing components of the care that we currently provide to other NHS/ private providers.
1	<b>Additional Comparator Option</b>	c. 72m	Continuation of current arrangements, including the Trust's baseline annual capital programme over the appraisal period. Annual essential backlog items across both sites. This option also includes funding for additional modular ward capacity to address operational bed pressures due to bed capacity shortfalls and clinical pathway issues
2	<b>Core DMBC('Do Minimum')</b>	c. 312m (at submission of SOC)	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	<b>Delivering Future Fit and addressing key infrastructure issues</b>	c. 481m (at submission of SOC)	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	<b>Delivering Future Fit, addressing key infrastructure issues and improving health service integration</b>	c.534m (at submission of SOC)	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.



# Next Steps

The 5 short-listed options will now undergo further analysis through a qualitative and quantitative appraisal.

The **qualitative appraisal** will look at the 5 short-listed options against the qualitative investment objectives/ CSFs.

The **quantitative appraisal** will look at the 5 short-listed options against the quantitative investment objectives/ CSFs.

This will result in **agreement to and confirmation of the preferred option.**



## Table of Contents

Tab	Description
<b>Key Information</b>	
<a href="#">Risks</a>	A list of all risks included as part of the risk appraisal
<a href="#">Quantitative Risk Summary</a>	A summary of the quantitative risk scores by type
<a href="#">Qualitative Risk Summary</a>	A summary of the qualitative risk scores by type
<a href="#">Quantitative Risk Appraisal - Options 0-4</a>	The probability and impact scores of each quantitative risk for options 0-4 as well as the mitigations in place for each risk and the allocated risk owner of each risk.
<a href="#">Qualitative Risk Appraisal - Options 0-4</a>	The probability and impact scores of each qualitative risk for options 0-4 as well as the mitigations in place for each risk and the allocated risk owner of each risk.
<a href="#">Quantitative Risk Calculations</a>	The calculations used to quantify the quantitative risks
<b>CIA Model Inputs</b>	
<a href="#">CIA Inputs Options 0-4</a>	The calculations required for the risks tab in the CIA Model.
<b>Supporting Information</b>	
<a href="#">Probability / Impact Ratings Guides</a>	The reasoning behind each score for probability and impact.



RISKS		
Qualitative	Quantitative	Risk ID
	There is a risk that there is <b>insufficient and/or inexperienced capacity within the construction sector</b> . As a result, the programme may not be able to be delivered within the required time frame and set out in the OBC. In order to access construction resources, a premium may be required.	1
There is a risk that <b>design changes</b> may be requested by the Trust/ operator before or during the build, resulting in delay to the programme and a need for redevelopment of original designs.		2
	There is a risk that <b>increases in demand result in increased pressure</b> above what is forecast as bed capacity assumptions are insufficient (e.g. local care programme demand mitigation not delivered/ shift to out of hospital care fails to be delivered).	3
<b>External political and economic factors</b> and/or longer development timescales may increase the capital requirements and/or impact the design plans for the hospital sites.		4
The Trust <b>does not have adequate capacity and capability</b> to deliver the scheme/ they cannot secure the right resources.		5
	Expected cost of the preferred option <b>exceeds indicated HTP allocated funding</b> and affordability indicators leading to additional investigation and potential for a sub-optimal solution for the scheme.	6
The scheme is dependent on government funding. There is a risk that <b>funding from the government is no longer available</b> , resulting in inability to deliver the scheme.		7
	There is a risk that the Trust continues to <b>experience significant recruitment and retention challenges</b> if the problems with the working environment are not appropriately addressed.	8
	There is a risk that the <b>workforce needs to grow more than anticipated</b> in order to facilitate the programme.	9
There is a risk that a shortage of workforce capacity leads to <b>further deterioration in working environment for current staff</b> .		10
	The <b>enabling works</b> that need to be completed in order for works to go ahead, <b>take longer than expected</b> . This causes delay to the programme and leads to increasing costs.	11
<b>Construction work on-site causes disruption to hospital operations</b> , impacting both patients and staff. This may lead to a reduction in staff and patient satisfaction.		12
<b>Interdependent capital projects are not fully aligned</b> to HTP which may increase costs and lead to delays.		13
Other clinical, operational or strategic priorities may affect the <b>availability of key leaders and staff</b> to support the development of the FBC and delivery of the scheme.		14
<b>Clinical adjacencies</b> cannot be sustained during and after the project.		15
	Clinical and operational teams are <b>unable to engage in the design process</b> which could result in <b>inability to adapt to the change in ways of working</b> that will be required to deliver the next stage of	16
	Despite PSCP being appointed, there are issues with their supply chain and <b>subcontractors can't agree to terms</b> .	17
	There may be <b>delays in the approval process</b> as a result of a <b>stakeholders</b> failing to engage or a change in government approach resulting in <b>competing national initiatives</b> having priority.	18

There is a risk that the standard of buildings and clinical model is not good enough to provide the necessary <b>infection control</b> environment.		19
There is a risk that the <b>build will not reach the net zero targets</b> , meaning that a penalty cost is incurred.		20
The development of the <b>new Energy Centre, electrical power supply and infrastructure is not achieved in time</b> to support the programme which could lead to delays and increasing costs.		21
	<b>Increased provision of single rooms</b> results in a short term pressure in staffing as processes, culture and technology adjust.	22
There is a risk that we are <b>unable to deliver the benefits associated with HTP</b> (specifically the identified workforce benefits due to workforce supply) which could lead to <b>internal and external reputational damage</b> .		23
	There is a risk that there are <b>delays to approval of planning permission</b> .	24
	There is a risk that <b>without investment, services deteriorate more significantly</b> than expected leading to service failures which will increase estates/ financial costs.	25
There is a risk that the specification of the building is <b>not set up for future environmental changes</b> associated with climate change, resulting in delays and increasing costs.		26
There is a risk that the trust is <b>unable to meet the required regulatory healthcare/ emergency standards</b> .		27
System (ICS Local Care Programme) assumptions, dependencies and interdependencies may change during the development of the OBC, <b>requiring changes to the scope and plans</b> .		28
There is a risk that the <b>digital requirements</b> during the <b>enabling works</b> are more <b>costly</b> than expected.		29
There is a risk that there is <b>not enough time</b> to prepare the site in order to provide the adequate <b>digital requirements</b> to support the running of the hospital during the <b>enabling works</b> .		30
If demand exceeds capacity there is a risk that <b>outsourcing</b> of services is required, meaning that <b>data transfer between systems</b> will be needed which could lead to <b>increasing digital costs</b> .		31
There is a risk that <b>EPR programme timelines</b> overlap with HTP timelines which could lead to increasing costs and delays (potential for inability to fulfil paper-lite requirement, extension of current digital contract).		32
There is a risk that there is <b>insufficient funding</b> to enable the digital aspirations of the digital strategy and clinical model of care which in some circumstances could impact delivery of specific digital benefits (e.g. automated dispensing)		33
There is a risk that the Trust cannot maintain continuity of provision of care due to a <b>deterioration in services</b> .		34

<b>Quantitative Risks - Summary Table (£'000)</b>					
	<b>BAU</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>Total risk cost</b>	<b>11,840</b>	<b>15,748</b>	<b>15,255</b>	<b>18,378</b>	<b>19,173</b>
<b>Risk Type</b>	<b>BAU</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Business	£ 11,840	£ 11,840	£ 5,415	£ 4,068	£ 4,068
Service	£ -	£ 2,295	£ 8,228	£ 12,698	£ 13,493
External	£ -	£ 1,613	£ 1,613	£ 1,613	£ 1,613
<b>Detailed Risk Type</b>	<b>BAU</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Design	£ -	£ -	£ -	£ -	£ -
Construction	£ 1,369	£ 3,341	£ 6,615	£ 9,150	£ 9,945
Performance	£ -	£ -	£ 1,290	£ 1,290	£ 1,290
Operating	£ 4,172	£ 4,494	£ 2,238	£ 4,225	£ 4,225
Revenue	£ 6,300	£ 7,913	£ 5,113	£ 3,713	£ 3,713
Termination	£ -	£ -	£ -	£ -	£ -
Technology	£ -	£ -	£ -	£ -	£ -
Control	£ -	£ -	£ -	£ -	£ -
Residual Value	£ -	£ -	£ -	£ -	£ -
Other	£ -	£ -	£ -	£ -	£ -
Additional	£ -	£ -	£ -	£ -	£ -
Spare	£ -	£ -	£ -	£ -	£ -

Qualitative Risks - Summary Table					
	BAU	1	2	3	4
<b>Total risk factor</b>	139	140	130	137	137
<b>Risk Type</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Business	124	108	35	28	28
Service	5	20	86	100	100
External	10	12	9	9	9
<b>Detailed Risk Type</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Design	10	10	19	20	20
Construction	13	13	44	42	42
Performance	49	45	20	19	19
Operating	57	48	16	20	20
Revenue	8	20	15	15	15
Termination	0	0	10	15	15
Technology	0	0	0	0	0
Control	0	0	0	0	0
Residual Value	0	0	0	0	0
Other	2	4	6	6	6
Additional	0	0	0	0	0
Spare	0	0	0	0	0

ID	Detailed risk type (CIA model category)	Detailed Risk Code	CIA Model Sub-Category	Summary Risk type	Risk Owner	Risk Description	Mitigation	Quantification basis	Relevant Years	Logic	Years from base year (2022/23 = year 0) in which risk occurs (midpoint taken if there is a relevant period)	Qualitative/ Quantitative	Capital or Revenue	Probability of occurring post mitigation (1-5)					Cost of risk occurring (£'000)					Probability x Magnitude (£'000)				
														BAU	1	2	3	4	BAU	1	2	3	4	BAU	1	2	3	4
1	Construction	B	B15	Service	Estates	There is a risk that there is <b>insufficient and/or inexperienced capacity within the construction sector</b> . As a result, the programme may not be able to be delivered within the required time frame and set out in the OBC. In order to access construction resources, a premium may be required.	The scheme aims to meet the 70% MMC benchmark.	Premium cost of delivery (5% on construction costs)	Period of build	23/24-26/27 is period of build	2	Quantitative	Capital	0	2	2	2	2	-	3,350	15,600	24,050	26,700	-	1,005	4,680	7,215	8,010
3	Revenue	E	E4	Business	Clinical/ BI	There is a risk that <b>increases in demand result in increased pressure</b> above what is forecast as bed capacity assumptions are insufficient (e.g. local care programme demand mitigation not delivered/ shift to out of hospital care fails to be delivered).	Further testing of demand and capacity modelling at OBC stage and further development of out of hospital strategy. Capacity and demand refresh work currently underway, however, much remains to be done given the level of detail currently available within both SaTH and the ICS.	25% of additional capacity benefit over 5 years	5 years post opening	Opens 26/27	6.5	Quantitative	Revenue	5	5	3	2	2	7,000	7,000	7,000	7,000	7,000	6,300	6,300	3,500	2,100	2,100
6	Operating	D	D5	Service	Finance	Expected cost of the preferred option <b>exceeds indicated HTP allocated funding and affordability</b> indicators leading to additional investigation and potential for a sub-optimal solution for the scheme.	Further challenge and testing of capital costs will be done through the OBC review process.	Programme Team costs x potential delay	23/24	Delay of 1Q	1	Quantitative	Capital	0	1	1	4	4	3,225	3,225	3,225	3,225	3,225	-	323	323	2,258	2,258
8	Operating	D	D11	Business	Workforce	There is a risk that the Trust continues to <b>experience significant recruitment and retention challenges</b> if the problems with the working environment are not appropriately addressed.	The Trust has a well developed Recruitment and Retention strategy that we follow in order to address these issues.	Pay premium for growth roles identified (assumed c.38% agency premium) (taken from the workforce model)	5 years post opening	Opens 26/27	6.5	Quantitative	Revenue	5	5	2	2	2	3,724	3,724	3,475	3,475	3,475	3,352	3,352	1,042	1,042	1,042
9	Operating	D	D11	Business	Workforce	There is a risk that the <b>workforce needs to grow more than anticipated</b> in order to facilitate the programme.	Detailed workforce modelling has taken place at OBC stage to ensure requirements are met.	5% uplift on staffing costs over 5 years	5 years post opening	Opens 26/27	6.5	Quantitative	Revenue	2	2	2	2	2	2,734	2,734	2,734	2,734	2,734	820	820	820	820	820
11	Construction	B	B2	Service	Estates	The <b>enabling works</b> that need to be completed in order for works to go ahead, <b>take longer than expected</b> . This causes delay to the programme and leads to increasing costs.	Regular progress updates from enabling works teams.	Programme Team costs x potential delay	FBC period	FBC due to be finalised 23/24	1	Quantitative	Capital	0	0	2	2	2	3,225	3,225	3,225	3,225	3,225	-	-	968	968	968
16	Performance	C	C6	Service	Clinical	Clinical and operational teams are <b>unable to engage in the design process</b> which could result in <b>inability to adapt to the change in ways of working</b> that will be required to deliver the next stage of the programme.	Initial engagement sessions have taken place with the executive leadership team and each divisional leadership team. Further coaching and support will be provided to each workstream as the programme progresses.	Programme Team costs x potential delay	Year of opening	Opens 26/27	4	Quantitative	Capital	0	0	2	2	2	3,225	3,225	3,225	3,225	3,225	-	-	968	968	968
17	Performance	C	C3	Service	Commercial	Despite PSCP being appointed, there are issues with their supply chain and <b>subcontractors can't agree to terms</b> .	Framework Procurement was selected as the preferred way forward as part of the SOC as this is the recommended approach in line with business case guidance.	Programme Team costs x potential delay	23/24	When PSCP is due to be appointed	1	Quantitative	Capital	0	0	1	1	1	3,225	3,225	3,225	3,225	3,225	-	-	323	323	323
18	Revenue	E	E3	External	PMO	There may be <b>delays in the approval process</b> as a result of a <b>stakeholders</b> failing to engage or a change in government approach resulting in <b>competing national initiatives</b> having priority.	Ongoing engagement with stakeholders, regional and national NHSEI representatives to ensure that the priority of this proposal is clearly understood.	Programme Team costs x potential delay	Year of opening	Opens 26/27	4	Quantitative	Capital	0	3	3	3	3	3,225	3,225	3,225	3,225	3,225	-	1,613	1,613	1,613	1,613
22	Operating	D	D11	Business	Workforce	<b>Increased provision of single rooms</b> results in a short term pressure in staffing as processes, culture and technology adjust.	Staff will be briefed/ provided with training in order to smooth the transition to increases single rooms.	5% uplift on staffing costs for 72% of a general medical ward	5 years post opening	Opens 26/27	6.5	Quantitative	Revenue	0	0	2	2	2	-	-	175	351	351	-	-	53	105	105
24	Construction	B	B5	Service	Estates	There is a risk that there are <b>delays to approval of planning permission</b> .	Shropshire Council are aware of the scheme and are supportive. Early engagement with planners has taken place.	Programme Team costs x potential delay	23/24	When planning permission is due to be achieved	1	Quantitative	Capital	0	2	2	2	2	3,225	3,225	3,225	3,225	3,225	-	968	968	968	968
25	Construction	B	B3	Business	Estates	There is a risk that <b>without investment, services deteriorate more significantly</b> than expected leading to service failures which will increase estates/ financial costs.	The HTP will eliminate some high and significant backlog.	5% of backlog maintenance pre-works	Year of opening	Opens 26/27	4	Quantitative	Capital	4	4	0	0	0	1,955	1,955	-	-	-	1,369	1,369	-	-	-

11,840	15,748	15,255	18,378	19,173
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ID	Detailed risk type (CIA model category)	Detailed Risk Code	Summary Risk type	Risk Owner	Risk Description	Mitigation	Qualitative/ Quantitative	Probability of occurring post mitigation (1-5)					Risk impact post mitigation (1-5)					Overall risk scores					Qualitative rationale for probability and impact
								BAU	1	2	3	4	BAU	1	2	3	4	BAU	1	2	3	4	
2	Design	A	Service	Estates	There is a risk that <b>design changes</b> may be requested by the Trust/ operator before or during the build, resulting in delay to the programme and a need for redevelopment of original designs.	Early review of key assumptions with staff and system stakeholders. Ongoing engagement throughout the OBC to ensure that any potential issues are addressed as soon as possible. There is a contingency in place for design changes.	Qualitative	0	0	3	4	4	0	0	3	3	3	0	0	9	12	12	The likelihood is higher in options 3 and 4 compared to option 2 because the designs are more complex/ involve further input.
4	Other	J	External	PMO	<b>External political and economic factors</b> and/or longer development timescales may increase the capital requirements and/or impact the design plans for the hospital sites.	Allocated capital confirmed through the SOC approval process. If capital requirements for this programme change, programme scope will be reviewed alongside the relative priority of other system capital plans. Confirmation of the options will help to mitigate the risks.	Qualitative	2	2	2	2	2	1	2	3	3	3	2	4	6	6	6	External political / economic factors will have a greater impact on the 'Do Something' options than the comparator options because of the implications for approval/ designs. The probability is fairly low across the options because thorough planning has taken place
5	Operating	D	Service	PMO	The Trust <b>does not have adequate capacity and capability</b> to deliver the scheme/ they cannot secure the right resources.	Plans for internal and external resourcing requirements have been developed. People and procurement workstreams have been established and are progressing. There is detailed phasing of the programme to spread the capital costs over a series of years but earlier benefits are delivered at a reduced cost envelope.	Qualitative	0	0	2	3	3	0	0	4	4	4	0	0	8	12	12	The probability is 3 in options 3 and 4 due to the knowledge of a specific amount of allocated funding. The impact is high across the 'Do Something' options due to inability to deliver the revised clinical model if this were to occur.
28	Design	A	Business	Clinical	System (ICS Local Care Programme) assumptions, dependencies and interdependencies may change during the development of the OBC, <b>requiring changes to the scope and plans.</b>	Early review of key assumptions with staff and system stakeholders. Ongoing engagement throughout the OBC to ensure that any potential issues are addressed as soon as possible.	Qualitative	2	2	2	2	2	5	4	4	3	3	10	8	8	6	6	Likelihood is consistent across the options due to the system assumptions having an impact on the Trust, regardless of the chosen option. The impact is lower in the 'Do Something' options because the plans were developed with the ICS in mind.
7	Termination	F	Service	Finance	The scheme is dependent on government funding. There is a risk that <b>funding from the government is no longer available</b> , resulting in inability to deliver the scheme.	Detailed assessment of the risks, benefits and synergies have been carried out to ensure that the selected preferred option is the most appropriate and desirable for the government.	Qualitative	0	0	2	3	3	0	0	5	5	5	0	0	10	15	15	Higher likelihood in options 3 and 4 due to the allocated budget from the government. Impact very high across the 'Do Something' options due to a lack of funding resulting in inability to deliver the HTP.
10	Operating	D	Business	Workforce	There is a risk that a shortage of workforce capacity leads to <b>further deterioration in working environment for current staff.</b>	Detailed workforce modelling has taken place at OBC stage to ensure requirements are met.	Qualitative	4	4	2	2	2	4	4	2	2	2	16	16	4	4	4	Higher likelihood in comparator options due to lack of measures in place to increase capacity. Higher impact in comparator options due to an already poor working environment that will not be addressed.
12	Performance	C	Service	Clinical	<b>Construction work on-site causes disruption to hospital operations</b> , impacting both patients and staff. This may lead to a reduction in staff and patient satisfaction.	Communication with patients and staff throughout the programme is important - early feedback suggests positive feelings towards the proposed changes.	Qualitative	0	1	2	3	3	0	1	2	2	2	0	1	4	6	6	Likelihood higher in options 3 and 4 due to more major works.
13	Design	A	Service	Estates	<b>Interdependent capital projects are not fully aligned</b> to HTP which may increase costs and lead to delays.	Clear development control plan in place regarding site development in relation to HTP so estates are aware of relevant programmes.	Qualitative	0	1	1	1	1	0	2	2	2	2	0	2	2	2	2	Low likelihood throughout due to awareness of interdependent projects.
14	Revenue	E	Service	Clinical	Other clinical, operational or strategic priorities may affect the <b>availability of key leaders and staff</b> to support the development of the FBC and delivery of the scheme.	Ongoing prioritisation by senior leaders, emphasising importance for the trust and system. Work innovatively and flexibly to free up the required resources (across the system).	Qualitative	0	4	2	2	2	0	3	3	3	3	0	12	6	6	6	Low likelihood for 'do-something' options because key stakeholders understand the importance of the HTP for improving services. Higher likelihood for the additional comparator as if the HTP is not delivered, priorities will be elsewhere.
15	Operating	D	Business	Estates	<b>Clinical adjacencies</b> cannot be sustained during and after the project.	Seeking early implementation of proposed changes through necessary approvals and commencement of service change plans. The details of the building plans are being evaluated to understand the potential effect on services. The OBC enables provision of modern, safe, effective and accessible care from dedicated emergency and planned care facilities in PRH and RSH.	Qualitative	4	4	2	2	2	4	4	2	2	2	16	16	4	4	4	Likelihood and impact higher in BAU due to the need to outsource certain services meaning that adjacencies will not be maintained. Likelihood and impact lower in the 'Do Something' options due to the new clinical model improving clinical pathways.
20	Construction	B	Service	Estates	There is a risk that the <b>build will not reach the net zero targets</b> , meaning that a penalty cost is incurred.	HTP has a robust Net Zero Carbon strategy. All design and construction phases aim to meet the net zero standard.	Qualitative	0	2	2	2	2	0	0	3	3	3	0	0	6	6	6	The impact of this risk is fairly high across the 'Do Something' options as it is essential for the programme to achieve the Net Zero targets. The probability is low as the Trust has a robust Net Zero Carbon Strategy in place.
19	Construction	B	Business	Clinical	There is a risk that the standard of buildings and clinical model is not good enough to provide the necessary <b>infection control</b> environment.	Best practise on infection control (e.g. maximising the number of single rooms) was taken into account when creating the clinical model.	Qualitative	4	4	3	2	2	2	2	2	2	2	8	8	6	4	4	The probability is highest in the comparator options as the clinical model is not addressed in these scenarios.

ID	Detailed risk type (CIA model category)	Detailed Risk Code	Summary Risk type	Risk Owner	Risk Description	Mitigation	Qualitative/ Quantitative	Probability of occurring post mitigation (1-5)					Risk impact post mitigation (1-5)					Overall risk scores					Qualitative rationale for probability and impact
								1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	
21	Construction	B	Service	Estates	The development of the <b>new Energy Centre, electrical power supply and infrastructure is not achieved in time</b> to support the programme which could lead to delays and increasing costs.	The energy centre is subject to a funding submission to the Public Sector Decarbonisation Scheme as part of the Trust's wider strategic plan.	Qualitative	1	1	3	3	3	5	5	5	5	5	5	5	15	15	15	The Energy Centre/ electrical power supply is essential for powering the new build elements of the HTP. Therefore, the impact is high across the options. The likelihood is also high across the options due to the need to locate a funding source for this interdependent project.
29	Construction	B	Service	Digital	There is a risk that the <b>digital requirements</b> during the <b>enabling works</b> are more <b>costly</b> than expected.	The digital plans were developed in detail and all costs should be accounted for.	Qualitative	0	0	3	3	3	0	0	2	2	2	0	0	6	6	6	The probability and likelihood are consistent across the do something options. The impact is fairly low due to the development of the design meaning that less enabling works are required than initially expected.
30	Construction	B	Service	Digital	There is a risk that there is <b>not enough time</b> to prepare the site in order to provide the adequate <b>digital requirements</b> to support the running of the hospital during the <b>enabling works</b> .	The digital team and experienced in delivering digital schemes of this nature and are prepared for potential delays.	Qualitative	0	0	2	2	2	0	0	1	1	1	0	0	2	2	2	The probability and impact are fairly low due to the experience of the digital team in delivering schemes of this nature and their ability to deliver the digital requirements within tight timescales as a result.
31	Revenue	E	Business	Digital	If demand exceeds capacity there is a risk that <b>outsourcing</b> of services is required, meaning that <b>data transfer between systems</b> will be needed which could lead to increasing digital costs.	Effective communication with outsourced services will take place to ensure alignment where possible.	Qualitative	4	4	0	0	0	2	2	0	0	0	8	8	0	0	0	Only applies to comparator options as outsourcing is relied upon heavily in these options to keep up with demand. Likelihood is high in these options due to D&C modelling predictions of 100% outsourcing of additional demand.
32	Construction	B	Service	Digital	There is a risk that <b>EPR programme timelines</b> overlap with HTP timelines which could lead to increasing costs and delays (potential for inability to fulfil paper-lite requirement, extension of current digital contract).	Digital Services are engaged within the HTP Programme so have sight of both timelines (EPR and HTP).	Qualitative	0	0	3	3	3	0	0	3	3	3	0	0	9	9	9	Probability is fairly high because the EPR and HTP timelines are due to overlap. Impact is also fairly high as the paper-lite requirements are necessary to deliver the HTP.
33	Revenue	E8	Service	Digital	There is a risk that there is <b>insufficient funding</b> to enable the digital aspirations of the digital strategy and clinical model of care which in some circumstances could impact delivery of specific digital benefits (e.g. automated dispensing)	Initial meetings to discuss the digital aspirations took place at SOC stage and continue to be clarified at OBC. The design team is clear on the Trust's Digital Strategy and will continue to use the HIP digital blueprint to progress delivery of the digital vision. Bidding for additional funding is currently taking place and some funding has already been granted.	Qualitative	0	0	3	3	3	0	0	3	3	3	0	0	9	9	9	Likelihood is high across the options - alternative funding may need to be sourced. Impact is fairly high across the options due to HTPs requirement to be 'paper lite'.
23	Performance	C	Business	PMO	There is a risk that we are <b>unable to deliver the benefits associated with HTP</b> (specifically the identified workforce benefits due to workforce supply) which could lead to <b>internal and external reputational damage</b> .	Detailed assessment of the benefits has been carried out.	Qualitative	5	5	3	2	2	5	4	3	3	3	25	20	9	6	6	The impact is higher in the comparator options as if HTP doesn't happen, reputational damage is likely to be higher. The likelihood is lower in options 3 and 4 because they deliver more of the Future Fit ambitions.
26	Performance	C	External	Finance	There is a risk that the specification of the building is <b>not set up for future environmental changes</b> associated with climate change, resulting in delays and increasing costs.	Designs are continually being developed and the wider HTP Team are regularly consulted on changes.	Qualitative	2	2	1	1	1	4	4	3	3	3	8	8	3	3	3	Likelihood is low across the options due to the designs being built in line with building regulations.
34	Operating	D	Business	Clinical	There is a risk that the Trust cannot maintain continuity of provision of care due to a <b>deterioration in services</b> .	The proposed plans as part of the HTP improve services and therefore prevent deterioration.	Qualitative	5	4	0	0	0	5	4	0	0	0	25	16	0	0	0	Likelihood is high for the 'do-nothing' options as the problems with the clinical model are not addressed. Doesn't apply to the 'do-something' options as the HTP prevents the deterioration of services.
27	Performance	C	Business	PMO	There is a risk that the Trust is <b>unable to meet the required regulatory healthcare/ emergency standards</b> .	Designs are in line with regulations/ national standards.	Qualitative	4	4	2	2	2	4	4	2	2	2	16	16	4	4	4	The revised clinical model is designed in line with the latest regulatory healthcare/ emergency standards so the likelihood is low in the 'Do Something' options.

139	140	130	137	137
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QUALITATIVE PROBABILITY AND IMPACT

Scale	Probability of occurrence				Impact on project			Total risk score
	Qualitative scale used	Probability	Probability score	Explanation	Project cost (if applicable)	Qualitative impact <i>**refer to more detailed rationale below**</i>	Qualitative Impact score used	
Very low	1	<10%	0.1	Will probably never happen	<1%	Temporary defects, causing minor short term consequences	1	Impact score * Probability score
Low	2	10%-<30%	0.3	Not expected to happen but it is possible that it may	1%-<2%	Performance shortfall in area of tertiary or minor importance	2	Impact score * Probability score
Medium	3	30%-<50%	0.5	Might happen occasionally	2%-<4%	Performance shortfall in area of secondary importance	3	Impact score * Probability score
High	4	50%-<70%	0.7	Will probably happen but is not a persisting issue	4%-<8%	Moderate performance shortfall in area of critical or primary importance	4	Impact score * Probability score
Very High	5	70%+	0.9	Will undoubtedly happen, possibly frequently	8%+	Significant performance shortfall against a critical or primary purpose.	5	Impact score * Probability score

QUANTITATIVE PROBABILITY AND IMPACT

Scale	Probability of occurrence				Impact on Project	Total risk score
	Qualitative scale used	Probability	Probability score	Explanation		
Very low	1	<10%	0.1	Will probably never happen	£ (if known)	Cost of risk occurring * Probability score
Low	2	10%-<30%	0.3	Not expected to happen but it is possible that it may	£ (if known)	Cost of risk occurring * Probability score
Medium	3	30%-<50%	0.5	Might happen occasionally	£ (if known)	Cost of risk occurring * Probability score
High	4	50%-<70%	0.7	Will probably happen but is not a persisting issue	£ (if known)	Cost of risk occurring * Probability score
Very High	5	70%+	0.9	Will undoubtedly happen, possibly frequently	£ (if known)	Cost of risk occurring * Probability score

QUALITATIVE IMPACT SCORE RATIONALE

Projects Risk Management Impact Scores					
	Very Low (1)	Low (2)	Moderate (3)	High (4)	Very High (5)
Cost	Very Low	Low	Moderate	High	Very high
Time	Delays that are less than 2 weeks	Delays that are likely to be in the region of more than 2, and less than 4 weeks	Delays that are likely to be in the region of more than 4, and less than 6 weeks	Delays that are likely to be in the region of more than 6, and less than 8 weeks	Greater than 8 weeks delay to operational opening of new accommodation or project delivery (including termination)
Operational Impact	Project causes disruption for less than an hour that has no impact on delivery of patient care.	Project causes short term operational disruption.	Project causes operational disruption for less than 1 week.	Project causes major operational disruption for longer than 1 week.	Project triggers large scale severe disruption that may lead to a loss of core services/ facility.
Reputation	Internal Reputational impact/ rumours at Project Manager, Client Representative or Project Team level.	Internal Reputational damage in the local media that is short term. Has a minor effect on staff morale.	Internal Reputational damage in the local media that is long term. Has an impact on the public perception of the Trust and staff morale.	Reputational Damage within the national media. Confidence in the organisation is undermined and the use of services is affected.	Reputational Damage potentially involving national/ international adverse publicity for longer than 3 days. Total loss of public confidence.
Increase in costs	Very minimal increases to costs.	Minor cost changes that can be mitigated in other areas of the programme	Moderate increase in costs.	Major increase in costs.	Large scale increase in costs.
Plans	Very minimal changes to scope/ plans.	Minor changes to the scope/ plans that don't affect the wider programme.	Moderate changes to the scope/ plans that don't impact the overall programme.	Significant changes to initial programme plans.	Changes to plans require large scale alterations.



The Shrewsbury and  
Telford Hospital  
NHS Trust

# Hospitals Transformation Programme

## OBC Qualitative Appraisal

9<sup>th</sup> December 2022



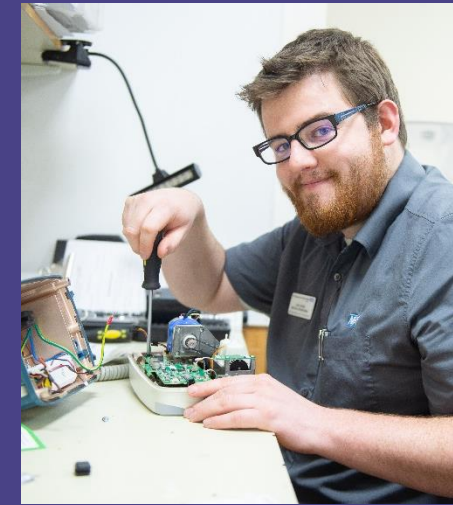
**Integrated  
Care System**  
Shropshire, Telford and Wrekin



# Agenda

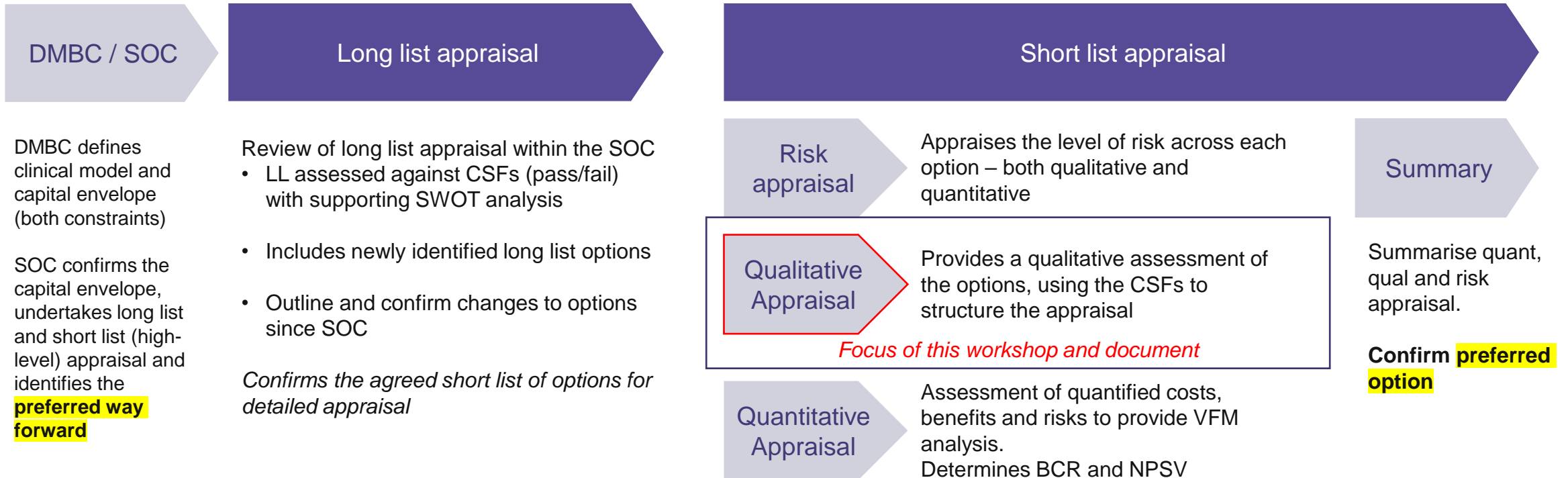
Agenda Item	Lead(s)
Long list appraisal overview	PA
Purpose and Process	PA
Investment Objectives	PA
Overview of the Options	PA / HTP
Qualitative Appraisal	Clinical – Clinical leads Workforce – Simon Balderstone Commercial – Will Savage Estates – Adam Ellis-Morgan
Summary and Next Steps	PA

# Purpose and Process



# Appraisal Process

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.



# Purpose

The **purpose** of this meeting is to...

- ✓ Review the **final definition of options**
- ✓ Identify and consider **qualitative assessment** of options
- ✓ Complete a detailed **appraisal of options vs. Critical Success Factors**
- ✓ Consideration of trade-offs between options and identify a **preferred option from the qualitative** appraisal based on the available evidence

This meeting **is not** intended to...

- ✗ Review or amend the agreed **Critical Success Factors**
- ✗ **Reconsider decisions and options appraisals from the PCBC/DMBC** – including the previous LL/SL
- ✗ Present finalised **costs, benefits or risks** of the options (*these are subject to revision*), or *include a quantitative appraisal of the options*
- ✗ Make any **final decisions** about Preferred Option – this will be done following the completion of the full appraisal including qualitative, quantitative and risk components.



## Review the shortlist of options

- A **shortlist of five options** has been developed for consideration in the OBC – building on the DMBC and SOC work
- We will review these options, including:
  - **Definition** and what is included/excluded from each option
  - **Benefits** – which will be developed further and quantified as part of next steps
  - **Risks** associated with the options
- This will provide a **high-level understanding of the options** before we appraise them

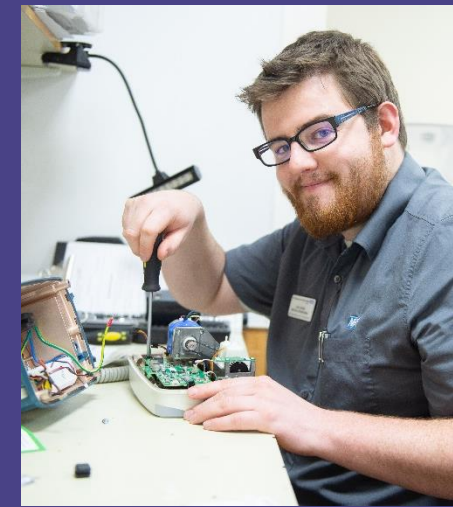
## Qualitatively appraise the options against the CSFs

- We will then **appraise each short list option** in detail against the Critical Success Factors, assessing options qualitatively against the evidence available
- We will then agree if options:
  - **Fail** a Critical Success Factor – *are not expected to meet a Critical Success Factor*
  - **Pass** a Critical Success Factor – *are expected to meet a Critical Success Factor*
  - Are **preferred** against a Critical Success Factor – *is expected to be most favourable against a Critical Success Factor*
- This assessment forms the basis of the short-list qualitative appraisal for the OBC
- The qualitative and quantitative appraisals will be combined to identify and agreed a **Preferred Option**.



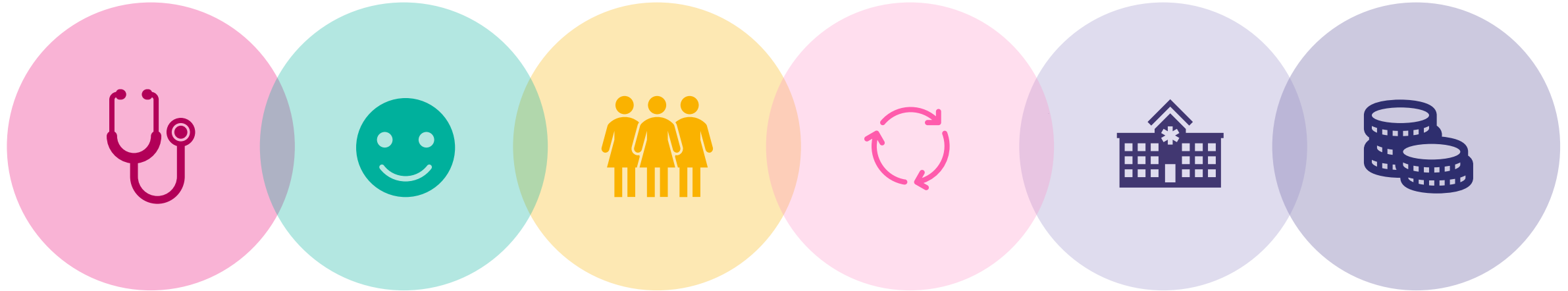


# Investment Objectives





# Investment Objectives



## Clinical Quality and Safety

- (1) **PRIORITY** – Moving towards the **DMBC decision and model of care**
- (2) Deliver **safe, effective** and **quality** healthcare services for patients

## Patient Experience

- (3) Improve **patient satisfaction** and **wellbeing** in purpose-built buildings

## Workforce

- (4) Be an **attractive place to work** and enable sustainable staffing

## Effectiveness

- (5) Deliver **improved adjacencies** and **enhanced patient flow**, supporting the efficient operation of the hospital

## Estate

- (6) Deliver a **financially sustainable estate** and reduce backlog maintenance

## Finance

- (7) Contribute to overall financial sustainability (**revenue affordability**)
- (8) Delivering within the available capital envelope (**capital affordability**)

# Investment Objectives vs CSFs

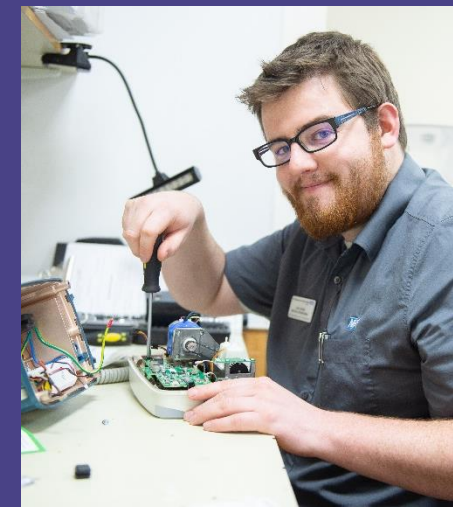
	Investment Objective	Critical success factor	Description	HMT Category
Qualitative	1. <b>PRIORITY OBJECTIVE</b> Consultation	Clinical model	<ul style="list-style-type: none"> <li>Delivering the core DMBC requirements (defined in DMBC S9.3, and associated capacity) and moving towards the wider 'Future Fit' ambitions</li> </ul>	<i>Strategic fit and business needs</i>
	2. Clinical Quality and Safety	Clinical quality and patient experience	<ul style="list-style-type: none"> <li>Supports required improvement in service and clinical quality and safety</li> </ul>	
	3. Patient Experience		<ul style="list-style-type: none"> <li>Supports required improvement in patient experience</li> </ul>	
	4. Workforce	Workforce	<ul style="list-style-type: none"> <li>Supports required improvement in workforce availability and sustainability</li> </ul>	
	5. Effectiveness	Effectiveness / Access	<ul style="list-style-type: none"> <li>Services must be located to maintain or improve access for local population (patients and staff) and to improve adjacencies and enhance patient flow</li> </ul>	
	6. Estate	Commercial viability	<ul style="list-style-type: none"> <li>Procurement route facilitates access to suppliers with capacity and appropriate capability</li> </ul>	
Quantitative	7. Finance	Value for money	<ul style="list-style-type: none"> <li>Net present social value and benefit-cost ratio</li> </ul>	<i>Potential value for money</i>
	8. Finance	Revenue affordability	<ul style="list-style-type: none"> <li>Net contribution to the system's income and expenditure position</li> </ul>	<i>Potential affordability</i>
		Capital affordability	<ul style="list-style-type: none"> <li>Relative capital affordability of the option versus the original allocated capital of c. £312m</li> </ul>	

Assessed qualitatively (today)

Assessed as part of quantitative appraisal



# Overview of the Options



# Description of the options

0	<b>Business As Usual</b>	c. £ minimal	<p><i>As per JIC condition #6, a new BAU option with no / minimal capital investment is included in the options appraisal</i></p> <ul style="list-style-type: none"> <li>✓ Critical estate works</li> <li>✓ Essential backlog maintenance only</li> </ul>
1	<b>Additional Comparator Option</b>	c. 72m	<ul style="list-style-type: none"> <li>✓ Critical estate works</li> <li>✓ Essential backlog maintenance only</li> <li>✓ Potential for capital programme for winter bed pressures</li> </ul>
2	<b>Core DMBC ('Do Minimum')</b>	c. 312m (at submission of SOC)	<p><i>"The minimum capital investment required to deliver only the priority Investment Objective" (DHSC/HMT guidance) – i.e. <b>deliver the base DMBC requirements and move towards wider 'Future Fit' ambitions</b> (revised priority objective)</i></p> <p>First development phase only:</p> <ul style="list-style-type: none"> <li>✓ Combined A&amp;E, critical care and 4 new wards at RSH</li> <li>✓ W&amp;C at RSH</li> <li>✓ Some upgrades at RSH (imaging, pharmacy, pathology) and PRH (breast, UTC, bariatrics, surgery, imaging)</li> <li>✓ Enabling and infrastructure works</li> </ul>
3	<b>Core DMBC + key estates risks</b>	c. 481m (at submission of SOC)	<p>Option 2 plus second development phase:</p> <ul style="list-style-type: none"> <li>✓ 4 new wards and ward block refurbishment and upgrade at RSH</li> <li>✓ Theatre refurbishments and upgrades at RSH</li> </ul>
4	<b>Core DMBC + key estates risks + integration</b>	c.534m (at submission of SOC)	<p>Option 3 plus third development phase:</p> <ul style="list-style-type: none"> <li>✓ Optimisation of estate utilisation (both sites)</li> <li>✓ Outpatient transformation (both sites)</li> <li>✓ Ward upgrades at PRH</li> <li>✓ Integrated Health &amp; Wellbeing Centre at PRH</li> </ul>





# Option 0: Business as Usual

## Description

*As per JIC condition #6, a new BAU option with no / minimal capital investment is included in the options appraisal*

*Includes:*

- *Any projects the Trust is committed to, or is already expected to undertake, for example routine works and an allowance for emergency works based on historic requirement*
- *RSH & PRH energy centre renewal (dependent project and outside core scope)*
- *Critical works*
- *As per guidance, RSH & PRH annual essential backlog only will be addressed which is risk adjusted (that can be delivered through depreciation-funded capital)*
- *Increased revenue costs associated with outsourcing/ out of hours work to deliver all elective activity*

*Does not include:*

- *Capital programme for winter bed pressures*
- *Additional capacity to meet future demand, or address further backlog maintenance*

## Benefits

By definition Business as Usual has no benefits, as other options are compared to this.

## Risks

- Increased likelihood of patient harm due to increased demand and deteriorating clinical environment and service failure
- Increase risk of critical incidents due to increases in demand not met by additional capacity and poor patient flow
- Increase risk of workforce (recruitment and retention) challenges resulting in clinical sustainability challenges and financial challenges
- Increase risk to service sustainability due to the above
- Risk that external providers cannot meet additional demand for outsourced services
- Increased risk of unplanned cessation of a key services such as critical care
- Poor patient experience due to reduced patient flow through the system
- Risk of estate failure in key areas



# Option 0: Business as Usual

## Disadvantages

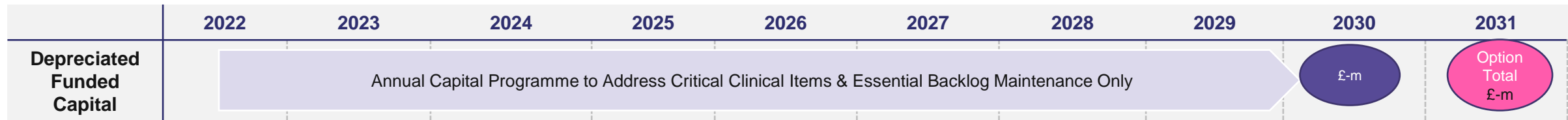
- Clinical quality and safety improvements are not realised as a consequence of not enacting the Clinical Model, including continued ambulance handover delays and poor patient experience (UEC and elective).
- Increase in operational bed pressures due to increase in demand not being met by additional capacity
- Knock on impact on emergency pathway flow due to growing demand in existing capacity constraints. Cannot accommodate growth in a coordinated and managed way
- Increase dependence on external providers for elective services and use of expensive internal additional capacity
- The Trust cannot address issues around the quality of its clinical built environment or patient pathways with estate continuing to degrade which will impact the delivery of many of the cash releasing benefits
- Risk of both service and estate failure in key clinical services
- No improvement in single rooms and post-COVID-19 separation - due to the age profile of the RSH and PRH sites, there is limited single room provision
- In-patient elective surgical capacity continues to be vulnerable to cancellations due to surges in emergency demand with no separation of flows
- Continued and increasing resourcing risk due to vulnerability of emergency rotas across key specialties e.g., Emergency Department, Acute Medicine, Intensive Care within the workforce
- Deterioration in the clinical environment will perpetuate worsening experience to patients and workforce, impacting on patient experience, recruitment and retention of workforce
- Reliance on a transient agency workforce will lead to increasing costs

## Advantages

No capital investment required

## Consequences

- Poor patient experience / increased patient harm
- Continuation of high likelihood of critical incidents
- Uncontrolled cessation of key services
- Impact on surrounding Trusts
- Negative effect of system patient care
- De-scopes backlog maintenance including significant /high risk backlog
- No development at RSH
- Inefficient solution which will not fully address wider clinical risks (including CQC feedback).
- It will fail to meet stakeholder expectations, fail to deliver all the benefits stated and will result in continued poor infrastructure risk
- Outsourcing required to deliver elective activity which will have a knock-on impact on emergency pathway flow due to growing demand and existing capacity constraints





# Option 1: Additional Comparator

## Description

This option considers what can be achieved with c. 72m of capital expenditure – this is additional to the Trust's baseline annual capital programme over the appraisal period to provide continued investment to maintain key departments (e.g. ED and Critical Care) with the addition of additional ward capacity to continue current arrangements which will require nationally allocated capital each year.

This option includes:

- Any projects the Trust is committed to, or is already expected to undertake, for example routine works and an allowance for emergency works based on historic requirement
- RSH & PRH energy centre renewal
- Critical works
- As per guidance, RSH& PRH annual essential backlog only will be addressed (that can be delivered through depreciation-funded capital)
- Potential capital programme for winter bed pressures

## Benefits

The Additional Comparator has no benefits over the current situation and is used as a comparison for other options. Through the provision of additional capacity, it has some benefits over the BAU in reducing demand pressures, reducing the need for outsourcing activity and potentially improving patient flow as a result.

## Risks

- Increased likelihood of patient harm due to increased demand and failure of delivery of the clinical model and failure of some key clinical services.
- Increase risk of critical incidents due to increases in demand not met by additional capacity and poor patient flow.
- Increased risk of estates failure in key areas (e.g., theatres and ward block at RSH)
- Increase risk of workforce (recruitment and retention) challenges resulting in clinical sustainability challenges and financial challenges
- Increase risk to service sustainability due to the above



# Option 1: Additional Comparator

## Advantages

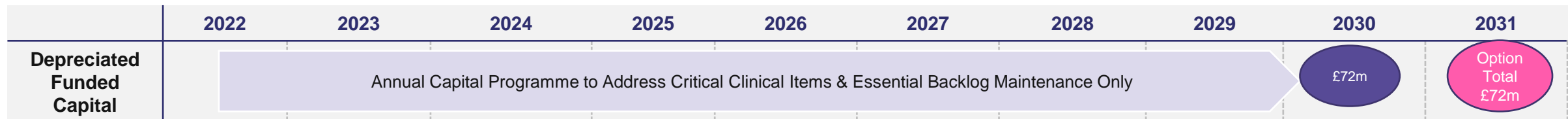
Less capital investment required

## Consequences

- De-scopes backlog maintenance including significant /high risk backlog
- Uncontrolled cessation of key services
- Impact on surrounding Trusts
- Reduces the scale of the development at RSH
- Less efficient solution which will not fully address wider clinical risks (including CQC feedback)
- It will fail to meet stakeholder expectations, fail to deliver all the benefits stated and will result in continued poor infrastructure risk

## Disadvantages

- No changes in overall clinical model – risk to the sustainability of clinical services will continue to increase and resultant deterioration of the current clinical state
- No strategic capacity and configuration solution, no change in major pathways resulting in greater revenue costs
- Additional capacity will provide limited benefits as a result of a lack of clinical adjacencies
- Will not address the major areas of clinical risk nor deliver the improvements in quality and performance
- Risk of service and estate failure in key clinical services
- Still some outsourcing, although less than in Option 0
- Dependent on additional ability to outsource additional capacity
- 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)
- Reliance on a transient agency workforce will lead to increasing costs
- Continued and increasing resourcing risk due to vulnerability of emergency rotas across key specialties e.g., Emergency Department, Acute Medicine, Intensive Care within the workforce
- Deterioration in the clinical environment will perpetuate worsening experience to patients and workforce, impacting on patient experience, recruitment and retention of workforce
- The Trust cannot address issues around the quality of its clinical built environment or patient pathways with estate continuing to degrade which will impact the delivery of many of the cash releasing benefits



# Option 2: Core DMBC ('Do Minimum')

## Description

This scenario considers what is required to deliver the core DMBC outcome including the configuration and new clinical model set out through the Future Fit consultation. It is achieved within a capital budget of £312m, which was the estimated cost of implementing the core DMBC requirements and wider Future Fit ambitions in 2016. This helps us to address our most pressing clinical challenges and establishes solid and sustainable foundations upon which to make further improvements.

Due to inflation in build costs and additional mandatory build requirements (including the need for buildings to be Net Zero ready), £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:

- Deliver new consolidated emergency department facilities, consolidated critical care, all emergency medical and surgical specialist teams collocated with the ED, women and children's inpatient services and some additional ward capacity at RSH and PRH (through the release of the Women's and Children's estate at PRH)
- Deliver an improved and expanded Emergency Department at RSH as part of an enabling works package, to be completed following OBC approval.
- Provide 24/7 enhanced urgent care at both PRH and RSH
- Consolidate planned care at PRH (particularly, when considered alongside day case hub investments)
- Provide ongoing care for patients on a planned pathway of care with the support of therapist led wards at PRH.
- Provide required expansion of pathology and pharmacy (sufficient to support increased activity levels)
- Provide improved sustainability performance by enabling the hospital to move towards the goal of achieving net zero emissions by 203.

## Benefits

- Better patient outcomes (including improved morbidity and mortality) – urgent and emergency care
- Reduced emergency waiting times (including ambulance handovers)
- Improved emergency department throughput, better emergency access target performance
- Improvements to clinical adjacencies and flow
- Improvements in planned care with reduced cancellations and improved theatre utilisation
- 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 with a risk of estate failure
- 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 2: Core DMBC ('Do Minimum')

## Advantages

- Delivers the consulted clinical model (core DMBC requirements), improving emergency and planned care pathways and some improvements in facilities for staff and patients
- Delivers many of the planned pathway benefits
- Provides physical capacity needed for future demand
- Increases single room provision at RSH (from <5% to c. 19 %)

## Consequences

- Does not address backlog maintenance, including significant / high risk backlog predominantly at RSH
- 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
- 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

## Disadvantages

- 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.
- Limits clinical adjacencies, reducing efficiency improvement opportunity
- Does not address the key estates issue of RSH theatres
- 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



# Option 3: 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 to enable decommissioning of three upper floors of the RSH ward block as well as clinical areas, 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, all emergency medical and surgical specialist teams, women and children's inpatient services, and some additional ward capacity at RSH and PRH 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 RSH ward block to repatriate off-site support services, administration, and education
- Refurbishment of theatres

## 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 HCAs)
- 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





# Option 3: Core DMBC + key estates risks

## Advantages

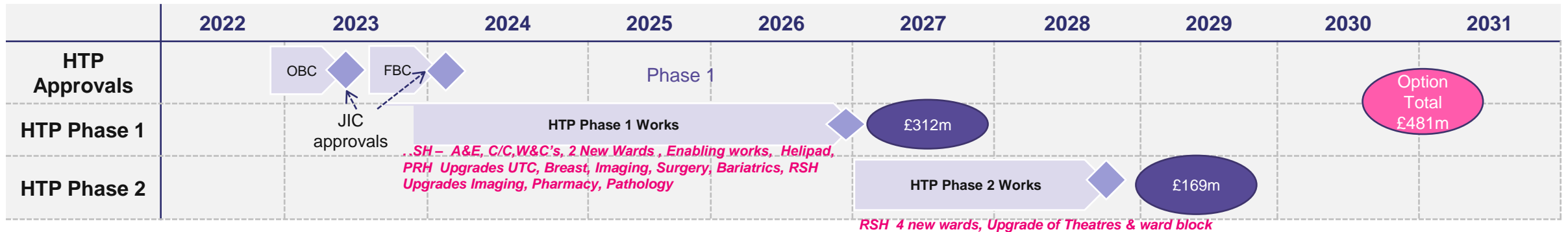
- Delivers the core DMBC requirements and some of the wider Future Fit ambition, improves most of the facilities for staff and patients
- Delivers the benefits associated with the improved unplanned and planned pathways
- Provides increased single room provision (c. 36% RSH , 16% PRH)
- Addresses areas 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 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)

## Consequences

- Will not improve patient quality and experience across the entirety of the estate
- Will not support wider optimisation of activities on each site



# Option 4: 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, all emergency medical and surgical specialist teams collocated with ED, 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

## Risks

Interdependent on the progression of both the day case hub and energy centre developments

## 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 HCAs)
- 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



# Option 4: Core DMBC + key estates risks + integration

## Advantages

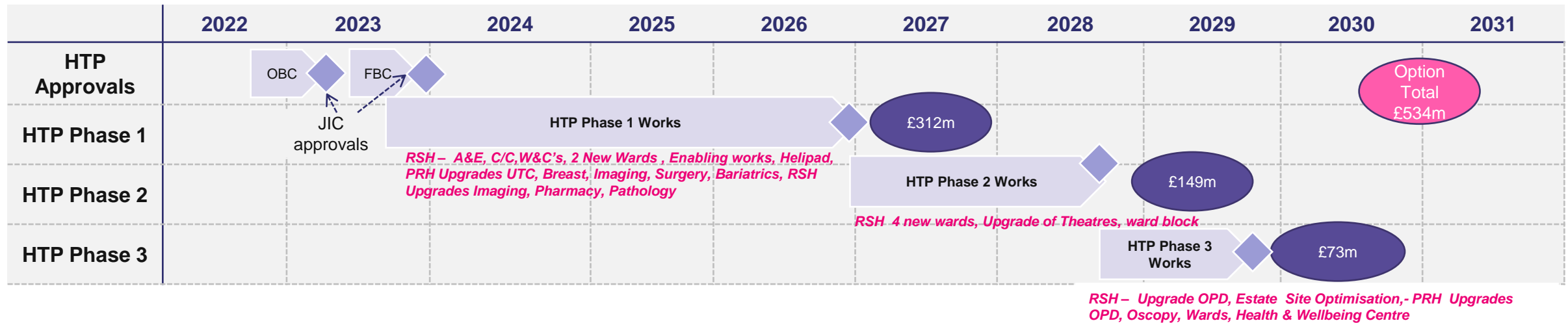
- Delivers the core DMBC requirements and most of the wider Future Fit ambition, improves all facilities for staff and patients
- Delivers the benefits associated with the pathways
- Provides increased single room provision (c. 35% RSH , 16% PRH)
- Addresses key estates risks
- The capacity we need for 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 As per acute note above

## Disadvantages

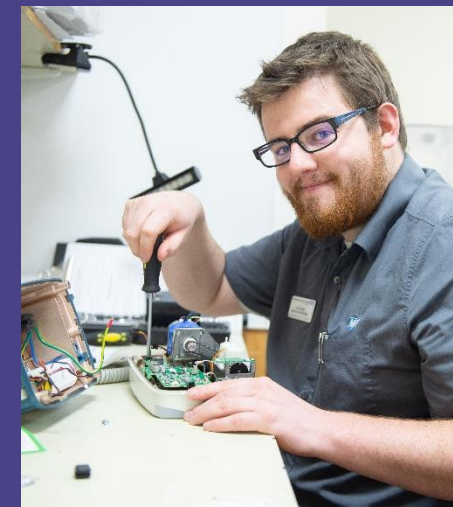
When implemented through a phased approach, delivery timelines are extended (and overall costs increased)

## Consequences

Limited adverse consequences as this option delivers the core DMBC requirements and most of the wider Future Fit ambition



# Qualitative Appraisal





# Investment Objectives vs CSFs

	Investment Objective	Critical success factor	Description	HMT Category
Qualitative	1. <b>PRIORITY OBJECTIVE</b> Consultation	Clinical model	<ul style="list-style-type: none"> <li>Delivering the core DMBC requirements (defined in DMBC S9.3, and associated capacity) and moving towards the wider 'Future Fit' ambitions</li> </ul>	<i>Strategic fit and business needs</i>
	2. Clinical Quality and Safety	Clinical quality and patient experience	<ul style="list-style-type: none"> <li>Supports required improvement in service and clinical quality and safety</li> </ul>	
	3. Patient Experience		<ul style="list-style-type: none"> <li>Supports required improvement in patient experience</li> </ul>	
	4. Workforce	Workforce	<ul style="list-style-type: none"> <li>Supports required improvement in workforce availability and sustainability</li> </ul>	
	5. Effectiveness	Effectiveness / Access	<ul style="list-style-type: none"> <li>Services must be located to maintain or improve access for local population (patients and staff) and to improve adjacencies and enhance patient flow</li> </ul>	
	6. Estate	Commercial viability	<ul style="list-style-type: none"> <li>Procurement route facilitates access to suppliers with capacity and appropriate capability</li> </ul>	
Quantitative	7. Finance	Value for money	<ul style="list-style-type: none"> <li>Net present social value and benefit-cost ratio</li> </ul>	<i>Potential value for money</i>
	8. Finance	Revenue affordability	<ul style="list-style-type: none"> <li>Net contribution to the system's income and expenditure position</li> </ul>	<i>Potential affordability</i>
		Capital affordability	<ul style="list-style-type: none"> <li>Relative capital affordability of the option versus the original allocated capital of c. £312m</li> </ul>	

Assessed qualitatively (today)

Assessed as part of quantitative appraisal





# CSF1: Clinical Model

Delivery of core DMBC requirements and move towards the wider Future Fit ambitions before 2029

BAU/ Economic Comparator	Do Something Options
<ul style="list-style-type: none"><li>Includes <b>no major service change</b> – not enacting the changes agreed in the DMBC</li><li>Failure to deliver any major service changes will result in deterioration of the current clinical state.</li></ul>	<ul style="list-style-type: none"><li><b>Do minimum and full options include changes in configuration</b> to deliver:<ul style="list-style-type: none"><li>An emergency care site at <b>RSH</b></li><li>A planned care site at <b>PRH</b></li><li>Urgent treatment centres, outpatients and diagnostics at <b>both hospitals</b></li></ul></li><li>This moves services towards the <b>outcome agreed in the DMBC</b></li><li><b>Options 4 and 5 delivers further aspirations of the DMBC as per the table. Ward refurbishment, theatre refurbishment and significant backlog reduction</b></li><li><b>Elective elements</b> of the consultation are <b>out of scope</b> of this appraisal</li></ul>



# CSF1: Clinical Model

Options		Delivery of core DMBC requirements and move towards the wider Future Fit ambitions before 2029	
0	Business-as-usual	Will not deliver the DMBC decision, and will result in deterioration of the current clinical state.	Fail
1	Additional Comparator	Will not deliver the DMBC decision, and will result in deterioration of the current clinical state.	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
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: Quality and Experience

(1/2) Supports improvement in service and clinical quality and safety from current levels

BAU	Additional Comparator	Option 2	Option 3	Option 4
<ul style="list-style-type: none"> <li>Through the PCBC, DMBC and wider stakeholder engagement it is recognised that the current acute hospital configuration is <b>not sustainable</b>. We face longstanding challenges that are exacerbated by the inefficient configuration of services, creating significant clinical performance issues. <b>Acute risk</b> that our <b>critical care services</b> will <b>fail</b> with a subsequent threat to patient safety and increasing critical incidents.</li> <li>Increasing clinical risk across non-elective services without provision of capacity to meet future demand</li> <li><b>Does not deliver the proposed clinical model</b></li> <li>Will result in <b>deterioration of the current clinical model</b>, impacting clinical sustainability and leading to increased risk of <b>patient harm</b></li> <li>Increased likelihood of <b>failure to achieve service / operational targets and standards</b>.</li> <li><b>Insufficient/non-compliant accommodation</b> or facilities               <ul style="list-style-type: none"> <li>Significant proportion of estate is <b>"expired/unacceptable"</b> and is likely to deteriorate further</li> <li>Impact on <b>patient flow</b></li> </ul> </li> <li><b>Already high occupancy levels</b> in bed base increase further, with continued lack of isolation rooms</li> </ul>	<ul style="list-style-type: none"> <li>Through the PCBC, DMBC and wider stakeholder engagement it is recognised that the current acute hospital configuration is <b>not sustainable</b>. We face longstanding challenges that are exacerbated by the inefficient configuration of services, creating significant clinical performance issues. <b>Acute risk</b> that our <b>critical care services</b> will <b>fail</b> with a subsequent threat to patient safety and increasing critical incidents.</li> <li><b>Does not deliver the proposed clinical model</b></li> <li>Will result in <b>deterioration of the current clinical model</b>, impacting clinical sustainability and leading to increased risk of <b>patient harm</b></li> <li>Increased likelihood of <b>failure to achieve service / operational targets and standards</b>.</li> <li><b>Insufficient/non-compliant accommodation</b> or facilities               <ul style="list-style-type: none"> <li>Significant proportion of estate is <b>"expired/unacceptable"</b> and is likely to deteriorate further</li> <li>Impact on <b>patient flow</b></li> </ul> </li> <li><b>Already high occupancy levels</b> in bed base increase further, with continued lack of isolation rooms</li> </ul>	<ul style="list-style-type: none"> <li><b>Realisation of the clinical model</b> will have benefits articulated in the DMBC, inc:</li> <li>A single emergency care site with a dedicated emergency department, where specialist doctors treat the most serious cases, is safer and provides better results for patients</li> <li>Enhanced facilities will deliver some <b>benefits associated with pathways</b></li> <li>The capacity needed for the future to provide a clinical safe and quality service would be met.</li> <li>Will support Trust plans to implement 7 day working standards</li> <li>Delivery of comprehensive MDT working across emergency specialities</li> <li>Ward block retained, maintaining existing challenges and risks with patient safety.</li> <li>Length Of Stay – improved recovery time and consequent QALY – REFERENCE – Fable 2.0</li> <li>Improved single room provision (new build at 72%, total site at RSH c.20% and PRH c16% and associated <b>infection control, privacy and dignity improvements</b></li> </ul>	<ul style="list-style-type: none"> <li><b>Benefits of the clinical model</b> (as Do Minimum)</li> <li>In addition, enhanced facilities provide <b>additional quality improvements</b>:               <ul style="list-style-type: none"> <li>Enhanced <b>clinical support services</b> at RSH</li> <li>Reduced risk <b>estates risks to quality</b></li> <li>Improved <b>patient flow and adjacencies</b></li> </ul> </li> <li><b>Addressing areas of high risk backlog</b> will improve patient and staff wellbeing</li> <li><b>Modern design features and layout</b> will increase patient visibility and safety</li> <li>Further improvement to single room provision</li> </ul>	<ul style="list-style-type: none"> <li><b>Benefits of the clinical model</b> (as Option 4)</li> <li>In addition, enhanced facilities provide <b>additional quality improvements</b>:               <ul style="list-style-type: none"> <li>Enhanced <b>clinical support services</b> at RSH</li> <li>Reduced risk <b>estates risks to quality</b></li> <li>Improved <b>patient flow and adjacencies</b></li> <li>Improved <b>outpatient facilities</b></li> </ul> </li> <li><b>Eliminating high risk backlog</b> will improve patient and staff wellbeing</li> <li><b>Modern design features and layout</b> will increase patient visibility and safety</li> <li>Further improvement to single room provision</li> </ul>

# CSF2: Quality and Experience

(2/2): Supports improvement in patient experience from current levels

BAU	Additional Comparator	Option 2	Option 3	Option 4
<ul style="list-style-type: none"> <li>Poor patient experience, flow and privacy/ dignity issues at present <b>do not reach minimum standards</b> and will deteriorate further due to increasing demand and inability to facilitate this increased demand, <b>leading to system failure</b>.</li> <li>All <b>patients do not</b> continually receive <b>safe, high quality care and treatment</b>. The best service that can be delivered is being given in extremely challenging circumstances which <b>are only likely to worsen</b>.</li> <li>Does not align to <b>integrated clinical model</b> and coordination of care</li> </ul>	<ul style="list-style-type: none"> <li>Poor patient experience, flow and privacy/ dignity issues at present <b>do not reach minimum standards</b> and will deteriorate further due to increasing demand and inability to facilitate this increased demand, <b>leading to system failure</b>.</li> <li>All <b>patients do not</b> continually receive <b>safe, high quality care and treatment</b>. The best service that can be delivered is being given in extremely challenging circumstances which <b>are only likely to worsen</b>.</li> <li>Does not align to <b>integrated clinical model</b> and coordination of care</li> </ul>	<ul style="list-style-type: none"> <li>Improvements in patient experience from new clinical model – including <b>improved outcomes, reduced waiting times</b></li> <li>The clinical model better integrates care, enabling coordinated and <b>seamless patient experience across the pathway</b></li> <li><b>Build environment not as developed as in full options</b> – meaning less impact on environment, wellbeing and privacy/dignity</li> <li>Does not provide <b>optimal flow</b> of patients – impacting patient and staff experience</li> <li>Ward block retained – this option continues to provide <b>suboptimal patient environment</b>.</li> <li><b>Privacy and dignity enhanced</b> Improved single room provision (new build at 72%, total site at RSH c.20% and PRH c16%)</li> </ul>	<ul style="list-style-type: none"> <li><b>Benefits of the clinical model</b> (as Do Minimum), plus:</li> <li>Further investment in estate offers further improvements in experience – <b>modern fit-for-purpose improve the experience, whilst design features contribute to improved wellbeing and environment</b></li> <li>Better separated <b>patient flows</b></li> <li>Further improvement to single room provision</li> </ul>	<ul style="list-style-type: none"> <li><b>Benefits of the clinical model</b> (as Option 4), plus:</li> <li>Enhanced <b>outpatient department</b></li> <li>Improved patient experience with an integrated <b>health and wellbeing centre</b> on site</li> <li>Further improvement to single room provision</li> </ul>

# CSF2: Quality and Experience

Options		Supports improvement in service and clinical quality and safety from current levels	Supports improvement in patient experience from current levels	
0	Business-as-usual	<p>Substantial issues with quality and safety not addressed</p> <p>Risk of further deterioration and threat to patient safety</p> <p>Risk of increasing critical incidents</p> <p>Increased risk of patient harm</p> <p>Risk of service and estate failure</p>	<p>Patient experience likely to deteriorate- potential for system failure</p>	Fail
1	Economic Comparator	<p>Substantial issues with quality and safety not addressed</p> <p>Risk of further deterioration and threat to patient safety</p> <p>Risk of increasing critical incidents</p> <p>Increased risk of patient harm</p> <p>Risk of service and estate failure</p>	<p>Patient experience likely to deteriorate – potential for system failure</p>	Fail
2	Core DMBC ('Do minimum')	<p>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)</p> <p>Provides improvements to some pathways</p> <p>Lack of redevelopment of OPD impacts on improvements to capacity and patient experience</p> <p>Continued use of the existing ward accommodation in the tower block</p>	<p>Improvements in experience driven by consulted clinical model (waiting times, coordination of care)</p> <p>Provides improved facilities, but only in the new build areas of the development</p> <p>Continued use of the existing ward accommodation in the tower block (poor environment)</p>	Pass
3	Core DMBC + key estates risks	<p>As Option 3, plus:</p> <p>Improvements in quality and safety driven by enhanced build environment (pandemic / infection control, resilience)</p> <p>Provides improvements to most pathways</p> <p>Allows mitigation of all significant clinical risks</p> <p>Upgrades of Breast, Bariatrics &amp; Surgical services</p> <p>Lack of redevelopment of OPD impacts on improvements to capacity and patient experience</p> <p>Provides enough new bed capacity to vacate the ward block (mitigates IPC risk)</p>	<p>As Option 3, plus:</p> <p>Improvements in experience driven by enhanced build environment (design, privacy, dignity)</p> <p>Increased single room provision (privacy, dignity)</p> <p>Provides enough new bed capacity to vacate the ward block (mitigating poor experience)</p>	Pass
4	Core DMBC + key estates risks + integration	<p>As Option 4, plus:</p> <p>Further improvements driven by estate optimisation, additional upgrades (OPD, wards) and Health &amp; Wellbeing services</p>	<p>As option 4, plus:</p> <p>The Integrated Health &amp; 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.</p> <p>Provides further improvements to site utilisation and operational effectiveness</p>	Preferred



# CSF3: Workforce

Supports improvement in workforce availability and sustainability from current levels

BAU	Additional Comparator	Option 2	Option 3	Option 4
<ul style="list-style-type: none"> <li>The Trust has <b>substantial vacancies across several areas</b>. The resourcing model predicts vacancy rates will increase:               <ul style="list-style-type: none"> <li>The vacancy gap for nursing has been an average of 235 WTE each month (<b>13% of budget</b>)</li> <li>The vacancy gap for consultants has been an average of 40 WTE each month (<b>14% of budget</b>)</li> </ul> </li> <li>849 FTEs left the Trust between December 2021 and November 2022. 17% of these FTEs left due to work-life balance. 8% left as a result of increased rewards elsewhere. This will only worsen in this scenario.</li> <li>Will lead to <b>increased reliance on agency staff</b> in order to service OOH demand, leading to increased costs and failure to meet clinical standards.</li> <li>Increased risk of <b>deterioration in health and wellbeing</b> for clinical staff.</li> <li>Ability to attract new staff likely to reduce and some new staff likely to leave if HTP is not delivered</li> <li><b>Poor clinical decision making</b> likely as a result of over-worked staff due to poor staffing levels and increased demand with resulting impact on patient care.</li> <li><b>Duplication of rotas</b></li> <li>With current services there is consistent failure in 7 days working standards in acute services that are delivered across the 2 sites (largely sit with Medicine).</li> </ul>	<ul style="list-style-type: none"> <li>The Trust has <b>substantial vacancies across several areas</b>. The resourcing model predicts vacancy rates will increase:               <ul style="list-style-type: none"> <li>The vacancy gap for nursing has been an average of 235 WTE each month (<b>13% of budget</b>)</li> <li>The vacancy gap for consultants has been an average of 40 WTE each month (<b>14% of budget</b>)</li> </ul> </li> <li>849 FTEs left the Trust between December 2021 and November 2022. 17% of these FTEs left due to work-life balance. 8% left as a result of increased rewards elsewhere. This will only worsen in this scenario.</li> <li>Will lead to <b>increased reliance on agency staff</b> in order to service OOH demand, leading to increased costs and failure to meet clinical standards.</li> <li>Increased risk of <b>deterioration in health and wellbeing</b> for clinical staff</li> <li>Ability to attract new staff likely to reduce and some new staff likely to leave if HTP is not delivered</li> <li><b>Poor clinical decision making</b> likely as a result of over-worked staff due to poor staffing levels and increased demand with resulting impact on patient care.</li> <li><b>Duplication of rotas</b></li> <li>With current services there is consistent failure in 7 days working standards in acute services that are delivered across the 2 sites (largely sit with Medicine).</li> </ul>	<ul style="list-style-type: none"> <li><b>Realisation of the clinical model</b> will have benefits articulated in the DMBC, e.g.               <ul style="list-style-type: none"> <li>Improved <b>recruitment and retention</b> by offering a better place to work – reducing vacancy rates and need for agency staff</li> <li>Enhanced opportunity for <b>new roles and training</b> through the new model – providing a more attractive place to work</li> <li>Reduced duplication of <b>rotas</b> through consolidation</li> <li>Reduced likelihood of poor clinical decisions due to less need to over-work staff and a resultant improvement in the quality of the workforce.</li> </ul> </li> <li>There will be <b>disparity across the sites</b> between areas which have been redeveloped and though which have not – creating differential staff experience</li> <li>Will support Trust plans to implement 7 day working standards</li> <li>Delivery of comprehensive MDT working across emergency specialities</li> </ul>	<ul style="list-style-type: none"> <li><b>Benefits of the clinical model</b> (as Do Minimum)</li> <li>Enhanced environment offers a more attractive place to work and fit-for-purpose facilities – <b>improving staff morale, recruitment and retention</b></li> <li>Addressing high risk backlog improves <b>staff wellbeing</b></li> <li>Ward block refurbishment providing consolidation of space for training and education</li> <li>Delivers comprehensive Multi Disciplinary Team (MDT) working</li> </ul>	<ul style="list-style-type: none"> <li><b>Benefits of the clinical model</b> (as option 4)</li> <li>In addition further optimisation and upgrades supports <b>staff morale, recruitment and retention</b></li> <li>Increased staff engagement and role attractiveness through integrating with partners from the <b>Health and Wellbeing centre</b></li> </ul>

# CSF3: Workforce

Supports improvement in workforce availability and sustainability from current levels

Option	Supports improvement in workforce availability and sustainability from current levels	
0	Business-as-usual	Fail
1	Additional Comparator	Fail
2	Core DMBC ('Do minimum')	Pass
3	Core DMBC + key estates risks	Pass
4	Core DMBC + key estates risks + integration	Preferred



# CSF 4: Effectiveness/ Access

Services must be located to maintain or improve access for local population (patients and staff)

BAU/ Additional Comparator	Do Something Options
<ul style="list-style-type: none"> <li>• <b>Does not include any major service changes</b></li> <li>• <b>No change in travel time</b> to services</li> <li>• <b>Waiting times expected to deteriorate</b>– as no changes in clinical model and increasing demand</li> <li>• <b>Onward management</b> of the patient is likely to deteriorate</li> <li>• <b>No change in high level of cancellation of planned procedures</b></li> <li>• <b>Does not allow for demographic growth of population and bed requirements</b></li> </ul>	<ul style="list-style-type: none"> <li>• Includes <b>major service changes and associated changes in travel time</b> as services are consolidated at PRH/RSH:             <ul style="list-style-type: none"> <li>• Changes in median travel times “<b>relatively low</b>”; <b>majority of UEC patients (76%) would be unaffected</b></li> <li>• Some patients would face <b>longer travel times</b></li> </ul> </li> <li>• <b>Waiting times (UEC and diagnostics) expected to improve</b> as a result of changes in clinical model:             <ul style="list-style-type: none"> <li>• <b>UTC and ED waiting times &lt;3 hours</b> (immediate capacity for up to 99% in ED)</li> <li>• Reduced <b>diagnostic waits</b> from enhanced capacity</li> <li>• Reduced cancellations for diagnostics and planned procedures</li> </ul> </li> <li>• <b>Onward management</b> of the patient is improved – overall experience is more efficient and Length of Stay will reduce due to patients getting quicker access to the right care</li> <li>• DMBC agreed <b>mitigations to address impacts on access</b>, including:             <ul style="list-style-type: none"> <li>• Sufficient emergency and non-emergency <b>transport capacity</b></li> <li>• Clear and safe patient <b>transfer protocols</b></li> <li>• Mitigations for public <b>transport access delivered by partners</b></li> <li>• Enhanced <b>ambulance service capacity and performance</b></li> <li>• Reducing <b>unnecessary visits to hospital</b></li> </ul> </li> </ul>

# CSF 4: Effectiveness/ Access

Option		Services must be located to maintain or improve access for local population (patients and staff)	
0	Business-as-usual	<ul style="list-style-type: none"> <li>No change in travel time</li> <li>Deterioration in waiting times</li> <li>Onward management of patients is likely to deteriorate</li> </ul>	Fail
1	Additional Comparator	<ul style="list-style-type: none"> <li>No change in travel time</li> <li>Deterioration in waiting times</li> <li>Onward management of patients is likely to deteriorate</li> </ul>	Fail
2	Core DMBC ('Do minimum')	<ul style="list-style-type: none"> <li>Increases in travel time mitigated through DMBC actions</li> <li>Reductions in waiting times for hospital services delivered through clinical model</li> <li>Improved access to all appropriate specialists</li> <li>More effective onward management of patients leads to improvements in care provided</li> </ul>	Pass
3	Core DMBC + key estates risks	<ul style="list-style-type: none"> <li>Increases in travel time mitigated through DMBC actions</li> <li>Reductions in waiting times for hospital services delivered through clinical model</li> <li>Improved access to all appropriate specialists</li> <li>More effective onward management of patients leads to improvements in care provided</li> <li>Improved staff access to patients</li> </ul>	Pass
4	Core DMBC + key estates risks + integration	<ul style="list-style-type: none"> <li>Increases in travel time mitigated through DMBC actions</li> <li>Reductions in waiting times for hospital services delivered through clinical model</li> <li>Improved access to all appropriate specialists</li> <li>More effective onward management of patients leads to improvements in care provided</li> <li>Improved staff access to patients</li> <li>Health and wellbeing hub (Integrated) Care improves access further</li> </ul>	Preferred

# CSF 5: Commercial Viability

Procurement route facilitates access to suppliers with capacity and appropriate capability

BAU	Additional Comparator	Do Something Options
<ul style="list-style-type: none"> <li>• <b>No major changes</b> – usual Trust/NHS procurement practices would apply to access suppliers and achieve value for money. However, this is reliant on the ability to outsource all incremental demand to NHS services which would have a significant impact on ICS sustainability.</li> <li>• Travel and transport impacts need to be considered</li> </ul>	<ul style="list-style-type: none"> <li>• <b>No major changes</b> – usual Trust/NHS procurement practices would apply to access suppliers and achieve value for money.</li> <li>• Travel and transport impacts need to be considered</li> </ul>	<ul style="list-style-type: none"> <li>• Multiple potential procurement routes have been explored, including:               <ul style="list-style-type: none"> <li>• A <b>local tender</b> (Advertised on FTS in line with Public Contract Regs)</li> <li>• Competitive process via existing <b>national framework</b> for large-scale hospital construction (Procure23)</li> </ul> </li> <li>• <b>Procure 23</b> has been identified as the preferred route at this stage</li> <li>• All can <b>facilitate access to suppliers with capacity and capability</b> <ul style="list-style-type: none"> <li>• Early market engagement has not indicated any concerns around the proposed timetable and access to the supply chain in the market place at present. The PSCPs have provided positive feedback so far.</li> <li>• Procurement options and market engagement have been developed further at OBC stage but, consideration was given to:                   <ul style="list-style-type: none"> <li>• Nationally recommended or preferred routes to market</li> <li>• The pipeline of potential suppliers activity</li> <li>• Use of appropriate selection criteria including:                       <ul style="list-style-type: none"> <li>• Social Value &amp; Net Zero Carbon</li> <li>• Relevant Experience</li> <li>• Care, Quality and Productivity</li> <li>• Stakeholder Engagement</li> <li>• Smart Infrastructure and MMC</li> </ul> </li> </ul> </li> </ul> </li> <li>• Consultants &amp; Technical Service providers (eg. <i>Design services, Surveyors, Cost Advisors</i>) will be procured against capability factors such as <i>continuity of knowledge</i> where necessary and proven current <i>experience of working within the chosen procurement vehicle and construction model contracts</i>; as well as value for money.</li> <li>• Travel and transport impacts need to be considered</li> </ul>



# CSF 5: Commercial Viability

Option		Procurement route facilitates access to suppliers with capacity and appropriate capability	
0	Business-as-usual	BAU Trust procurement can apply but is reliant on ability to outsource to NHS services Potential to impact ICS sustainability	Fail
1	Additional Comparator	BAU Trust procurement can apply but will require outsourcing of some services.	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 All potential routes to market have been reviewed and the preferred and recommended route at this stage is via the P23 mechanism	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 All potential routes to market have been reviewed and the preferred and recommended route at this stage is via the P23 mechanism	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 All potential routes to market have been reviewed and the preferred and recommended route at this stage is via the P23 mechanism	Pass



# CSF 6: Build Deliverability

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

BAU	Additional Comparator	Option 2	Option 3	Option 4
<ul style="list-style-type: none"> <li>• <b>Limited redevelopment</b> – planned developments/maintenance only</li> <li>• <b>Backlog will increase</b> and ability to invest in new infrastructure diminished</li> <li>• <b>Delivery plans in place</b> based on existing programme</li> <li>• Does not provide <b>additional capacity</b></li> <li>• Single room provision of 5%</li> <li>• Existing footprint <b>unable to accommodate</b> capacity</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Limited redevelopment</b> – planned developments/maintenance only</li> <li>• <b>Backlog will increase</b> and ability to invest in new infrastructure diminished</li> <li>• <b>Delivery plans in place</b> based on existing programme</li> <li>• Does not provide enough <b>additional capacity</b>, meaning that services will be more inefficient</li> <li>• Single room provision of 5%</li> <li>• Existing footprint <b>unable to accommodate</b> capacity</li> </ul>	<ul style="list-style-type: none"> <li>• Redevelops the estate to deliver consultation outcome</li> <li>• <b>Does not include</b> redevelopment of RSH ward block/outpatients, theatres, and significant/high risk backlog</li> <li>• Expected completion Dec <b>2026</b> (clinical model from <b>2027</b>)</li> <li>• Can be <b>accommodated on sites</b></li> <li>• Modelled bed requirement as capacity. 12% of bed capacity meet latest standards Improved single room provision (new build at 72%, total site at RSH c.20% and PRH c16% and associated <b>infection control, privacy and dignity improvements</b>)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Fuller development</b> – including additional ward, and theatre refurbishment and reduction in significant/high risk backlog</li> <li>• Designed to <b>maximise benefit of redeveloping the estate</b></li> <li>• Expected completion: <ul style="list-style-type: none"> <li>• Phase 1 (do min): Dec 2026</li> <li>• Phase 2 (additional works): Dec 26 – Dec 28</li> </ul> </li> <li>• Can be <b>accommodated on sites</b></li> <li>• 27% of bed capacity meet latest standards. Further improvement to single room provision</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Fuller development</b> – including additional ward, outpatient and theatre refurbishment, development of health and wellbeing centre and reduction in all risk backlog</li> <li>• Designed to <b>maximise benefit of redeveloping the estate</b></li> <li>• Expected completion: <ul style="list-style-type: none"> <li>• Phase 1 (do min): Dec 2026</li> <li>• Phase 2 (additional works): Dec 26 – Dec 28</li> <li>• Phase 3: Dec 28 – Dec 29</li> </ul> </li> <li>• Can be <b>accommodated on sites</b></li> <li>• 29% of bed capacity meet latest standards. Further improvement to single room provision</li> </ul>

For consistency, using the same criteria as mentioned in the bed bridge within the Strategic Case (exclude maternity, neonates and critical care, and include ambulatory emergency care places, daycase places and medical assessment unit)



# CSF 6: Build Deliverability

Option	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	
0 Business-as-usual	Does not address backlog and estates issues	Ongoing programme	Existing site footprint cannot accommodate capacity -outsourcing would be required (inability to outsource emergency care impacts elective care)	Unlikely to be supported – does not deliver system aims	Fail
1 Additional Comparator	Does not address backlog and estates issues Limited additional capacity will make services more inefficient	Ongoing programme	Existing site footprint cannot accommodate capacity -outsourcing would be required (inability to outsource emergency care impacts elective care)	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 Will address a small number of the estates risks but some risks will still remain	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

# Outcome of the Qualitative Appraisal

## Definitions:

- **Fail** a Critical Success Factor – *are expected to **not meet** a Critical Success Factor*
- **Pass** a Critical Success Factor – *are expected to **meet** a Critical Success Factor*
- **Preferred** against a Critical Success Factor – *is expected to be **most favourable** against a Critical Success Factor*

	CSF 1: Clinical Quality and Patient Experience	CSF 2: Workforce	CSF 3: Effectiveness	CSF 4: Clinical Model	CSF 5: Commercial Viability	CSF 6: Build Deliverability
0. Business-as-usual	Fail	Fail	Fail	Fail	Fail	Fail
1. Additional Comparator	Fail	Fail	Fail	Fail	Pass	Fail
2. Core DMBC ('Do minimum')	Pass	Pass	Pass	Pass	Pass	Pass
3. Core DMBC + key estates risks	Pass	Pass	Pass	Pass	Pass	Pass
4. Core DMBC + key estates risks + integration	Preferred	Preferred	Preferred	Preferred	Pass	Pass

**ECONOMIC COSTS ANALYSIS - £m**

[Back to User Instructions](#)

[Back to Model Structure](#)

Summary (Discounted) - £m	Option 0 - Business as Usual	Option 1 - Additional Comparator (c. £72m capex)	Option 2 - Do Minimum (c.£312m capex)	Option 3 - Core DMC + key estates risks (c.£481m capex)	Option 4 - Core DMBC + key estates risks + integration (c.£534m capex)
Opportunity costs	£0.00	£0.00	£0.00	£0.00	£0.00
Capital costs	£0.00	£70.25	£319.75	£431.93	£472.02
Capital costs optimism bias uplift	£0.00	£6.90	£32.00	£55.70	£60.99
Capital costs + optimism bias uplift	£0.00	£77.14	£351.75	£487.63	£533.02
Revenue costs	£0.00	£19.06	£26.88	£20.29	£4.31
Transitional costs	£0.00	£0.00	£2.22	£3.15	£3.44
Externality costs	£0.00	£0.00	£0.00	£0.00	£0.00
Net Contribution costs	£0.00	£0.00	£0.00	£0.00	£0.00
<b>Total costs</b>	<b>£0.00</b>	<b>£96.20</b>	<b>£380.85</b>	<b>£511.08</b>	<b>£540.76</b>

Opportunity costs - £m			
Option	Present Cost	% of highest cost	Rank
Option 0 - Business as Usual	£0.00		
Option 1 - Additional Comparator (c. £72m capex)	£0.00		
Option 2 - Do Minimum (c.£312m capex)	£0.00		
Option 3 - Core DMC + key estates risks (c.£481m capex)	£0.00		
Option 4 - Core DMBC + key estates risks + integration (c.£534m capex)	£0.00		

Capital costs - £m			
Option	Present Cost	% of highest cost	Rank
Option 0 - Business as Usual	£0.00		
Option 1 - Additional Comparator (c. £72m capex)	£70.25	15%	1
Option 2 - Do Minimum (c.£312m capex)	£319.75	68%	4
Option 3 - Core DMC + key estates risks (c.£481m capex)	£431.93	92%	5
Option 4 - Core DMBC + key estates risks + integration (c.£534m capex)	£472.02	100%	6

Capital costs optimism bias uplift - £m			
Option	Present Cost	% of highest cost	Rank
Option 0 - Business as Usual	£0.00		
Option 1 - Additional Comparator (c. £72m capex)	£6.90	11%	1
Option 2 - Do Minimum (c.£312m capex)	£32.00	52%	3
Option 3 - Core DMC + key estates risks (c.£481m capex)	£55.70	91%	5
Option 4 - Core DMBC + key estates risks + integration (c.£534m capex)	£60.99	100%	6

Revenue Costs - £m			
Option	Present Cost	% of highest cost	Rank
Option 0 - Business as Usual	£0.00		
Option 1 - Additional Comparator (c. £72m capex)	£19.06	71%	2
Option 2 - Do Minimum (c.£312m capex)	£26.88	100%	6
Option 3 - Core DMC + key estates risks (c.£481m capex)	£20.29	75%	3
Option 4 - Core DMBC + key estates risks + integration (c.£534m capex)	£4.31	16%	1

Transitional costs - £m			
Option	Present Cost	% of highest cost	Rank
Option 0 - Business as Usual	£0.00		
Option 1 - Additional Comparator (c. £72m capex)	£0.00		
Option 2 - Do Minimum (c.£312m capex)	£2.22	65%	3
Option 3 - Core DMC + key estates risks (c.£481m capex)	£3.15	92%	4
Option 4 - Core DMBC + key estates risks + integration (c.£534m capex)	£3.44	100%	5

Externality costs - £m			
Option	Present Cost	% of highest cost	Rank
Option 0 - Business as Usual	£0.00		
Option 1 - Additional Comparator (c. £72m capex)	£0.00		
Option 2 - Do Minimum (c.£312m capex)	£0.00		
Option 3 - Core DMC + key estates risks (c.£481m capex)	£0.00		
Option 4 - Core DMBC + key estates risks + integration (c.£534m capex)	£0.00		

Net Contribution costs - £m			
Option	Present Cost	% of highest cost	Rank
Option 0 - Business as Usual	£0.00		
Option 1 - Additional Comparator (c. £72m capex)	£0.00		
Option 2 - Do Minimum (c.£312m capex)	£0.00		
Option 3 - Core DMC + key estates risks (c.£481m capex)	£0.00		
Option 4 - Core DMBC + key estates risks + integration (c.£534m capex)	£0.00		

Total costs - £m			
Option	Present Cost	% of highest cost	Rank
Option 0 - Business as Usual	£0.00		
Option 1 - Additional Comparator (c. £72m capex)	£96.20	18%	1
Option 2 - Do Minimum (c.£312m capex)	£380.85	70%	4
Option 3 - Core DMC + key estates risks (c.£481m capex)	£511.08	95%	5
Option 4 - Core DMBC + key estates risks + integration (c.£534m capex)	£540.76	100%	6



## Economic Summary (Discounted) - £m

	Option 0 - Business as Usual	Option 1 - Additional Comparator (c. £72m capex)	Option 2 - Do Minimum (c.£312m capex)	Option 3 - Core DMC + key estates risks (c.£481m capex)	Option 4 - Core DMBC + key estates risks + integration (c.£534m capex)
Incremental costs - total	£0.00	(£99.79)	(£384.65)	(£518.02)	(£548.44)
Incremental benefits - total	£0.00	£98.50	£1,702.84	£1,981.49	£2,478.96
Risk-adjusted Net Present Social Value (NPSV)	£0.00	(£1.29)	£1,318.19	£1,463.47	£1,930.52
Benefit-cost ratio		0.99	4.43	3.83	4.52

## Detailed Economic Summary (Discounted) - £m

	Option 0 - Business as Usual	Option 1 - Additional Comparator (c. £72m capex)	Option 2 - Do Minimum (c.£312m capex)	Option 3 - Core DMC + key estates risks (c.£481m capex)	Option 4 - Core DMBC + key estates risks + integration (c.£534m capex)
<b>Costs</b>					
Incremental cost increase - opportunity cost	£0.00	£0.00	£0.00	£0.00	£0.00
Incremental cost increase - capital (including optimism bias)	£0.00	(£77.14)	(£351.75)	(£487.63)	(£533.02)
Incremental cost increase - revenue	£0.00	(£19.06)	(£26.88)	(£20.29)	(£4.31)
Incremental cost increase - transitional	£0.00	£0.00	(£2.22)	(£3.15)	(£3.44)
Incremental cost increase - externality	£0.00	£0.00	£0.00	£0.00	£0.00
Incremental cost increase - net contribution	£0.00	£0.00	£0.00	£0.00	£0.00
Incremental cost increase - risks	£0.00	(£3.59)	(£3.80)	(£6.94)	(£7.69)
<b>Incremental costs - total</b>	<b>£0.00</b>	<b>(£99.79)</b>	<b>(£384.65)</b>	<b>(£518.02)</b>	<b>(£548.44)</b>
<b>Benefits</b>					
Incremental cost reduction - opportunity cost	£0.00	£0.00	£0.00	£0.00	£0.00
Incremental cost reduction - capital (including optimism bias)	£0.00	£0.00	£0.00	£0.00	£0.00
Incremental cost reduction - revenue	£0.00	£0.00	£0.00	£0.00	£0.00
Incremental cost reduction - transitional	£0.00	£0.00	£0.00	£0.00	£0.00
Incremental cost reduction - externality	£0.00	£0.00	£0.00	£0.00	£0.00
Incremental cost reduction - net contribution	£0.00	£0.00	£0.00	£0.00	£0.00
Incremental cost reduction - risks	£0.00	£0.00	£0.00	£0.00	£0.00
Incremental benefit - cash releasing	£0.00	£98.50	£654.63	£742.74	£801.93
Incremental benefit - non-cash releasing	£0.00	£0.00	£206.92	£341.80	£429.14
Incremental benefit - societal	£0.00	£0.00	£841.29	£896.95	£1,247.89
<b>Incremental benefits - total</b>	<b>£0.00</b>	<b>£98.50</b>	<b>£1,702.84</b>	<b>£1,981.49</b>	<b>£2,478.96</b>
<b>Value for Money</b>					
Risk-adjusted Net Present Social Value (NPSV)		(£1.29)	£1,318.19	£1,463.47	£1,930.52
Benefit-cost ratio		0.99	4.43	3.83	4.52

## Cost and Risk Summary (Discounted) - £m

	Option 0 - Business as Usual	Option 1 - Additional Comparator (c. £72m capex)	Option 2 - Do Minimum (c.£312m capex)	Option 3 - Core DMC + key estates risks (c.£481m capex)	Option 4 - Core DMBC + key estates risks + integration (c.£534m capex)
<b>Present Cost</b>	£0.00	(£96.20)	(£380.85)	(£511.08)	(£540.76)
<b>Total Risk</b>	(£9.71)	(£13.30)	(£13.51)	(£16.65)	(£17.40)
<b>Risk-adjusted Present Cost</b>	(£9.71)	(£109.50)	(£394.36)	(£527.73)	(£558.16)

## Detailed Cost, Risk and Benefit Summary (Discounted) - £m

	Option 0 - Business as Usual	Option 1 - Additional Comparator (c. £72m capex)	Option 2 - Do Minimum (c.£312m capex)	Option 3 - Core DMC + key estates risks (c.£481m capex)	Option 4 - Core DMBC + key estates risks + integration (c.£534m capex)
<b>Opportunity Costs</b>					
Capital Expenditure	£0.00	(£70.25)	(£319.75)	(£431.93)	(£472.02)
Capital Expenditure Optimism Bias Uplift	£0.00	(£6.90)	(£32.00)	(£55.70)	(£60.99)
Revenue Expenditure	£0.00	(£19.06)	(£26.88)	(£20.29)	(£4.31)
Transitional Costs	£0.00	£0.00	(£2.22)	(£3.15)	(£3.44)
Externality Costs	£0.00	£0.00	£0.00	£0.00	£0.00
Net Contribution Costs	£0.00	£0.00	£0.00	£0.00	£0.00
<b>Present Cost</b>	<b>£0.00</b>	<b>(£96.20)</b>	<b>(£380.85)</b>	<b>(£511.08)</b>	<b>(£540.76)</b>
<b>Risks</b>					
Design Risks	£0.00	£0.00	£0.00	£0.00	£0.00
Construction Risks	(£1.19)	(£3.07)	(£6.24)	(£8.60)	(£9.35)
Performance Risks	£0.00	£0.00	(£1.15)	(£1.15)	(£1.15)
Operating Risks	(£3.39)	(£3.70)	(£1.87)	(£3.78)	(£3.78)
Revenue Risks	(£5.13)	(£6.53)	(£4.25)	(£3.11)	(£3.11)
Termination Risks	£0.00	£0.00	£0.00	£0.00	£0.00
Technology Risks	£0.00	£0.00	£0.00	£0.00	£0.00
Control Risks	£0.00	£0.00	£0.00	£0.00	£0.00
Residual Value Risks	£0.00	£0.00	£0.00	£0.00	£0.00
Other Risks	£0.00	£0.00	£0.00	£0.00	£0.00
Additional Risks	£0.00	£0.00	£0.00	£0.00	£0.00
<b>Total Risk</b>	<b>(£9.71)</b>	<b>(£13.30)</b>	<b>(£13.51)</b>	<b>(£16.65)</b>	<b>(£17.40)</b>
Unmonetised Risk Score	38.5	30.8	25.5	27.8	27.8
<b>Risk-adjusted Present Cost</b>	<b>(£9.71)</b>	<b>(£109.50)</b>	<b>(£394.36)</b>	<b>(£527.73)</b>	<b>(£558.16)</b>
Cash Releasing Benefits	£0.00	£98.50	£654.63	£742.74	£801.93
Non-Cash Releasing Benefits	£0.00	£0.00	£206.92	£341.80	£429.14
Societal Benefits	£0.00	£0.00	£841.29	£896.95	£1,247.89
<b>Total Benefits</b>	<b>£0.00</b>	<b>£98.50</b>	<b>£1,702.84</b>	<b>£1,981.49</b>	<b>£2,478.96</b>

OUTLINE BUSINESS CASE		COST FORM OB1		
TRUST/ORGANISATION:	<b>SATH</b>	ORGANISATION CODE:		
SCHEME:	<b>Alternative</b>	DIRECTORATE:		
DATE:	<b>20-Feb-23</b>			
PHASE:	<b>Stage 2 Design - OBC Draft Feb 23</b>			
PROJECT DIRECTOR:				
<b>CAPITAL COSTS SUMMARY</b>				
		Cost Excl. VAT	VAT	Cost Incl. VAT
		£	£	£
1	Departmental Costs (from Form OB2)	155,746,817	31,149,363	186,896,180
2	On Costs (from Form OB3)			
	(0.00% of Departmental Cost)	0	0	0
3	Works Cost Total (1+2)	155,746,817	31,149,363	186,896,180
	(Tender Price index level 1995 = 100 base)			
3a	Lump sum additional works (RSH)	0	0	0
3b	Lump sum additional works (PRH)			
4	Provisional location adjustment (if applicable)			
	(0.00 % of Works Cost)	-2,315,807	-463,161	-2,778,968
<b>5</b>	<b>Sub Total (3+4)</b>	<b>153,431,011</b>	<b>30,686,202</b>	<b>184,117,213</b>
6	Fees (c)		(d)	
	(16.96% of sub-total 5)	26,015,200		26,015,200
7	Non-Works Costs (from Form OB4) (e)		0	
	Planning Fee		0	
	Building Regulations Fee	0	0	0
8	Equipment Costs (from Form OB2)			
	(13.00% of Departmental Cost)	19,943,983	3,988,797	23,932,780
9A	Contingency 9.07% of 5+6+7+8	18,075,000	3,615,000	21,690,000
<b>10A</b>	<b>SUB-TOTAL (5+6+7+8+9)</b>	<b>217,465,194</b>	<b>38,289,999</b>	<b>255,755,193</b>
10B	Deduct for reclaimable VAT (Various Rates)			0
10C	Optimism Bias 16.23% of 5+6+7+8+9A	35,285,000	7,057,000	42,342,000
<b>10D</b>	<b>TOTAL (for approval purposes)</b>	<b>252,750,194</b>	<b>45,346,999</b>	<b>298,097,193</b>
11	Inflation adjustments (f)	11,798,722	2,359,744	14,158,466
	Inflation Adjustment for revised phasing of works	0	inc	0
12	FORECAST OUTTURN BUSINESS CASE			
	TOTAL (10+11)	264,548,916	47,706,743	312,255,659

# Option Agreement

## Qualitative Appraisal / Long List Appraisal Participants

Friday 9<sup>th</sup> December 2022 (13:30–15:00)

Co-Medical Director	SaTH
Technical Director	SaTH
Programme Delivery Director	SaTH
Workforce and OD Workstream Lead	SaTH
Procurement Workstream Lead	SaTH
Strategic Estates Workstream Lead	SaTH
Finance and Business Manager	SaTH
PMO Project Manager	SaTH
PMO Project Manager	SaTH
Finance Officer	SaTH
Consultant	PA Consulting
Consultant	PA Consulting
Consultant	PA Consulting

## Quantitative Appraisal Participants

Session 1: Tuesday 4<sup>th</sup> April 2023 (15:00-15:30)

Session 2: Friday 17<sup>th</sup> March 2023 (12:30-13:30)

HTP Medical Director	SaTH
Technical Director	SaTH
Programme Delivery Director	SaTH
Workforce and OD Workstream Lead	SaTH
Strategic Estates Workstream Lead	SaTH
Finance Workstream Lead	SaTH
Clinical Implementation Lead	SaTH
Clinical Implementation Lead	SaTH
Finance and Business Manager	SaTH
Workforce and OD Consultant	SaTH
Associate Director Strategic Estates	SaTH
Consultant	PA Consulting
Consultant	PA Consulting
Consultant	PA Consulting
Consultant	PA Consulting

## Risk Appraisal Invitees

Thursday 23<sup>rd</sup> March 2023 (15:00-15:30)

Workforce and OD Workstream Lead	SaTH
Associate Director Strategic Estates	SaTH
Procurement Workstream Lead	SaTH
Strategic Estates Workstream Lead	SaTH
Finance Workstream Lead	SaTH
Finance and Business Manager	SaTH
Finance Officer	SaTH
Technical Director	SaTH
PMO Programme Manager	SaTH
PMO Programme Officer	SaTH
Workforce and OD Consultant	SaTH
Consultant	PA Consulting
Consultant	PA Consulting
Consultant	PA Consulting

# Shrewsbury and Telford Hospital NHS Trust

## Life Cycle Costs - Options 2, 3 and 4



Date: 3 May 2023

a business based on  
people, personalities and performance





**Client:** Shrewsbury & Telford Hospitals NHS Trust

**Project:** Hospital Transformation Programme

## Life Cycle Costing Exercise

### 1.0 Production of Life Cycle Costs

1.1 The Life Cycle cost information has been developed by Edmond Shipway LLP by MRICS qualified cost managers

### 2.0 Basis of Costs

2.1 The basis of the costs are the cost estimates produced for Options 2, 3 and 4, with estimated total project costs as follows

- **Option 2 - £312m - Notional costs as issued 1 March 2023**

- **Option 3 - £482m - as issued 14 March 2023**

- **Option 4 - £534m - as issued 14 March 2023**

2.2 Whilst costs for Option 2 have been assessed on an elemental basis as the works had been measured in that manner, options 3 and 4 had not been measured or assessed to the same detail. Accordingly the costs for these options have been apportioned in the same manner as the elements within option 2

2.3 Life Cycle Costs are calculated to include both maintenance and replacement costs. The frequency of these works are identified in Appendix A

2.4 The following elements have been removed from the total project cost to calculated LCC elements in accordance with the PA exclusions

- Omission of allowance for profession fees

- Omission of allowance for Optimism Bias

- Omission of allowance for equipment

- Omission of allowance for inflation

2.5 From the adjustments noted in 2.4, the updated capital costs for each element, as used in the LCC are as follows:

- **Option 2 - £178.58m**

- **Option 3 - £252.67m**

- **Option 4 - £375.04m**

Yearly details are included in Appendix B

2.6 The summary report attached commences at Year 4, 2026/27. Whilst accurate from current date, this would be year 1 for post construction and accordingly LCC cost have been applied on that basis

2.7 The total LCC values as detailed in Appendix B are summarised as follows:

- **Option 2 - £282.33m**

- **Option 3 - £403.99m**

- **Option 4 - £597.58m**

Yearly details are included in Appendix B

### 3.0 Non - Edmond Shipway Amendments

3.1 The template as issued makes the following assumptions and these have been maintained, although not in line with the full LCC calculations

2026/27 - Year 4 Option 3 & 4 assumed aligned with Option 2

2027/28 - Year 5 Option 3 & 4 assumed aligned with Option 2

2028/29 - Year 6 Option 3 & 4 assumed aligned with Option 2

2029/30 - Year 7 Option 3 & 4 assumed aligned with Option 2

2030/31 - Year 8 Option 4 assumed aligned to Option 3

**Client: Shrewsbury & Telford Hospitals NHS Trust**

**Project: Hospital Transformation Programme**

Element	Maintenance Cycle			Replacement Cycle		
	Life cycle	Work period	Start year	Life cycle	Work period	Start year
Enabling Works	-	-	-	-	-	-
1 Substructure	-	-	-	-	-	-
2A Frame	-	-	-	-	-	-
2B Upper floors	15	1	16			
2C Roof	15	1	16	30	1	31
2D Stairs	5	1	6			
2E External walls	15	1	16	-	-	-
2F Windows and external doors	10	1	11	15	1	16
2G Internal walls and partitions	10	1	11	-	-	-
2H Internal doors	5	1	6	15	1	16
3A Wall finishes	4	1	5	-	-	-
3B Floor finishes	5	1	6	10	2	11
3C Ceiling finishes	5	1	6	20	2	21
4 Fixtures and fittings	10	1	11	25	2	26
5A Sanitary appliances	5	1	6	15	1	16
5B Services equipment	1	1	1			
5C Disposal installations	1	1	1	15	1	16
5D Water installations	1	1	1			
5E Heat source	1	1	1			
5F Space heating and air treatment	1	1	1	15	2	16
5G Ventilating systems	1	1	1	15	2	16
5H Electrical installation	1	1	1	15	2	16
5I Gas installations	1	1	1			
5J Lift and conveyer installation	1	1	1	15	1	16
5K Protective installations	1	1	1	15	2	16
5L Communication installations	1	1	1	15	2	16
5M Special installations	1	1	1	15	2	16
5N Builders work in connection with services	1	1	1	15	2	16
5O Builder's attendance	1	1	1	-	-	-
6A Site works	5	1	6	30	3	31
6B Drainage	10	1	11	-	-	-
6C External services	10	1	11	1	15	16
6D Minor building works	10	3	11	-	-	-

**Client** Shrewsbury & Telford Hospital NHS Trust  
**Project Title** Hospital Transformation Programme  
**Produced by** Edmond Shipway LLP  
**Date** 03-May-23  
**Assumptions**

1. Elemental cost allowances for Options 3 and 4 have been developed from the detailed Option 2 costs as elemental costs plans had not been produced for options 3 and 4
2. No allowance made for professional fees within original capital costs
3. No allowance included for VAT within original capital costs
4. No allowance for Optimism Bias within original capital costs
5. No allowance for Inflation within original capital costs
6. No allowance for equipment

**Option 2      Option 3      Option 4**

<b>Total capital costs exc VAT, OB, sunk costs, inflation</b>	<b>178.58</b>	<b>252.67</b>	<b>375.04</b>
<b>% of Option 2 capital costs</b>	<b>100.0%</b>	<b>141.5%</b>	<b>210.0%</b>

Year	Year	Annual LCC (£M)		
2026/27	4	0.37	0.37	0.37
2027/28	5	0.37	0.37	0.37
2028/29	6	0.37	0.37	0.37
2029/30	7	0.37	0.37	0.37
2030/31	8	1.77	2.50	2.50
2031/32	9	3.94	5.57	8.27
2032/33	10	0.37	0.53	0.78
2033/34	11	0.37	0.53	0.78
2034/35	12	1.77	2.50	3.71
2035/36	13	0.37	0.53	0.78
2036/37	14	8.68	12.28	18.23
2037/38	15	3.81	5.38	7.99
2038/39	16	1.77	2.50	3.71
2039/40	17	0.37	0.53	0.78
2040/41	18	0.37	0.53	0.78
2041/42	19	33.59	48.36	71.78
2042/43	20	18.19	26.58	39.45
2043/44	21	0.37	0.53	0.78
2044/45	22	0.37	0.53	0.78
2045/46	23	0.37	0.53	0.78
2046/47	24	11.61	16.42	24.37
2047/48	25	5.72	8.09	12.01
2048/49	26	0.37	0.53	0.78
2049/50	27	0.37	0.53	0.78
2050/51	28	1.77	2.50	3.71
2051/52	29	7.73	10.93	16.23
2052/53	30	4.16	5.88	8.73
2053/54	31	0.37	0.53	0.78
2054/55	32	1.77	2.50	3.71
2055/56	33	0.37	0.53	0.78
2056/57	34	41.11	59.06	87.66
2057/58	35	21.35	31.05	46.08
2058/59	36	2.89	4.09	6.07
2059/60	37	0.37	0.53	0.78
2060/61	38	0.37	0.53	0.78
2061/62	39	3.94	5.57	8.27
2062/63	40	1.77	2.50	3.71
2063/64	41	0.37	0.53	0.78
2064/65	42	0.37	0.53	0.78
2065/66	43	0.37	0.53	0.78
2066/67	44	11.61	16.42	24.37
2067/68	45	5.72	8.09	12.01
2068/69	46	0.37	0.53	0.78
2069/70	47	0.37	0.53	0.78
2070/71	48	1.77	2.50	3.71
2071/72	49	33.59	48.36	71.78
2072/73	50	16.79	24.60	36.52
2073/74	51	0.37	0.53	0.78
2074/75	52	1.77	2.50	3.71
2075/76	53	0.37	0.53	0.78
2076/77	54	10.45	14.78	21.94
2077/78	55	7.59	10.74	15.95
2078/79	56	1.77	2.50	3.71
2079/80	57	0.37	0.53	0.78
2080/81	58	0.37	0.53	0.78
2081/82	59	3.94	5.57	8.27
<b>Total</b>		<b>282.33</b>	<b>403.99</b>	<b>597.58</b>

*Option 3 & 4 assumed aligned with Option 2*  
*Option 3 & 4 assumed aligned with Option 2*  
*Option 3 & 4 assumed aligned with Option 2*  
*Option 3 & 4 assumed aligned with Option 2*  
*Option 4 assumed aligned to Option 3*



The Shrewsbury and  
Telford Hospital  
NHS Trust

# Hospitals Transformation Programme

## OBC Quantitative Appraisal Session 3

18th April 2023



**Integrated  
Care System**  
Shropshire, Telford and Wrekin

# The quantitative appraisal focuses on undertaking an appraisal for value for money and affordability

## Definitions:

- **Fail** a Critical Success Factor – *are expected to **not meet** a Critical Success Factor*
- **Pass** a Critical Success Factor – *are expected to **meet** a Critical Success Factor*
- **Preferred** against a Critical Success Factor – *is expected to be **most favourable** against a Critical Success Factor*

CSF	Description
<b>Value for money</b>	<p><b>Benefits cost ratios (BCRs)</b> and <b>Net Present Social Values (NPSVs)</b> are similar metrics which <b>Treasury uses to measure long term value for money</b>. They <b>combine all benefits</b> which can be quantified (financial and economic), <b>costs and investments</b> over a <b>long time horizon</b> (60 years), and express these as a single number.*</p> <p>The metrics are <b>compared to the BAU option</b> (therefore the BAU does not have a BCR or NPSV). A BCR of 2:1 suggests £2 of benefit for every £1 invested (a relative measure), where as a NPSV provides an absolute different between the forecast costs and benefits of an option. A high level economic model has been developed to estimate these metrics in line with NHSEI / DHSC / HMT definitions. See specific slide for details of assumptions.</p>
<b>Affordability (revenue)</b>	<p>This refers to <b>financial revenue affordability</b> and captures the <b>expected difference</b> between the <b>additional financial costs per annum</b> and the <b>additional financial benefits per annum</b> for the first year of opening.</p> <p>The revenue impact is <b>compared to the BAU option</b> (therefore the BAU does not have an impact itself). A high level simplistic financial analysis has been undertaken to estimate these metrics – see specific slide for details of assumptions.</p>
<b>Affordability (capital)</b>	<p>This refers to the <b>affordability of the capital ask in relation to the capital allocation</b> the Trust has received for HTP.</p>

\* Note that per Green book guidance, NPSVs and BCRs are presented in real terms and so exclude inflation. Note there are a number of exclusions (per Green book guidance), including transfer payments (therefore trust income, PDC, VAT).



# CSF 7: Value for Money

**Net Present Social Value (NPSV):** the present value of benefits less the present value of costs.

**Benefit-cost Ratio:** the ratio of the present value of benefits to the present value of costs.

These are calculated using the CIA Model.

Metric	Ref	0. Business As Usual	1. Additional Comparator	2. Core DMBC ('Do minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Incremental costs	A	£0	-£100	-£384	-£517	-£547
Incremental benefits(discounted over 60 years)	B	£0	£99	£1,506	£1,785	£2,282
Net present social value (NPSV) (60 years) excl. PDC vs. BAU (£m)	C = A + B	£0	-£2	£1,123	£1,268	£1,735
Benefit Cost Ratio	D = B/C		0.98	3.93	3.45	4.17
Conclusion		Fail	Fail	Pass	Pass	Preferred



# CSF 8: Revenue Affordability

*Revenue affordability is shown in the year following build completion compared to the BAU. Full financial statements for each option showing affordability in each year are included as an appendix to the OBC*

	0. Business As Usual	1. Additional Comparator Completed 31/32	2. Core DMBC ('Do minimum') Completed 26/27	3. Core DMBC + key estates risks Completed 28/29	4. Core DMBC + key estates risks + integration Completed 29/30
Impact on I&E	-	£2.6m	£2.9m	£5.7m	£12.8m
Conclusion	-	Pass	Pass	Pass	Preferred

# CSF 9: Capital Affordability



**Integrated  
Care System**  
Shropshire, Telford and Wrekin

**NHS**  
The Shrewsbury and  
Telford Hospital  
NHS Trust

£m, nominal capital cost	OB form reference	0. Business As Usual	1. Additional Comparator	2. Core DMBC ('Do minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Works, Fees and Equipment	Line 10A	0	46	218	298	327
Optimism Bias and Contingency	Line 10C	0	10	42	75	83
<b>Total from OB Forms</b>	<b>10A+10C</b>	<b>0</b>	<b>56</b>	<b>260</b>	<b>373</b>	<b>410</b>
Sunk Costs	Expected spend in 2022/23	0	0	5	5	5
<b>Economic case total (adjusted for sunk costs / included in CIA model)</b>	<b>OB Forms total – Sunk Costs</b>	<b>0</b>	<b>56</b>	<b>255</b>	<b>368</b>	<b>405</b>
Inflation	Line 11	0	10	14	62	70
Net Value Added Tax	Line 12 - VAT in 10C and 11	0	6	38	46	54
<b>Total Capital Cost</b>	<b>OB Forms total + Inflation + Net VAT</b>	<b>0</b>	<b>72</b>	<b>312</b>	<b>481</b>	<b>534</b>
<b>Conclusion</b>		<b>Pass</b>	<b>Fail</b>	<b>Pass</b>	<b>Fail</b>	<b>Fail</b>

## ASSUMPTIONS

- Spending in 22/23 not included in CIA model – sunk cost
- Assumed project life of 60 years (year 0 - 22/23)
- Assumed phasing for Options 3 and 4 consistent with SOC
- Assumed no sunk costs in Option 2 (as per OB Forms)



# The Sensitivities show that the Preferred Option is robust against uncertainty

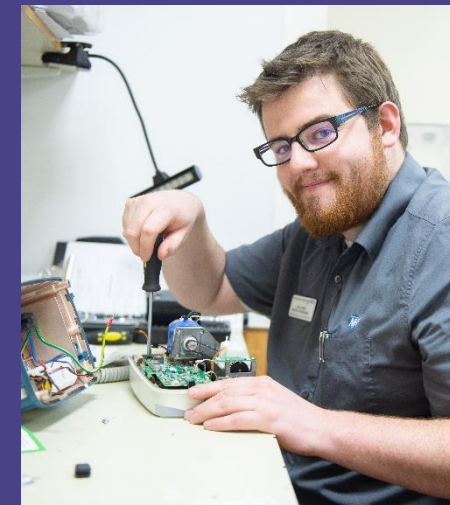
## BCR Impact

Net Present Social Value (£m)	0. Business As Usual	1. Additional Comparator	2. Core DMBC ('Do minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Capital Basecase, Benefits Basecase	£0	-£2	£1,123	£1,268	£1,735
Capital +10%, Benefits Basecase	£0	-£12	£1,084	£1,216	£1,680
Capital -10%, Benefits Basecase	£0	£8	£1,161	£1,320	£1,790
Capital Basecase, Benefits +20%	£0	£18	£1,424	£1,625	£2,192
Capital +10%, Benefits +20%	£0	£8	£1,386	£1,573	£2,137
Capital -10%, Benefits +20%	£0	£28	£1,462	£1,677	£2,246
Capital Basecase, Benefits -20%	£0	-£22	£821	£911	£1,279
Capital +10%, Benefits -20%	£0	-£32	£783	£859	£1,224
Capital -10%, Benefits -20%	£0	-£12	£860	£963	£1,333

## NPSV Impact

Benefit-Cost Ratio	0. Business As Usual	1. Additional Comparator	2. Core DMBC ('Do minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Capital Basecase, Benefits Basecase	0.00	0.98	3.93	3.45	4.17
Capital +10%, Benefits Basecase	0.00	0.89	3.57	3.14	3.79
Capital -10%, Benefits Basecase	0.00	1.09	4.36	3.84	4.63
Capital Basecase, Benefits +20%	0.00	1.18	4.71	4.14	5.00
Capital +10%, Benefits +20%	0.00	1.07	4.28	3.77	4.55
Capital -10%, Benefits +20%	0.00	1.31	5.24	4.60	5.56
Capital Basecase, Benefits -20%	0.00	0.78	3.14	2.76	3.34
Capital +10%, Benefits -20%	0.00	0.71	2.86	2.51	3.03
Capital -10%, Benefits -20%	0.00	0.87	3.49	3.07	3.71

# Delay Options



# CSF 7: Value for Money

**Net Present Social Value (NPSV):** the present value of benefits less the present value of costs.

**Benefit-cost Ratio:** the ratio of the present value of benefits to the present value of costs.

These are calculated using the CIA Model.

Metric	Ref	0. Business As Usual	Option 5 - Do Minimum (c.£312m capex) + 12 month delay	Option 6 - Do Minimum (c.£312m capex) + 24 month delay
Incremental costs	A	£0	<b>-£378.59</b>	<b>-£367.74</b>
Incremental benefits(discounted over 60 years)	B	£0	<b>£1,456.16</b>	<b>£1,407.25</b>
Net present social value (NPSV) (60 years) excl. PDC vs. BAU (£m)	C = A + B	£0	<b>£1,077.57</b>	<b>£1,039.50</b>
Benefit Cost Ratio	D = B/C	£0	<b>3.85</b>	<b>3.83</b>
<b>Conclusion</b>		<b>Fail</b>	<b>Pass</b>	<b>Pass</b>



# CSF 8: Revenue Affordability

£m,	0. Business As Usual	Option 5 - Do Minimum (c.£312m capex) + 12-month delay Completed 27/28	Option 6 - Do Minimum (c.£312m capex) + 24-month delay Completed 28/29
Incremental impact on I&E in 32/33	-	£3m	£3m
<b>Conclusion</b>	-	<b>Pass</b>	<b>Pass</b>

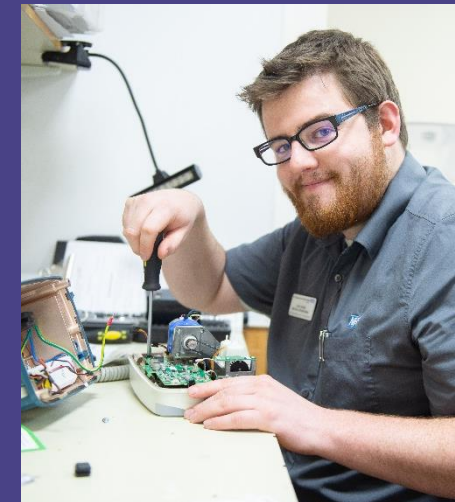
# CSF 9: Capital Affordability



£m, nominal capital cost	OB form reference	2. Core DMBC ('Do minimum')	2a. Core DMBC ('Do minimum') – 12 month delay	2b. Core DMBC ('Do minimum') – 24 month delay
Works, Fees and Equipment	Line 10A	217	217	217
Optimism Bias and Contingency	Line 10C	35	36	37
<b>Economic case total (included in CIA model*)</b>		<b>253</b>	<b>254</b>	<b>254</b>
Inflation	Line 11	12	18	23
Net Value Added Tax	Line 12	48	49	50
<b>Total Capital Cost (aligned to financial model and case)</b>		<b>312</b>	<b>320</b>	<b>328</b>
<b>Conclusion</b>		<b>Pass</b>	<b>Fail</b>	<b>Fail</b>

## ASSUMPTIONS

- Spending in 22/23 not included in CIA model – sunk cost
- Assumed project life of 60 years (year 0 - 22/23)
- Assumed phasing for Options 3 and 4 consistent with SOC
- Assumed no sunk costs in Option 2 (as per OB Forms)



# Option 0: Business as Usual

## Description

*As per JIC condition #6, a new BAU option with no / minimal capital investment is included in the options appraisal*

Includes:

- Any projects the Trust is committed to, or is already expected to undertake, for example routine works and an allowance for emergency works based on historic requirement
- RSH & PRH energy centre renewal (dependent project)
- Critical works
- As per guidance, RSH & PRH annual essential backlog only will be addressed which is risk adjusted (that can be delivered through depreciation-funded capital)
- Increased revenue costs associated with outsourcing/ out of hours work to deliver all incremental elective activity

Does not include:

- Capital programme for winter bed pressures
- Additional capacity to meet future demand

## Benefits

By definition Business as Usual has no benefits, as other options are compared to this.

## Risks

- Increased likelihood of patient harm due to increase demand and deteriorating clinical environment.
- Increase risk of critical incidents due to increases in demand not met by additional capacity.
- Increase risk of workforce (recruitment and retention) challenges resulting in clinical sustainability challenges and financial challenges
- Increase risk to service sustainability due to the above
- Risk that external providers cannot meet additional demand for outsourced services



# Option 0: Business as Usual

## Disadvantages

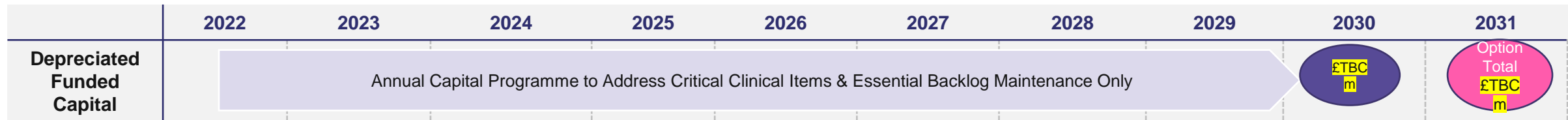
- Increase in operational bed pressures due to increase in demand not being met by additional capacity
- Knock on impact on emergency pathway flow due to growing demand in existing capacity constraints.
- Increase dependence on external providers for elective services.
- The trust cannot address issues around the quality of its clinical built environment or patient pathways with estate continuing to degrade.
- Clinical quality and safety improvements are not realised as a consequence of not enacting the Clinical Model.
- In-patient elective surgical capacity continues to be vulnerable to cancellations due to surges in emergency demand with no separation of flows.
- Vulnerability of emergency rotas across key specialties e.g., Emergency Department, Acute Medicine, Intensive Care within the workforce.
- Deterioration in the clinical environment will perpetuate worsening experience to patients and workforce, impacting on patient experience, recruitment and retention of workforce.
- Reliance on a transient agency workforce will lead to increasing costs.

## Advantages

No capital investment required

## Consequences

- De-scopes backlog maintenance including significant /high risk backlog
- No development at RSH
- Inefficient solution which will not fully address wider clinical risks (including CQC feedback).
- It will fail to meet stakeholder expectations, fail to deliver all the benefits stated and will result in continued poor infrastructure risk.
- Outsourcing required to deliver elective activity which will have a knock on impact on emergency pathway flow due to growing demand and existing capacity constraints.



# Option 1: Additional Comparator

## Description

This option considers what can be achieved with c. 72m of capital expenditure – this includes the Trust's baseline annual capital programme over the appraisal period, with the addition of potential expansion in capacity to continue current arrangements.

This option includes:

- Any projects the Trust is committed to, or is already expected to undertake, for example routine works and an allowance for emergency works based on historic requirement
- RSH & PRH energy centre renewal
- Critical works
- As per guidance, RSH& PRH annual essential backlog only will be addressed (that can be delivered through depreciation-funded capital)
- Potential capital programme for winter bed pressures

## Benefits

The Economic Comparator has no benefits over the current situation and is used as a comparison for other options. Through the provision of additional capacity, it has some benefits over the BAU in reducing demand pressures and reducing the need for outsourcing activity.

## Risks

- Increased likelihood of patient harm due to increase demand and deteriorating clinical environment.
- Increase risk of critical incidents due to increases in demand not met by additional capacity.
- Increase risk of workforce (recruitment and retention) challenges resulting in clinical sustainability challenges and financial challenges
- Increase risk to service sustainability due to the above





# Option 1: Additional Comparator

## Advantages

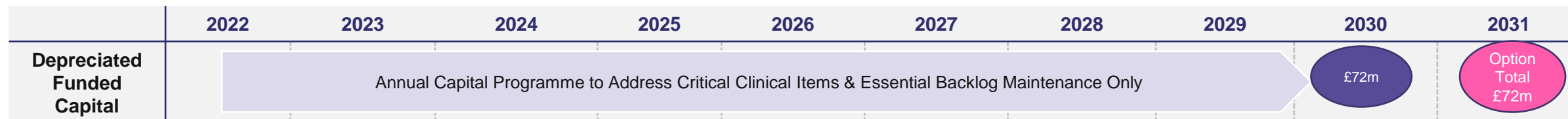
Less capital investment required

## Consequences

- De-scopes backlog maintenance including significant /high risk backlog
- Reduces the scale of the development at RSH
- Less efficient solution which will not fully address wider clinical risks (including CQC feedback)
- It will fail to meet stakeholder expectations, fail to deliver all the benefits stated and will result in continued poor infrastructure risk

## Disadvantages

- No changes in overall clinical model – risk to the sustainability of clinical services will continue to increase and resultant deterioration of the current clinical state
- 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)



# Option 2: 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 term 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

## 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



# Option 2: Core DMBC ('Do Minimum')

## 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. 19 %)

## 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

## Disadvantages

- 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



# Option 3: 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

## 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 HCAs)
- 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



# Option 3: Core DMBC + key estates risks

## Advantages

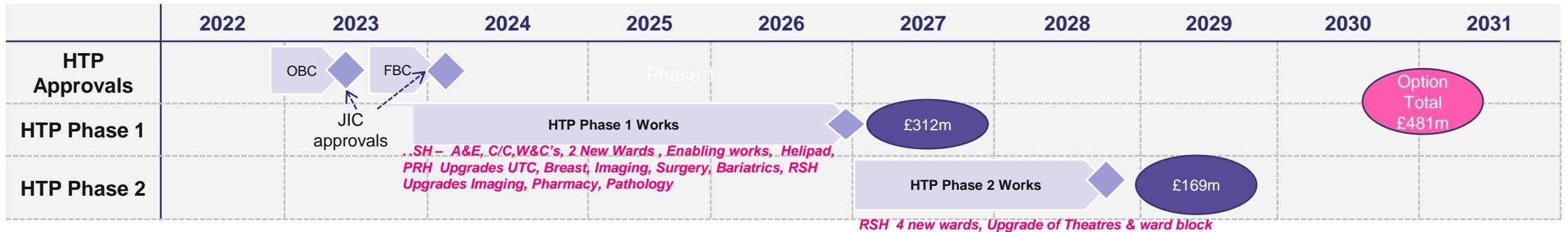
- Delivers the core DMBC requirements and some of the wider Future Fit ambition, improves most of the facilities for staff and patients
- Delivers the benefits associated with the pathways
- Provides increased single room provision (c. 36% RSH , 16% PRH)
- Addresses areas of highest-estate risk
- The capacity we need for the future would be met within new ward accommodation at RSH that meets latest standards
- Facilitates the colocation of Women and Children’s services
- Provides an increased footprint to repatriate off-site staff and deliver educational requirements As above comment re Acute discussions

## 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)

## Consequences

- Will not improve patient quality and experience across the entirety of the estate
- Will not support wider optimisation of activities on each site





# Option 4: 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

## Risks

Interdependent on the progression of both the day case hub and energy centre developments

## 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 HCAs)
- 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





# Option 4: Core DMBC + key estates risks + integration

## Advantages

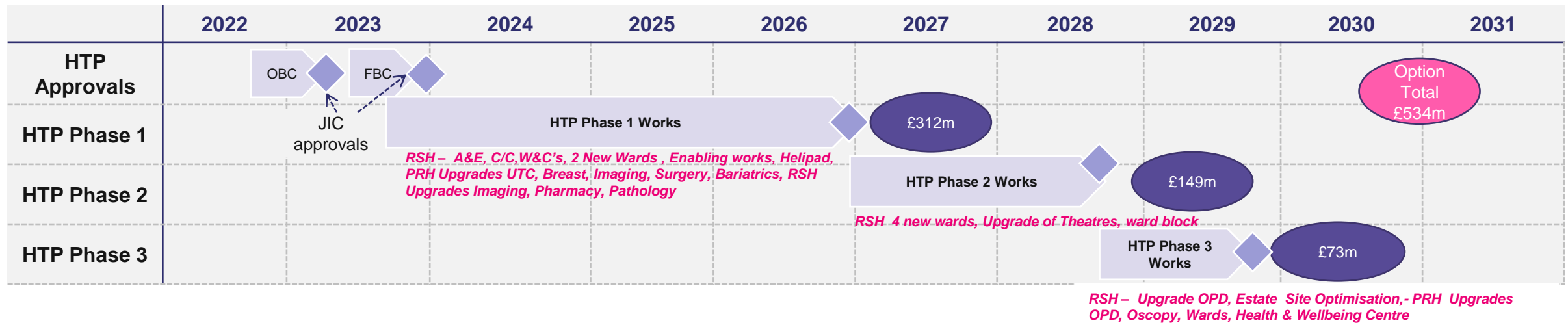
- Delivers the core DMBC requirements and most of the wider Future Fit ambition, improves all facilities for staff and patients
- Delivers the benefits associated with the pathways
- Provides increased single room provision (c. 35% RSH , 16% PRH)
- Addresses key estates risks
- The capacity we need for 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 As per acute note above

## Disadvantages

When implemented through a phased approach, delivery timelines are extended (and overall costs increased)

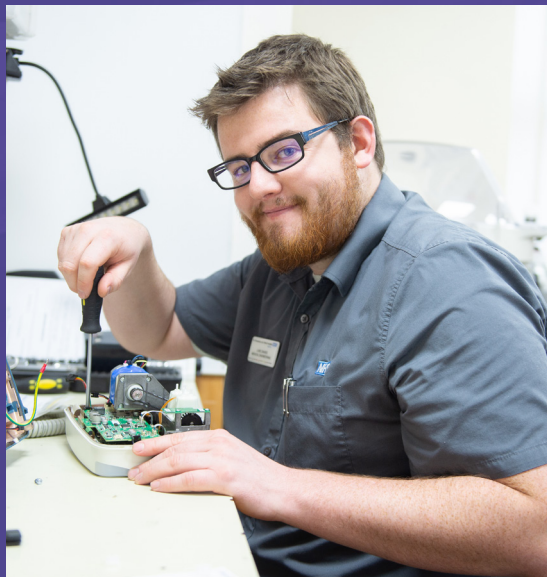
## Consequences

Limited adverse consequences as this option delivers the core DMBC requirements and most of the wider Future Fit ambition





**Integrated  
Care System**  
Shropshire, Telford and Wrekin



# COMMERCIAL APPENDICES



**The Shrewsbury and  
Telford Hospital**  
NHS Trust

# Hospitals Transformation Program Procurement Strategy

## Content

- 1. Local Context**
- 2. Procurement Approach – Vision and Aim**
- 3. Commercial Principals**
  - 3.1 Procurement and Commercial Pipeline
  - 3.2 Sourcing Routes
  - 3.3 Contract Management
- 4. The Design and Construction Requirement**
  - 4.1 Procurement routes & optimising management of risk
  - 4.2 The chosen route to market
  - 4.3 Market engagement
  - 4.4 Competitive procurement
  - 4.5 Scope of services
  - 4.6 Evaluation criteria
  - 4.7 PSCP appointment
  - 4.8 Design Stages versus Procurement stages
  - 4.9 Model Contract for the Principal Supply Chain Partner
- 5. Procurement of Professional services**
- 6. Equipping Procurement Approach**
- 7. Governance**



## 1. Local Context

The Shropshire Healthcare Procurement (SHPS) Team is a shared service, hosted by The Shrewsbury & Telford Hospital NHS Trust which supports the providers of acute, specialist orthopaedic hospital services and community care for Shropshire, Telford & Wrekin and into Mid-Wales.

SHPS were one of the first NHS Trust to achieve the Level 2 NHS Standard of Procurement, and in 2022, SHPS were one of the cohort members to pilot the new Government Commercial Function Operating Standards.

To give assurance of the procurement and commercial capability and maturity at a local level, the GCF standards scoring and associated maturity bands for the process undertaken in 2022 are as follows:

### Summary by Theme and Rating for the local Procurement function

Theme 1 Commercial Strategy, Planning and Governance	BETTER
Theme 2 Commercial Capability and Resourcing	BETTER
Theme 3 Commercial Lifecycle Define: pre-procurement	BETTER
Theme 4 Commercial Lifecycle Procure: procurement and contracting	BETTER
Theme 5 Commercial Lifecycle Manage: contract management	BETTER
Theme 6 Managing Categories, Markets and Supplier Relations	GOOD
Theme 7 Commercial systems, reporting and information	BETTER
Theme 8 Policy	GOOD
<b>2022 OVERALL RATING</b>	<b>BETTER</b>

## 2. Procurement Approach – Vision and Aim

This strategy, and the wider approach to our procurement and commercial activities, are designed to ensure the purchase of goods, works and services required for the programme is handled in a transparent, timely and cost-effective manner with due regard to procurement and commercial best practice.

The strategy reflects a vision, aim and scope that is driven by a combination of both the wider local (ICS) landscape and that of NHS England, to meet the healthcare needs of the population, and therefore incorporates:

A **vision** for the organisation to deliver their commercial activity at best value for the best patient outcomes possible, ensuring the most appropriate commercial outcomes are considered.

An **aim** to provide, develop and continually enhance the following service



offerings, building on the benefits throughout:

- **Benefits for patients:** The healthcare services they need are delivered on time and of the best quality.
- **Benefits for clinicians:** They are equipped with the goods and services they need to deliver world-class care.
- **Benefits for the taxpayer:** The NHS is achieving value for every pound spent and delivering government priorities such as sustainability, NetZero and eradicating modern slavery.
- **Benefits for suppliers:** The NHS is easier to do business with, with opportunities to develop more innovative solutions to meet NHS and government challenges.

For the avoidance of doubt, this strategy applies to all goods and services acquired by the programme, both for capital, works, commercial contracts, clinical and for non-clinical purposes.

The procurement processes established for the development and delivery of the Hospital Transformation Programme is acknowledged by all programme stakeholders as being key to ensuring all goods, works and services will:

- Represent best value and appropriate quality,
- be market tested to ensure best price,
- be protected by legally enforceable contracts,
- be purchased in compliance with
  - the Trusts Standing Financial Instructions and
  - Public Contract Regulations (and Procurement Policy Notes).
- Procured in a way that supports delivery of Social Value and Net Zero Carbon government policy.

### **3. Commercial Principals**

#### **3.1 Procurement and Commercial Pipeline**

An effectively managed commercial pipeline will enable the programme and contracting authority to forward plan and map out clearly the expected future commercial activity (new contract or framework, or major contract change or extension) that it is likely to require. The pipeline can be used alongside other information on internal business planning and governance stages, and other related activities.

As defined by the *Government Commercial Functional - Commercial Pipeline* guidance, by mapping out this management information and keeping this regularly refreshed, organisations can:

- Give sufficient planning time for developing and executing a robust commercial strategy,

ensuring that all business and commercial options have been thoroughly explored.

- Outline when the required services are intended to be procured.
- Track commercial delivery.
- Give clear management information to inform current and future resourcing for commercial delivery.
- Reduce the need for unwarranted contract extensions by improved planning.
- Support progressive and timely assurance and approvals, including spend controls.
- Stimulate the supplier market, including small and medium-sized enterprises (SMEs) and

voluntary, community and social enterprises (VCSEs), to make it aware of future opportunities,

ensuring a competitive market exists.

- Ensure transparency when going to market.

### 3.2 Sourcing Routes

With a requirement identified, the potential options for procurement sourcing routes are:

- Open
- Competitive quotation
- Call off from a Framework agreement
  - Direct Award
  - Mini-competition
- Call off from a Dynamic Purchasing System
- Catalogue purchase
- Direct Award (*though Single tender actions will be minimised by an effectively managed commercial pipeline*)

### 3.3 Contract Management

Shropshire Healthcare Procurement Service, working across Shropshire, Telford, and Wrekin ICS (STW ICS) are in the processing of introducing new processing for Contract Management (CM), to include Market Intelligence (MI), and Supplier Relationship Management (SRM), all of which will set a strong foundation and consistent approach



to contract and supplier management across the ICS whilst identifying and realising efficiencies and cost improvements (CIP) and adding overall value.

Contract Management and Supplier Relationship Management, as two separate processes, will fall under the departmental Procurement Strategy and ultimately form part of the overarching ICS Procurement Commercial Strategy which will align to wider NHSE and the GOV Commercial Standards Framework.

Therefore, HTP commercial and procurement activities will adopt these methods and standardised processes.

A Contract Management Risk Classification tool will assess risk against the key commercial contracts of the programme, on a variety of risk parameters which will calculate a risk management level of gold, silver or bronze and how each contract will be managed going forward.

This will be managed via the *HTP Commercial Contract Oversight Group* that has been established during the OBC development stage by the HTP PMO.

SHPS and the Oversight Group will provide a clear and standardised approach to managing contracts for all goods and services purchased by HTP in line with that being implemented across the Shropshire ICS Trusts.

The objective of the Contract Management approach is to ensure contractual commitments and obligations from contracts and suppliers are effectively managed and monitored, and overall value for money and efficiencies are demonstrated. The benefits of doing so are described here:

BENEFITS OF CONTACT MANAGEMENT	
<b>Value for money</b>	<ul style="list-style-type: none"> <li>• Obligations and deliverables of the contract are delivered</li> <li>• Best value for money is achieved / CIP realisation</li> <li>• Budgets are met and managed effectively</li> </ul>
<b>Stakeholder Management</b>	<ul style="list-style-type: none"> <li>• Stakeholders are involved and informed</li> <li>• Stakeholders maintain a good working relationship</li> </ul>
<b>Governance</b>	<ul style="list-style-type: none"> <li>• Key stakeholder roles and responsibilities are clearly defined</li> <li>• All contracts and renewals are managed with minimal disruption and are properly documented and evidenced</li> <li>• All parties are informed and aware</li> </ul>
<b>Performance Management</b>	<ul style="list-style-type: none"> <li>• Performance is constantly monitored against the contractual terms and standard KPI's</li> <li>• Performance issues are identified and rectified</li> <li>• Relationship building and on-going added value</li> </ul>
<b>Net Zero and Sustainability</b>	<ul style="list-style-type: none"> <li>• Collaborative working enables suppliers to meet the NHS commitment to deliver a net zero, fair and transparent supply chain free of modern slavery no later than 2045</li> <li>• Processes are in place to monitor and manage commitments made by suppliers</li> </ul>
<b>Risk Management</b>	<ul style="list-style-type: none"> <li>• Reduce contractual risk through the robust contract management practices.</li> <li>• Disputes are managed and resolved in an appropriate manner</li> </ul>



Residual value risks	●
Financing risks	●
Legislative risks	●
Other project risks	●

#### 4.2 The chosen route to market

The ProCure23 (P23) design and construction framework is the chosen route to market for the HTP as it meets all the above criteria. It is managed by NHSE 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 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 the HTP is fundamental to ensuring value for money and risk optimisation from the supplier base informing the procurement strategy. This is due to the time and cost constraints of the scheme. The phasing has been further considered as part of this OBC. A key element of the phasing of the scheme is an early enabling works package utilising the P23 contractor. This minimises costs and reduces risk, helping to alleviate long-term inflationary pressure on vulnerable aspects of the project.

P23 ensures consistency with government policy, HM 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)

The Trust project team (including Procurement and Strategic Capital Estates leads) conducted early engagement with the NHSE Procure framework from the outset of the HTP planning to ensure the suitability of this framework for this investment.

#### 4.3 Market engagement

An Invitation-to-Tender (ITT) document was issued by the Trust to appoint a preferred P23 Contractor in line with the Master Programme.

Informal communication with the PSCPs progressed well which offered early indication of PSCP interest, given the scale of the scheme. Participation from the SaTH team included the Trust Executive Director and Non-Executive Director representation, HTP

PMO, Estates, Finance and Procurement leads, plus NHSE colleagues from the P23 framework and Regional Estates and Facilities.

The informal sessions were an opportunity for us to demonstrate the credibility of the HTP and in turn give the suppliers confidence in this significant commercial opportunity.

The points covered were:

- Local context & background to the HTP (business case and approval status / NHSE + MP + ministerial support / our approach)
- Leadership & support for the HTP within SaTH (Board, Exec Team and Senior Leadership / Clinical and Medical Support)
- Local system & the Integrated Care Board role (the HTP is a major programme of the ICS > SaTH are the lead organisation for delivery)
- The design & construction requirements (including the design baseline)
- Procurement process and next steps

It also gave opportunity for the 8 PSCPs to feedback their thoughts on our approach to the procurement and to inform the choice of evaluation methodology and criteria (in line with the options available to us within the P23 framework process).

### Procurement process

With the ProCure23 call-off process being utilised as the procurement vehicle to appoint a Principal Supply Chain Partner, the Client (Trust) as Contracting Authority, must ensure their framework call-off process follows the defined process steps as this ensures compliance with Public Contract Regulations 2015 (and any Procurement Policy Notes).

The Trust's Procurement function, with support where necessary from the P23 implementation advisor will ensure the P23 framework scheduled Call-Off Tools (provided by NHSE) are used correctly and in a way that delivers a robust process with a strong commercial outcome.

## 4.4 Competitive procurement

The competitive procurement process as defined within the chosen framework route considers both qualitative and price tenders from PSCPs.

Under the framework, the process stages are outlined in Table 2.

**Table 1:** Competitive procurement stages

Stage	Activity
1	Client registers with CCS, and details the project
2	Early engagement with potential bidders: Issue of communication to all 8 PSCPs (in Lot 3 >£70m)
3	Client drafts their Client ITT Brief (HLIP as was) and appendices, plus makes process decisions (inc. Lot, swing-o-meter, criteria etc).
4	Client holds informal joint Pre-Tender Engagement session(s) with all PSCPs
5	Client issues tendering PSCPs their Client ITT Brief + appendices
6	Client holds open day with tendering PSCPs
7	Each PSCP submits to Client their Quality tender and Price tender

8	Client evaluates and consensus scores the Quality tenders
9	Client scores, behind an ethical wall, the Price tenders
10	Client interviews and negotiates with tenderers
11	Client finalises their evaluation and score of Quality tenders
12	Client blends each tenderers Quality (70%) and Price (30%) score, as per the pre-defined swing-o-meter choice
13	Client appoints PSCP with highest combined Quality/Price score
14	Client feeds-back to all tenderers, plus Award notifications

To guide and document the call-off process The Trust utilise the P23 Call-Off and Price Tools provided by our NHSE P23 Implementation Advisor (IA).

The P23 IA acts as an advisor to the Trust team in support of the procurement activities.

The timeline of the procurement activity, in line with the stages set out in the P23 Call-Off process, is as follows:

**Table 2:** Timeline of procurement activity

Task	Date/time
Register schemes	14 <sup>th</sup> Sept 2022
Initial Informal Pre-Tender Engagement session: 8 x PSCPs & Trust Leads	2 <sup>nd</sup> November 2022
Follow-up Pre-Tender Engagement session	15 <sup>th</sup> February 2023
Issue Client Invitation-to-Tender Brief (CITTB)	3 <sup>rd</sup> March 2023
PSCP Open day:	
i) Introductions & Designer Forum	8 <sup>th</sup> March 2023
ii) RSH site walk	
iii) PRH Telford site walk	
PSCPs to confirm to the Client and IA whether they will be bidding for the scheme	14 <sup>th</sup> March 2023
PSCPs submit Initial Tenders	6 <sup>th</sup> April 2023
Client to assess Initial Tenders	11 <sup>th</sup> - 14 <sup>th</sup> April 2023
Moderation Interviews	21 <sup>st</sup> / 24 <sup>st</sup> April 2023
<i>Down-selection and further negotiation with short-listed PSCP</i>	w/c 24 <sup>th</sup> April 2023
<i>Evaluation Decision Trust Approvals Cycle</i>	From 28 <sup>th</sup> April
PSCP appointment	26 <sup>th</sup> May 2023
P23 Launch workshop	w/c 29 <sup>th</sup> May 2023
P23 pre-construction training for project team	w/c 5 <sup>th</sup> June 2023





[REDACTED]

#### 4.7 PSCP appointment

The Trust aims to secure the full design and construction services of the PSCP by the 26<sup>th</sup> May 2023. The services acquired are outlined in the Contract Award Report [Appendix C-06]. This will ensure that the PSCP can immediately feed into the Stage 2 design process and assist the Trust in market testing construction material packages of work to ensure essential elements are market tested to demonstrate value, providing cost certainty for FBC completion. The P23 appointment will follow the standard processes and have the appropriate level of sign off prior to the start of the engagement. Our system partners will be involved throughout the process, ensuring that the ICS agrees with the appointment.

The Trust/ICS local procurement function also run Meet-the-Buyer events which give opportunity to businesses in the local economy (as well as to regional, national companies). This event is to be offered to the successful PSCP to develop its local third-party contractor base which is in support of the commitments to Social Value criteria made during the procurement process (outlined in Section 3.2.4).

#### 4.8 Design Stages versus Procurement stages

Upon PSCP appointment, they will 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



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 FBC and implementation.

These services have been and will continue to 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 an appropriate framework route contract (the Trust currently utilises the NHS Shared Business Services Multidisciplinary Consultancy Services framework for example), or via locally procured appointments that are in line with our Standing Financial Instructions.

## **6.0 Equipping Procurement Approach**

The Trusts Medical Devices and Equipment strategy during OBC sets out a systematic approach to the acquisition, deployment, and maintenance requirements (preventive maintenance and performance assurance) for all medical devices and equipment required to facilitate the additional requirements for the HTP. All other existing services or departments directly impacted in relation to equipment by the implementation of the HTP within the Trust will be considered during the detailed design process of FBC.

The Equipment strategy recognises the nature of the acute and planned care hospital service requirements, and the amount of significant, general and specialist equipment that will be required.

Through the FBC process, the Trust will develop a more detailed understanding of the equipment requirements, including the amount to be transferred and the equipment which will need to be purchased new to facilitate the new build elements of the HTP.

The FBC will provide a detailed financial and technical analysis of the equipment requirements.

The high-level Equipment Strategy and Plan is set out in [Appendix C-05].

Key principles of the Strategy include:

- The Trust will maintain continuous availability of equipment to avoid any service disruption, during final fit out and commissioning of the development.
- The Trust will procure all medical and non-medical equipment directly with suppliers. The Trust will take some risk on delivery and design issues relating to the building and timing of supply.
- The Trust will make use of existing national and local frameworks where possible.
- Fundraising will be used to support an element of new equipment.
- The Trust, where applicable and where best value is achieved, will pursue a standalone managed service deal for the equipment.

- The Trust will consider lease purchase and managed service contracts as options where appropriate to the product (and with consideration given to the impact of IFRS16).

A new development of this size requires project management for the delivery, storage and logistics and this will be resourced appropriately with a specialist equipping project manager during the FBC process.

An Equipment Workstream will be established at commencement of the FBC. The Equipment Workstream will follow the principles of procurement set out in the Trust's Procurement Strategy.

The Equipment Workstream will be led by the Trust's appointed equipping project manager with support from the PSCP equipping specialist

A detailed project plan will be developed at FBC stage, and this will underpin the work of the 'Equipment Workstream'.

## **7.0 Digital Procurement approach**

All purchases will be made via a process that is compliant with the Public Contract Regulations and/or Local Standing Financial Instructions, to ensure the appropriate governance and value for money can be demonstrated.

The proposed method will be to use one of the national preferred frameworks as detailed in the Digital and Technology Procurement framework Strategy Recommendations published by NHSE wherever applicable and providing these are valid at the time of procurement.

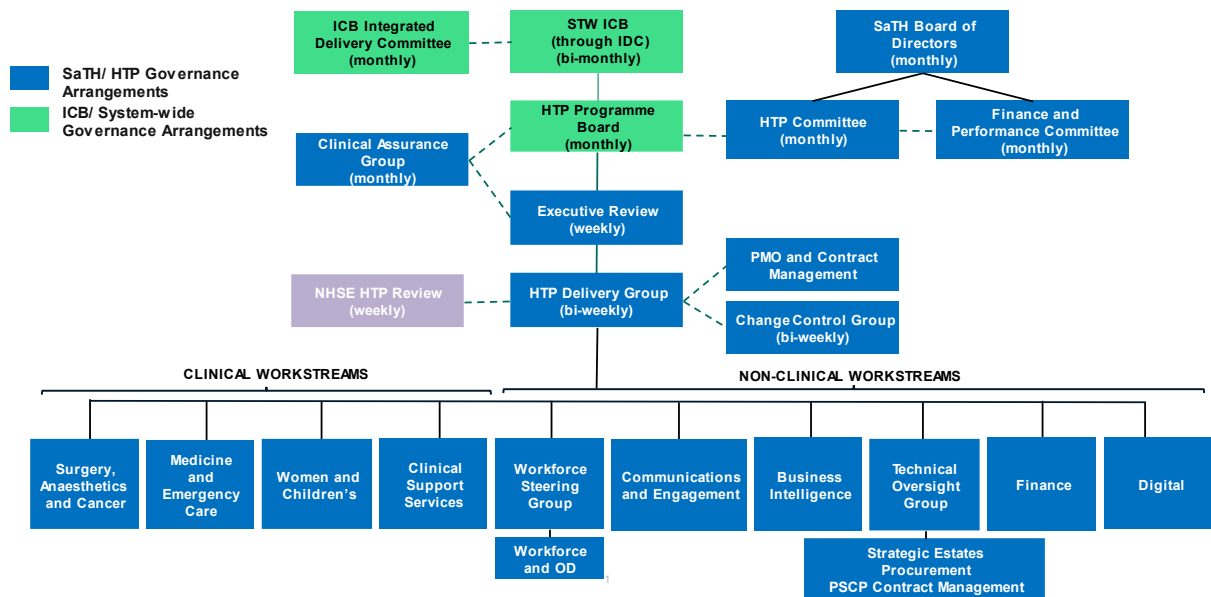
Where practicable, buying power will be leveraged to attain improved value for money (VFM), including but not limited to, the evaluation of shared instances and joint procurements relevant to the ICS.

## **8.0 Governance**

Internal governance will be aligned to the Programme and organisational structure that is implemented.

The procurement function of the programme will act in line with the Trust and local system (Shropshire, Telford & Wrekin ICB) (or approved structural) scheme of delegation, standing financial instructions and policies, ensuring these processes and practices are put in place and embedded into business-as-usual activities of the programme into its delivery stage.





Beyond internal governance, the procurement function will ensure delivery of statutory and policy obligations with particular focus given to:

- Public Contracts Regulations (and the Procurement Bill)
- Spend controls
- Terms and Conditions of contracts
- Public Policy Notes
- Data protection legislation

The HTP PMO and procurement function have established the **HTP Commercial Contract Oversight Group** which as well as the contract management approach described in section 3.3, also enables effective management of the following:

- Pre-award activities – strategic sourcing, contract negotiation and contract award. For further information on these activities please refer to the Commercial Policy and Procedures and SHPS procurement manual.
- Purchase to pay – process to raise requisitions, purchase orders and process payments promptly.
- Strategic supplier relationship management to unlock value release opportunities
- Delivery of relevant national category strategies such as those introduced by the NHS Central Commercial Function

# The Shrewsbury & Telford Hospital NHS Trust Stage 2 Report



## Hospitals Transformation Programme

The Shrewsbury and Telford Hospital NHS  
Trust

HTP-AHR-XX-XX-RP-A-04300

Stage 2 Report

# Hospital Transformation Programme

## Project team

Architect	AHR
Urban Design and Landscape Architecture	FIRA
MEP Engineer	DSSR
Structural Engineers	Ramboll
Transport	Systra
Helipad Design	WSP
Sustainable Construction Services	DSSR
Cost Consultant	Edmond Shipway
Fire Engineer	OFR

### Revision

Version	Issue Status	Version date	Dr By	App By	Comment
P01	Issued	17 February 2023			

# Contents

<b>1.0</b>	<b>Introduction</b>			
1.1	Introduction	05		
1.2	Executive Summary	06		
<b>2.0</b>	<b>Project Brief</b>			
2.1	Executive Summary	08		
	Programme	22		
	Functional briefs	23		
<b>3.0</b>	<b>Architecture</b>			
3.1	Context	163		
3.2	Design Implications of the hospital site			
3.2.1	Interaction with the hospital site	164		
3.2.2	Interaction with access routes	165		
3.2.3	Interaction with public spaces	165		
3.2.4	Topographical issues	165		
3.3	Character and innovation			
3.3.1	Aesthetic and movement	166		
3.3.2	Design rationale	166		
3.3.3	Atmosphere	166		
3.4	Use			
3.4.1	Safe delivery of healthcare	167		
3.4.2	Clinical demand and flexibility	168		
3.5	Access			
3.5.1	Universal access for all	169		
3.5.2	Movement	170		
3.5.3	Service access	170		
3.5.4	Fire strategy	170		
3.6	Space			
3.6.1	Layout	171		
3.6.2	Efficient spaces	171		
3.6.3	Bedroom options	172		
3.7	Forms and materials			
3.7.1	Surrounding environment	173		
3.7.2	External materials	173		
3.8	Design development	174		
3.9	Quality of environment			
3.9.1	Modelling concepts	181		
3.10	Security strategy			
3.10.1	Terrorism / threats to life	183		
3.10.2	Malicious damage	183		
3.10.3	Theft	183		
3.10.4	Disruptive behaviour	183		
3.11	Drawings and Plans			
	Schedule of accommodation	185		
	Existing department RSH	188		
	Building numbering	195		
	Existing department PRH	196		
	Enabling works RSH	200		
	GA plans	206		
	Elevations and sections	210		
	Typical bay section	213		
	Site phasing	214		
	Location plan	216		
	Departmental area plans	217		
	GIA plans	218		
3.12	Modern methods of construction strategy			
3.12.1	Introduction	219		
3.12.2	Targets	219		
3.12.3	Key elements	219		
3.12.4	Strategy	219		
3.12.5	Implementation	219		
3.12.6	MMC maturity	220		
3.12.7	Project standardisation	220		
3.12.8	Conclusion	220		
4.0	Structural engineering	22`		
5.0	MEP reports	245		
6.0	Environmental design	307		
7.0	Landscape	332		
8.0	Helipad design	337		
9.0	Traffic and transport assessment	353		
10.0	Fire Strategy	392		
11.0	Acess, servicing and maintenance strategy	415		
12.0	Cost plan	418		
13.0	To be endorsed	419		
	Appendix A - Architectural	420		
	Appendix B - MEP	490		
	Appendix C - Structural	589		

# Introduction



**1.1 Introduction**

During the development of the 2016 Strategic Outline Case the Trust considered how services could best be configured across the two sites (PRH and RSH) based on the need to provide:

- One Emergency Department(ED);
- One Critical Care Unit, to be co-located with the ED;
- Two Urgent Treatment Centres (UTC), one at each site
- A clinically optimum balance across the two sites (PRH and RSH)

One site would host the Emergency Department, Critical Care Unit & Women & Children's services becoming the Emergency Site. The site which accommodates the standalone UTC and Surgical Centre would become the Planned Care site. In January 2019, the CCG's approved Option 1 of the Public Consultation on:

RSH - Emergency site

PRH -Planned care site

This document sets out the brief and how it has been developed into a concept design for the project, through the early stages of the Outline Business Case. The document is intended to allow the Trust to endorse specific key principles and will identify areas which require further development before the next stage, scheme design (RIBA 3) is concluded.





## 1.2 Executive Summary

The design proposals have been developed in close collaboration with the Trust teams and Clinical Working Groups to support Service Transformation and deliver the Clinical Vision. In developing solutions for the Hospital Transformation Programme (HTP), the designs resolve a number of legacy issues on the site which are currently hampering effective and efficient clinical care.

The Brief considers the two sites holistically and is underpinned by the drive for efficiency highlighted by the Carter Report and the evidence-based principles developed by the Virginia Mason Institute.

At the centre of all the brief is the drive to improve the Patient Experience- ensuring Privacy and Dignity throughout and creating an environment that not only promotes and supports healing, but recognises the importance that staff and family well-being play in achieving this.

Flexibility and Adaptability are integral parts of the Brief, enabling departments to flex in the short-term and provide valuable adaptable assets which are well-placed to support the Trust in meeting the future healthcare needs of its patients.

The Functional Content derived from the clinical model has evolved into a baseline Schedule of Accommodation that further develop the illustrative space standards.

This baseline schedule represents a target to be achieved as far as is practicable and indicate how the services and functional units are required to be split across the Emergency Care Site and the Planned Care site.

A series of User Engagement sessions and workshops have been undertaken with the Clinical teams, which has informed the brief for the hospital-wide adjacencies, departmental flows, and functional content. It should be noted that since original clinical brief was first developed, there have been significant changes in operational practices arising out of the recent pandemic and technological advances since the inception of the project in 2016.

Although the HTP relates to the Royal Shrewsbury site (RSH) and Princess Royal Site (PRH) the Stage 2 Concept design report predominately focuses on the RSH site, as this has been developed in the most detail. Works at PRH will be outlined in the Stage 3 report. In broad terms the concept design provides 30,000sqm of accommodation as follows:

A 3200sqm emergency Department and Emergency Care facilities at Royal Shrewsbury Hospital (RSH), through the remodelling and expansion of the existing Emergency Department

- Expanded ambulance provision with full cover for 10 ambulances
- Enhanced patient drop off facilities
- A relocated Helipad
- A refreshed Urgent Care centre at Princess Royal (PRH)
- A 3200sqm Acute Medicine, Assessment and short stay Acute Medicine unit
- A 980sqm Early pregnancy and GATU unit in new Build accommodation
- A new Entrance, Reception and Hospitality offer for RSH
- A new 2500sqm Birthing Suite with collocated Midwifery Led unit in New Build Accommodation
- A new 1200sqm Neonatal unit (co-located with the birthing suite)
- A new 1850sqm Maternity inpatient unit in new accommodation
- A new 3200sqm Children's Centre in new accommodation with dedicated external play areas
- A new 2500sqm Critical Care unit in new accommodation with

dedicated "sky Decks" to assist in patient recovery

- A new 1500sqm Oncology and Haematology ward in new accommodation
- A new 1450sqm general inpatient ward

The concept design illustrated in this document has been developed in line with many Government initiatives and although not subject to many of the standards established in relation to the New Hospitals Program (NHP) has, where possible, followed the principles and targets contained within the NHP

In particular, the concept design is based on the following key principles:

- Provision of 72% single beds excluding short stay beds
- Planned on a well-established planning grid of 7.8m x 7.8m which is utilised by many of the P22 standard room configurations and is structurally efficient
- Uses Flat slab construction to minimise floor to floor heights (typically 4.4m) and maximise flexibility for service distribution
- Uses the grid to allow efficient use of standard materials and components
- Adopts the principle of "repeatable rooms" using templates derived from initiatives such as P22 Standard rooms, to reduce costs and increase flexibility
- Employs Standard Assemblies which can be utilised across the scheme.
- Designed to take advantage of Modern Methods of Construction (MCC)
- Places sustainability and Net Zero Carbon (NZC) as a key driver in design decisions, taking advantage of the existing building infrastructure where possible (Remodelling Emergency department and the use of Mechanical Ventilation and Heat recovery (MVHR))
- Minimising temporary works and replacement of existing

accommodation

The design solution illustrated is robust and deliverable, with phasing, decants and temporary works all developed in parallel with the Concept design.

The proposal for each site is consistent with the updated Development Control Plan for the long-term management of the Estate and combines best practice from elsewhere with a detailed understanding of the specific needs of clinical teams.

2.0

Stage 2 Report

# Project Brief

# Project Brief

The following pages illustrate the information that has been gathered by the design team in order to inform the development of the concept design.

## 2.1 Executive Summary

The design proposals have been developed in close collaboration with the Trust teams and Clinical Working Groups to support Service Transformation and deliver the Clinical Vision. In developing solutions for the Hospital Transformation Programme the designs resolve a number of legacy issues on the site which are currently hampering effective and efficient clinical care.

The Brief considers the two sites holistically and is underpinned by the drive for efficiency highlighted by the Carter Report and the evidence-based principles developed by the Virginia Mason Institute.

At the centre of all the brief is the drive to improve the Patient Experience- ensuring Privacy and Dignity throughout and creating an environment that not only promotes and supports healing, but recognises the importance that staff and family well-being play in achieving this.

Flexibility and Adaptability are integral parts of the Brief, enabling departments to flex in the short-term and provide valuable adaptable assets which are well-placed to support the Trust in meeting the future healthcare needs of its patients.

The design solutions should be robust and deliverable, with phasing, decants and temporary works all developed in parallel with the final solutions.

The proposals for each site should be consistent with the Development Control Plan for the long-term management of the Estate and combine best practice from elsewhere with a detailed understanding of the specific needs of clinical teams.

The Functional Content derived from the clinical model has evolved into a set of baseline Schedules of Accommodation that further develop the illustrative space standards.

These baseline schedules represent a target to be achieved as far as is practicable and indicate how the services and functional units are required to be split across the Emergency Care Site and the Planned Care site.

A series of Task & Finish Group Engagement sessions and workshops have been undertaken with the Clinical teams, which has informed the brief for the hospital-wide adjacencies, departmental flows, and functional content. It should be noted that since original clinical brief were first developed, there have been significant changes in operational practices arising out of the recent pandemic and technological advances since the inception of the project in 2016.

This brief should be developed over an established planning grid and the team is expected to undertake preliminary studies of 1:200 departmental layouts to validate the assumptions inherent in the planning grid.

The planning module establishes a discipline within the design to enable the building shell and service distribution design to be progressing while detailed decisions about room functions and arrangement of activities are still ongoing.

Wherever possible the design will utilise the Repeatable Rooms developed as part of the P22 process. This strategy of developing a standard room configuration can significantly reduce the amount of user and design team consultation time, create standardisation across the estate, and offer procurement savings offers clear benefits, and the design team will be developing further repeatable rooms for use on this project, for areas which have not yet been produced within the P22 Framework.

To obtain further benefits, the scheme will, wherever possible utilise the P22 Standard components. The principles of this will be expanded by the design team to produce Standard Assemblies which can be utilised across the scheme.

The new build elements of the scheme will be designed to maximise the opportunities to utilise Modern Methods of Construction (MMC).

The engineering services will be adapted, and where necessary system capacities increased, at each site to suit the proposed new developments and aligning with the proposed phasing. The implications on each primary service have been considered and have been discussed with the Trust's Estates personnel. The scheme will be aligned with national, NHS and Hospital targets in working towards Net Zero Carbon.

As a result of pressure to increase the extent of clinical accommodation and manage the anticipated impact of higher than expected inflation, the design team has been tasked with finding new ways of meeting the brief and re-evaluating previous assumptions about the site and how it could be best developed.



Briefing for the OBC stage of the HTP design process commenced in August 2022 with individual clinical user engagement sessions timetabled. The clinical user sessions set out the assumptions and functional briefs as they had been concluded at the completion of the Strategic Outline Case in late 2019.

Whilst many of the assumptions remained true, the intervening period of 3 years had resulted in the clinicians requesting updates to the functional briefs (and associated Schedules of accommodation). These changes typically arose as a result of one of the following:

- Changes in anticipated clinical activity (either increase or decrease) as a result of demographic trends established over the last 3 years
- Changes in anticipated clinical activity as a result of changes in clinical practice
- Changes in Clinical practice as a result of lessons learned from the COVID 19 pandemic

In addition to these clinical changes, the recent pandemic also ushered in new non-clinical working practices which has resulted in a lower level of administrative activity taking place on site. As a result of the above there have been several changes that may have a direct impact on the content of the scheme.

Finally, whilst there was a generous allowance made in the cost plan for inflation of 8%, recent events and global pressures have resulted in the current inflation rate for construction running closer to 12%. With a fixed grant allocation for the project this hike in forecast inflation inevitably translates to pressure on the SOA, challenging teams to find ways of limiting (or reducing) the extent of built accommodation.

### Stakeholders

- Estates Team, SaTH
- Senior management
- Estates and Facilities
- Human Resources department
- IT department
- Finance
- Clinical working groups
- Local CCGs
- Shropshire Council
- Telford and Wrekin Cooperative Council
- NHSEI
- Local Residents & Businesses
- Patients
- Visitors

### Critical care

Recent trends in clinical activity in Critical Care indicate that the original capacity of 30 beds is likely to be exceeded shortly after the planned opening of the new centre and as a result it has been requested to increase the number of beds from 30 to 32

### Medical assessment

New models of care have identified a need to increase the capacity of Acute Medical assessment (and decrease the associated capacity of the accident and emergency department) this has resulted in the accommodation which was originally identified as general inpatient accommodation being fully utilised by the Acute Medical specialty for a range of short stay bedded accommodation.

### Accident and Emergency

As noted above the shift of activity in the emergency platform will result in a reduced level of activity for accident and emergency, thereby reducing the anticipated schedule of area (SOA) associated with the A+E department

### Inpatient bed accommodation

As noted above the extent of true inpatient bed accommodation (originally envisaged as 4 no. 32 bed wards) has reduced by 2 now wards as a consequence of the shift to Acute Medicine. Furthermore, the prevalence of single bedrooms (72%) has resulted in one of the remaining wards being allocated to Oncology and Haematology, to allow for greater separation of vulnerable patients.

### Maternity and Delivery

Current trends in demographic data suggest that the anticipated capacity of the Maternity and Delivery department developed in 2016 will be outstripped within 5 years of opening the new building. Furthermore recent concerns regarding safety at other Delivery suites have raised concerns around the use of single elective theatres and emergency theatres. Finally Clinicians have expressed the view that there is a very real need to provide a co-located midwifery led unit, in addition to stand alone Midwifery led units and consultant led units.

The following changes to the schedule of accommodation have therefore been requested:

- increase the number of Maternity inpatient beds
- increase the number of theatres from 2 to 3
- retain the co-location of midwifery led delivery rooms (previously omitted in the re-submitted SOC)
- Administration and welfare space

The 2016 SOC had a reasonable allowance for off-ward support offices and centralised changing and staff rest areas. In order to contain the gross floor area, the 2022 SOC removed this space. It has been determined that this accommodation (where possible) should be sourced from refurbishment of existing accommodation rather than new built accommodation.





The design strategies for each of the sites and the architectural proposal will be developed through a close collaboration with the Clinical Working Groups and a clear understanding of the Programme drivers, Development Control Plan, Clinical Model and overall Trust Vision.

### Service Planning Assumptions

- In planning the facility requirements, certain key service planning principles have been established by the Sustainable Services Programme. These include:
  - The emergency route in to the Emergency Site (UCC & ED) will be via a single door;
  - Emergency and planned care facilities to be separated from each other;
  - Ambulatory Emergency Care is provided on the Emergency Site only
  - The balance of services across the emergency and planned care sites has been agreed in detail through iterative dialogue with Trust clinicians; some
  - specialties, such as breast surgery and bariatric surgery, are exploring how to develop their services on the planned care site as centres of excellence;
  - Cardiology is exploring the development of a Centre of Excellence on the Emergency Site.
  - Critical Care – physical capacity will be provided for 32 spaces; work is being undertaken to establish the staffed capacity to be provided from day 1 of the new unit opening;
  - Any proposed solution must be affordable and deliverable

### Design Strategy Drivers

The drivers behind the design strategy, which address legacy issues and maximise opportunities are consistent across both sites and evident through each of the options:

- Creating a more compact building footprint
- Embedding Lean Principles from the outset
- Separating Public, Blue Light and Service Traffic
- Improving flows internally and externally and reducing conflicts and cross flows between service, patient and public movements
- Improving departmental adjacencies
- Rationalising entrances and improving way-finding
- Using Evidence-based design to provide high-quality patient focused spaces

Accessibility of the building, is an integral part of the overall strategy to improve access to services. The design proposals are developed in the context of a Trust- Wide Travel Plan, and in the context of local and wider transport strategies and initiatives, and considerations such as public transport, car parking and cycle access are integral in the design of the site plan and landscaping.

The External Spaces will contribute to the Trust's aspirations for biodiversity and environmental enhancement, and the hard landscaping design will contribute to the coherence and legibility of the overall site. Each hospital site recognises and values its role within its community and consideration will be given as to how to expand the positive contribution each makes to the local area.

Rationalising entrances will reduce confusion and simplify site-wide directional signage; Unifying central spaces via elements such as an atrium will assist with orientation and way-finding and provide a central hub of information for patients and visitors. The opportunity to provide a food concession at the entrance caters for the changing needs of the hospital throughout the day, flexing in scale and offer to align with customer needs. The ability to adapt these spaces for a variety of uses is efficient and effective enabling this space to be used as an 'airport-style' lounge offering real-time information and high quality facilities for patients awaiting appointments within departments elsewhere within the site. The creation of a compact 3-dimensional building will make the shared use of central facilities a very deliverable solution.

Considered interior design, integrating art, way-finding and furnishings, will create a sense of place, and can make a genuine positive contribution to healing. Spatial quality and natural daylight promote well-being in staff and visitors and careful selection of quality durable materials ensure that the new facilities remain vibrant and functional for many years. The design will strive for inclusivity, recognising the diverse needs of the building users. Designs will be dementia-friendly and through engagement sessions the specific needs of user groups can be recognised. The value of outside space will be promoted within the design, using Sky-gardens for children's play areas and terraces and courtyards for reflective moments.

Designing patient- focused environments, respecting the need for privacy and dignity through all stages of care is paramount and the design team will continue to promote the development of innovative solutions and strategies to support this.

Design proposals should recognise that the building will need to be inherently flexible, throughout the day, to meet seasonal shifts and to adapt over time to a changing clinical need. Space utilisation opportunities should be maximised through careful consideration of adjacencies and the creation of multi-use spaces. Efficiency will be further maximised by detailed integration of the servicing and delivery strategy and integrating the lean techniques developed from SATH's collaboration with the Virginia Mason Institute.

Deliverability will be drive the design from the outset, with coherent phased solutions across both sites created to minimise disruption to the hospital operation and revenue streams and deliver the new clinical model and its resulting benefits as early as possible. The scheme will be designed to maximise the potential to utilise Modern Methods of Construction (MMC)

### Patient Area Standards

Due to significant cost pressures, derogation against space standards may be considered as the design is developed, but only after detailed circinal planning of affected rooms has been undertaken to assess the likely impacts of the derogation. In principle, standard guidance will be followed as deemed applicable to the engineering requirements of the project.

### Natural light and ventilation

Where practical, the design of the building should incorporate window designs to provide good natural daylight and access to external views from beds and seating areas. Evidence suggests there is a clear relationship between indoor daylight environments and a patient's average length of stay in hospital, this, together with access to fresh air and control of ventilation and the room environmental conditions has a therapeutic benefit to patients, enhances the working environment for staff and contributes to the wellbeing of all occupants. To prevent any reduction in the positive effects of maximising daylight within the building Solar gains will be controlled by a combination of measures including:

- Natural shading from recessed windows and overhanging eaves
- Building orientation
- Internal, or interstitial, blinds
- External planting of trees
- Building Information Modelling (BIM)
- note, External shading above the windows should be avoided to reduce maintenance costs

In accordance with the Government Construction Strategy, the project will be delivered to BIM Level 2, and will benefit from the collaborative behaviours and efficiencies in production that result from this method of design and delivery.

### Statutory Compliance

All buildings within the scheme will be designed and constructed in accordance with the principles and provisions of the suite of HTM documents which form the Firecode Series.

All buildings within the scope of the project will be designed and constructed to meet the requirements of all sections of the Building Regulations.

### Patient Space Standards

New Build areas of the scheme will be designed to align with HBN Standards or P22 templates where available, supported by Best Practice captured from successful schemes delivered elsewhere, and complemented by the efficiencies offered by the use of the Repeatable Room templates.

### Security

The design should integrate security design elements and considerations that address the delivery of patient care services in a safe and secure environment. The design of individual elements of the scheme should consider the recommendations of recognised standards such as the Park Mark safer parking scheme and the Secured by Design Guidance for Healthcare Premises. The scheme will meet the Regulatory and licensing requirements for Storage of Control drugs etc. and will work the user teams and IT workstreams to develop proposals which do not compromise security of information and data. The Security policies and brief will be developed in conjunction with the Trust's Security Adviser.

### Meeting the needs of patients and staff

The Trust has a vibrant Critical Friends Group that has contributed to discussions on design. This will continue as the project develops. The Trust also has a successful Communication Strategy which includes extensive engagement with patients past, present and future.

Where appropriate, the inpatient wards will be designed to enable parents and carers to stay overnight in the room with patients, supplemented by relatives lounges and shower facilities. Relatives rooms will be available for Neonatal parents. New food and beverage offers will be introduced to meet the needs of staff and visitors throughout the day and night. Where appropriate, new build in-patient areas will incorporate Gender- Specific day rooms.

### The Components of the Brief

Through the Clinical Working Groups and Task and Finish groups, the design team will develop hospital wide adjacency matrices and adjacency diagrams. These adjacencies will identify a hot core of existing clinically intensive space which becomes the heart of the scheme, with the related and dependant departments wrapping around as a mix new build and refurbished accommodation. This briefing information, together with the draft operational policies and clinical model establish the functional content of the scheme, which can then be developed by the Healthcare planners using HBN Guidance and best practice from elsewhere to form Schedules of Accommodation.

### Sustainability and Energy Strategy

The design team will review options and make recommendations for the most suitable Sustainability and Energy Strategy that will provide significant benefits for SATH and the wider environment. This work-stream consists of two primary considerations:

- Energy use in the day to day operation of the campus and its constituent buildings
- The carbon emissions generated by them

The developed design should review the energy and carbon targets required by legislation, and funding requirements and ensure that the energy targets are met, operational carbon is minimised and the performance gap between design intent and build reality is avoided.

## Design Guidance / Standards

A wide range of documents will be used to inform the design. These include the following:

### Health Building notes

The Latest Health Building Notes (HBN) which are applicable to the proposed accommodation are as follows:

HBN 00-01	General design principles	HBN 04-02	Critical care
HBN 00-02	Sanitary spaces	HBN 08-02	Dementia-friendly Health & Social Care Environments
HBN 00-03	Clinical and clinical support spaces	HBN 09-02	Maternity care facilities
HBN 00-04	Circulation and communication spaces	HBN 09-03	Neonatal
HBN 00-07	Resilience planning for the healthcare estate	HBN 12-01	A Supplement A: Consultation, examination and treatment facilities – Supplement A: Sexual and reproductive health clinics
HBN 00-08	Strategic framework for the efficient management of healthcare estates and facilities Estatecode	HBN 14-01	Pharmacy and Radio-pharmacy
HBN 00-08	Estatecode – Land and property appraisal	HBN 15-01	A&E
HBN 00-09	Infection control	HBN 6	Volume 1, Facilities for diagnostic imaging and interventional radiology. Volume 2, PACS and specialist imaging
HBN 00-10 A	Flooring	HBN 15	Accommodation/Facilities for pathology services
HBN 00-10 B	Walls & Ceilings	HBN 23	Hospital accommodation for children and young people
HBN 00-10 C	Sanitary Assemblies		
HBN 00-10 D	Windows & Associated Hardware		
HBN 02-01	Cancer Care – facilities for cancer services		
HBN03-02	Facilities for child and adolescent mental health services		
HBN 04-01	Adult in-patient facilities		
HBN 04-01	Schedules of accommodation		
HBN 04-01 A	Isolation rooms supplement		

### National Hospitals Programme Design standards

Whilst the project is not part of the National Hospitals Programme (NHP) it is suggested that the standards which have been developed as part of this initiative be shadowed in the HTP.

### Statutory regulations

The development shall comply with the requirements of the local Planning Authority and the works shall comply with the current Local Authority Building Regulations, EC Regulations and Directives, HSE rules, all relevant British Standards and Codes of Practice, IEE Regulations, the recommendations of the Fire Officer, the Public Health Officer, manufacturer's literature and the appropriate trade bodies good works practice guides.

The developments will be designed and constructed to standards in full compliance with the Equality Act 2010.

Relevant standards include:

- The Health and Safety at Work etc Act 1974 (HSWA)
- The Workplace (Health, Safety and Welfare) Regulations 1992, together with its Approved CoP's
- The Equality Act 2010 (EQA)
- The Regulatory Reform (Fire Safety) Order 2005 (RRFO)
- The Control of Substances Hazardous to Health Regulations 2002 (as amended) (COSHH)
- The Building Regulations
- Construction (Design and Management) Regulations 2015
- Environmental Protection Act 1990;
- Site Waste Management Regulations 2008

### BREEAM

The developments will be designed in accordance with the recommendations within the latest BREEAM design document for offices to achieve a BREEAM rating of 'Excellent' and an EPC rating of A.







The Royal Shrewsbury Hospital is located on the north side of Mytton Oak Road to the west of the town centre.



1. Outpatient department and entrance



2. Emergency entrance and SDEC

The Royal Shrewsbury Hospital is located on the north side of Mytton Oak Road to the west of the town centre. The hospital was founded in 1979 following the closure of the Royal Salop Infirmary which had occupied a position in the centre of Shrewsbury. The current estate of the Royal Shrewsbury Hospital was formed by merging of the Copthorne Hospital and Copthorne Maternity Hospital which were situated either side of Mytton Oak Road. In 2004 Copthorne Hospital closed and all departments transferred across to the main site on the north side of Mytton Oak Road. This historical context as part of a wider health campus is reflected in the nature of the surrounding context. Some new healthcare accommodation has been constructed in the form of the Redwood Mental Health Facility to the west of the site, while historic hospital estate to the North West is currently being converted to Residential. There is extensive new build low rise residential taking place to the south of the hospital site, and existing residential to the North and East.

The hospital in its current form occupies a site of approximately 21 hectares, with a variety of building types and scales. A large proportion of the site is single or 2-storey, but includes a 5 storey ward block. The estates mix dates from the 1970's up to the present day. The architectural style of the campus is eclectic with a wide variety materials and design approaches.

As a result there is no cohesive architectural language for the site enabling a new development to respond to the immediate context and design brief rather than having to align with any restrictive site wide aesthetic.

The topography of the site at Shrewsbury offers both challenges and opportunities with a 3 storey level change across the site. While this currently presents some significant challenges with circulation and way-finding from entrances at different levels it presents some interesting opportunities for vertical zoning. There are a series of significant existing retaining structures associated with these level changes evident throughout the site.

The Royal Shrewsbury Hospital has not had the benefit of being developed within a cohesive masterplan, and has been developed over a period of time in a piecemeal manner. As a result of this departmental adjacencies are sub-optimal, circulation routes, both horizontal and vertical are indirect and indistinct, and there is no segregation of flows of visitor, patient and FM traffic. The site has large areas of single storey accommodation, resulting in a linear footprint and extended travel times between these departments and a lack of efficiency as a result.

SATH has been very successful in accessing various government funding initiative in the period since the original SOC was submitted. As a result a number of further developments have taken place which are relevant to the HTP, most notably a significant refurbishment of the existing A+E department and the addition of a modular Same day emergency Centre (SDEC)

Key departments are 'land-locked' by narrow public circulation routes, compromising clinical adjacencies and reducing patient dignity. Existing building footprints and section heights are inappropriate for use as modern effective clinical space and the condition of the existing estate is poor in many instances.








The lack of a clear architectural style means that entrances are not clearly defined, both in terms of their location and architectural style. Multiple entrances compound this problem and the lack of open orientation spaces make way-finding is very challenging. The sightlines to A&E are blocked by temporary accommodation and shielded from view by existing buildings. The site externally, though benefiting from some areas of green space is not a coherent overall site and the existing hard landscape and soft landscaping do not contribute to way-finding or opportunities for social or personal use.

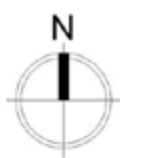
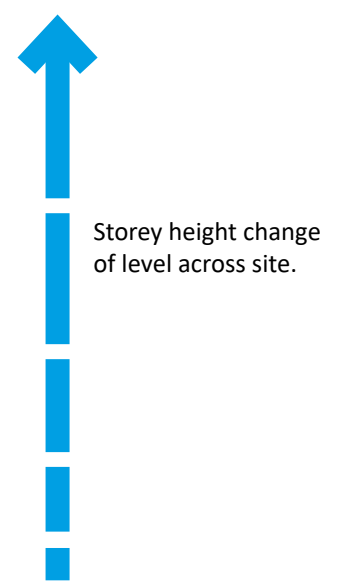
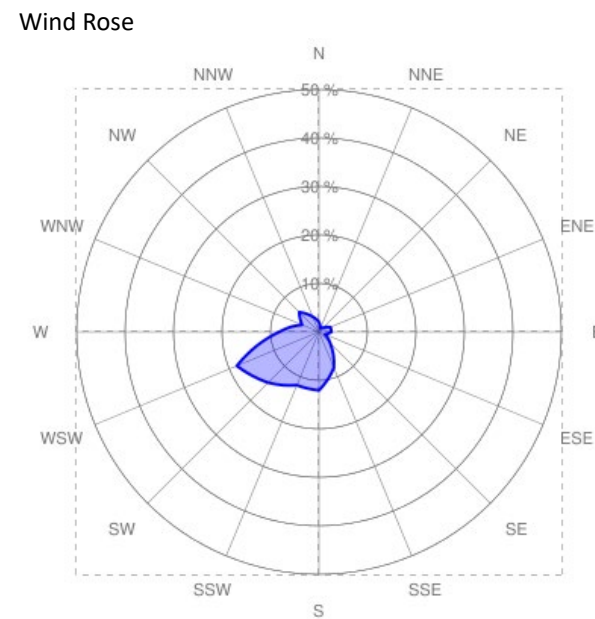
The new development should seek to address these issues in order to deliver a truly sustainable future for the RSH site.



- A: Recent good quality clinical accommodation
- B: FM and Non-Clinical accommodation in core clinical space
- C: Clinical Support accommodation
- D: Low Rise Congested deep plan 'hot' clinical accommodation
- E: Recent good quality clinical accommodation

- F: Education and Conference Zone
- G: Largely Vacant land - primary access to Hospital

-  Hospital Street
-  Mature Trees to Boundary
-  Noise
-  Hospital Entrance
-  Sun Path
-  Photograph Locations
-  Level Change





- ..... Visitor Pedestrian Routes
- ..... Visitor Car Routes
- ..... Service Routes
- - - - - Blue Light
- - - - - Staff Routes
- - - - - Fire Tender Access
- - - - - Public Transport Route
- - - - - Recycling & Waste Service Route
- ▶ Hospital Entrances



- A:  
Service Zone
- B:  
Day Case / Treatment Centre
- C:  
Renal
- D:  
Education / Admin
- E:  
Support Services
- F:  
Theatres
- G:  
In Patients
- H:  
Emergency / Diagnostic
- I:  
Radiotherapy
- J:  
Outpatients
- K:  
Residential / Admin
- L:  
Empty Maternity
- M:  
Mental Health







The Princess Royal Hospital (PRH) site covers approximately 14 hectares and lies in the north-east of Telford, to the north of Wellington.



Main entrance



Women and childrens

The Princess Royal Hospital (PRH) site covers approximately 14 hectares and lies in the north-east of Telford, to the north of Wellington. The PRH site is surrounded by woodland, effectively screening it from surrounding roads and developments. The site was developed in the late 1980's following the 'Nucleus' design philosophy, with a repeating cruciform pattern of departmental templates, linked via a main corridor or 'hospital street'. It was originally designed as a single entity, with further extension and development over time, most notably the construction of the Women & Children's Unit which was completed in 2014. Surrounding buildings comprise Clinical Uses in the form of Melling Health and the Severn Hospice. Family homes bound the northern and eastern edges of the hospital site.

The natural topography of the site is gently sloping, but in the construction of the original building and subsequent developments, the levels have been altered by moving earth to open areas of the site, which has resulted in localised banking and level changes. Vehicles access the site from two alternative entrances, and buses are able to undertake a through-route across the site. This dual entrance enables segregation of service vehicles from public and blue light traffic, and there is a further perimeter route which 'fast-tracks' blue light vehicles to the Emergency department without being obstructed by visitor traffic. There is site wide resilience enabled by a circular route around the site.

The existing buildings are 2-storey brick built structures with pitched roofs, planned as a series of nucleus templates around a series of courtyards. There are separate pedestrian entrances for Emergency and Main entrance users, although these are signified by signage rather than intuitive measures within the architecture. Secondary entrances exist for the Women & Children's Unit, the MLU and Day Hospital and the Fracture Clinic/ termination of the hospital street.

The site overall feels 'leafy' and 'green' and there is evidence of the use of external spaces socially by both staff and visitors. There is street furniture along the South-facing pedestrian path between the hospital and visitor car parking. The site connects to the adjoining Silken Way cycleway.

The existing nucleus templates and hospital street enable effective circulation; the majority of internal traffic utilises the ground floor street, with the first floor route less congested. There is a mixture of visitor patient and FM traffic; while this is generally able to be accommodated within the width of the hospital street, there are some serious challenges presented by the integration of pedestrians, bed traffic and tugs.

The existing main entrance is cluttered and congested, and retail and catering opportunities are not maximised. Way-finding is heavily dependent on signage, and users may find themselves walking a considerable distance from the main entrance to access their relevant departments.

Within the template wards and departments, glazing is limited, and views from beds are restricted. Central staff areas within departments have no access to daylight. The existing hospital street has large areas of glazing to the internal courtyards and feels lights and airy but courtyard spaces are generally unoccupied and underused.

As with the RSH, SATH has been very successful in sourcing alternative forms of funding and several of the key projects envisioned under the HTP have been implemented already including the creation of a new entrance and the formation of the elective care hub.









A: Recent good quality clinical accommodation

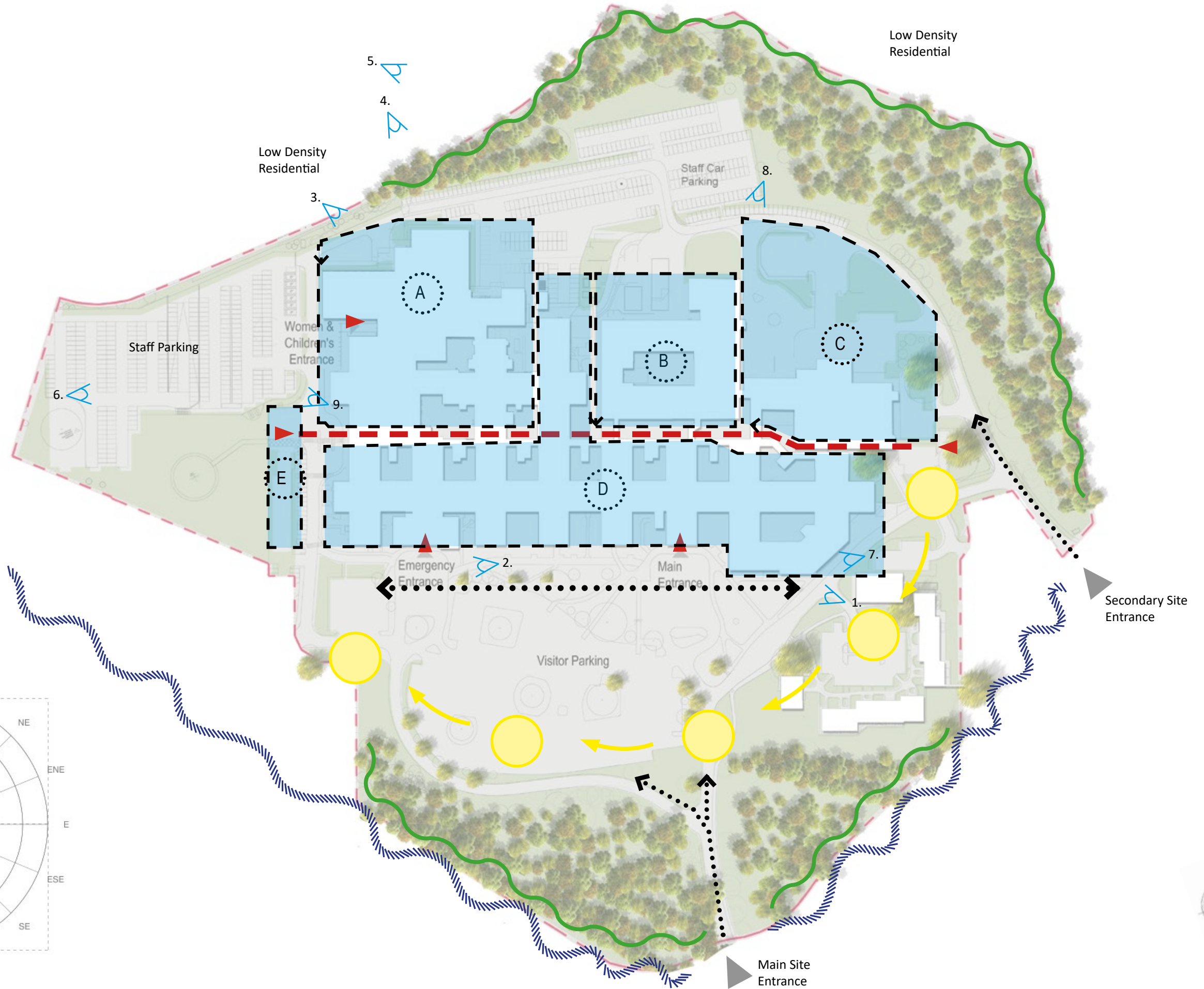
B: Clinical & Non-clinical support

C: FM & Service Accommodation

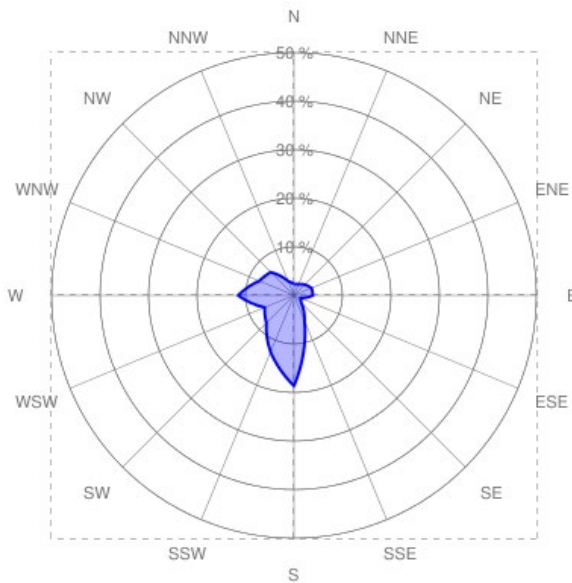
D: Nucleus templates, cruciform blocks

E: Temporary Buildings

-  Hospital Street
-  Mature Trees to Boundary
-  Noise
-  Hospital Entrance
-  Sun Path
-  Photograph Location



Wind Rose





- ..... Visitor Pedestrian Routes
- ..... Visitor Car Routes
- ..... Service Routes
- - - - - Blue Light
- - - - - Staff Routes
- - - - - Fire Tender Access
- - - - - Public Transport Route
- ▶ Hospital Entrances



- A:  
Women's and Children's
- B:  
Theatres and Wards
- C:  
Clinical and Non-Clinical
- D:  
Service Zone
- E:  
MLU
- F:  
Day Hospital
- G:  
Out Patient / In Patient
- H:  
Emergency / Diagnostic
- I:  
Temporary Accommodation
- J:  
Residential / Offices

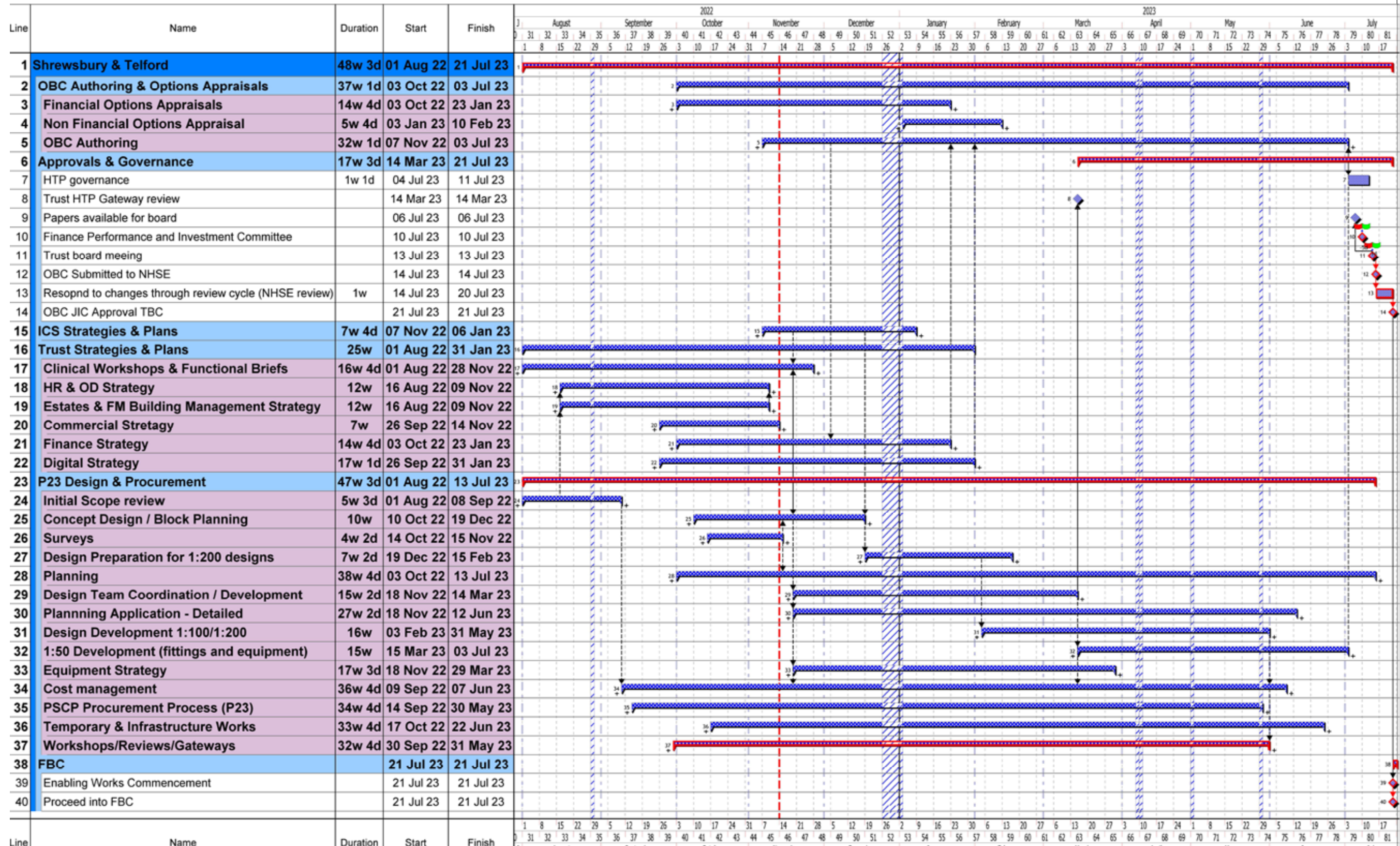




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For Information Only





Recent events have proved that innovation and digital technology can transform the way services are delivered in the NHS. Covid-19, saw 6000 hospital outpatient consultations being conducted remotely in the UK (HSJ, 2020) and has created an environment which is now much more receptive to technological change for system transformation. We must be ready to take advantage of this to bring about a positive impact on activity and how and where clinical services are delivered.

The digital journey is gathering pace. The increase in Diagnostic Wearable Devices, compatible Electronic Patient Records, wider use of Telemed consultations and an increasingly technologically adept population will provide health professionals with greater volumes of data, which in turn will require new method of analysis to optimise the healthcare estate to respond in new ways to realise the potential to reduce healthcare costs, increase access and improve outcomes.

However the NHS has been slow to respond up until now with many of the technologies remaining relatively immature in the healthcare sector and with no clear scalable new models of care have emerging worldwide due to technologies which are siloed in specialist areas of interest; a UK hospital environment that has yet to fully digitised its systems of record and therefore uses multiple system platforms to construct the electronic patient record, with many parts still in paper form; Technology organisations which largely approach system design from a traditional data entry perspective, failing to acknowledge the context of time pressed physicians, surgeons, allied professionals and nurses.; and finally a general under investment in technology and infrastructure, resulting in patchy, unreliable connections, poor speed performance and slow login times.

All of which frustrates a workforce, which though often keen to adopt better systems is left with low levels of trust in Information Technology (IT) and poor compliance contributing to sizable issues with data quality.

The HTP has the potential to overcome the above issues, by utilising the following key principles:

Patient and staff experience- safe and integrated-useful and usable to support effective decision making and planning

Smart Buildings- embed a digital culture and improvement method.

To benefit from technological advancements- to revolutionise delivery of patient care, and improve environmental and social elements of healthy hospital

Core infrastructure – integrate into trusts network, safe and secure, value and cost focussed and flexible

Digital information systems- actively managed clinical and corporate systems to facilitate improvement on the delivery of patient services etc.

Digital devices- that enhance productivity and efficiency of both patient and staff experience- gathering and using data for research and education

the brief must emphasise the ethos that “A digital hospital should be seen less as a specific item and more as a ‘way of doing things digitally”.

### 1. Patient and staff experience

The project needs to ensure that barriers to uptake are addressed within early engagement, identifying any concerns the Stakeholders may have about reliability, training, cost and privacy. Addressing the benefits of technology within a naturally risk-averse environment requires a full organisational culture shift within the Trust, which the Estates solution can support. we are able to much more effectively apply appropriate technology.

### 2. Smart Buildings

The ability of buildings to interact directly with users and staff and streamline operations and logistics is not new. AHR worked with Cleveland Clinic Abu Dhabi, 10 years ago where they made extensive use of, IR tagging of patient rooms to enable housekeeping to map patient movements and react quickly to patient discharge, “turning the room around” within minutes of a patient’s departure to reduce “down time” and maximise the inpatient accommodation.

More recently The royal college of Physicians at the Spine – their state of the art Platinum Well standard building in Liverpool, utilised a wide range of sensors to monitor and display air quality (carbon dioxide levels), noise levels and energy usage, to ensure that users understand their environment and how it is being controlled. As a result of this the college is expecting to see significant improvements in neural activity and work performance which result in savings of up to 25%.

### 3. Core infrastructure

Projects such as Cleveland Clinic, Abu Dhabi, make the best use of their world renowned Cardio Thoracic surgeons in Cleveland Ohio for their middle eastern operation by creating digital theatres that are fully digitally enabled to allow operations to be guided from the US as they were being undertaken. Cleveland Clinic also featured widespread use of PIXIS automated dispensing units to place prescribed medications at the fingertips of doctors and nurses.

The computer-controlled dispensing cabinets were installed in the patient tower, as well as throughout the interventional floors, to order, dispense and track medicine, allowing the clinicians to spend more time caring for their patients. The computer controlled nature of the units, combined with local fridges, keep an electronic record of transactions and provide real-time reports detailing who removed what drug, when and for which patient, as well as alerting the pharmacy to the need to replenish supplies.

### 4. Digital information systems

Digital information will become a given in the Hospital of the future. Automated image interpretation in radiology and pathology as utilised at Cleveland Clinic, Abu Dhabi will lead to faster diagnosis. transforming patient-generated data into clinically useful information and empowering patients to manage their own health decisions.

Telemedicine services including telephone triage and video appointments has grown exponentially during the covid-19 pandemic, breaking down the public inertia which has previously dogged the adoption of this kind of technology. The impact on this technology on the spatial requirements of acute care is already feeding into accommodation schedules and typologies, hich can significantly reduce the direct patient flows through the building, reducing the intensity of healthcare services, as well as reducing the associated travel journeys and impact on people’s lives to receive medical treatment. This will allow SATH to create advantages for the building to be much more adaptable to future changes in the needs of users of the building.

Genomics also has the potential to transform healthcare with more accurate diagnoses of a broader range of diseases with a genetic basis. To gather, organise, store and manipulate the vast quantities of information involved the new hospital will need to refocus some of their accommodation away from the traditional “clinical” settings. A smaller palette of room types with greater flexibility is the most likely way of meeting this fast-evolving branch of medicine . Projects such as Akershus, AUH incorporated design flexibility allowing them to reduce the number of room types from over 150 to just 25,

Similarly, the changing profile of the population and the growing awareness of the danger posed by global pandemics means that all clinical space needs to be capable of rapid transformation. The use of modularity of inpatient rooms with Acute care and step-down care differentiated only by staffing ratios rather than type of room was a key design driver at Cleveland Clinic Abu Dhabi, where all of the 100% single rooms in its 18 storey inpatient tower can be converted to intensive care rooms with minimal renovation and all rooms are telemetry capable.

### 5. Digital devices

Our Design team are at the forefront of many of the most innovative and technologically advanced developments across the globe. Projects such as Cleveland Clinic Abu Dhabi, made extensive use of AI-based technologies using “Hidden” Automated Guided vehicles (AVG) on service decks for collection and transportation of used and clean laundry, waste transportation and pharmacy supplies.

This approach has reduced direct Labour costs, avoids workforce shortages and increases productivity as well as avoiding mistakes. DaVinci robotic systems have been implemented in its operating theatres and automated testing is used in the central laboratories for the performance of highly repetitive tasks, replacing human operators in the preparation and transport of specimens, with robotic devices. Laboratory automation consolidates the control of multiple different analytical instruments to a smaller number of operators, thus reducing the costs in laboratory testing. The system is believed to speed up results by 40% and improve efficiency and accuracy in the lab, where more than 150,000 patient samples are incubated and tested each year.

In addition to the above, Mott MacDonald have produced a research paper detailing how Digital information can be successfully implimented. this paper identified the the importance of the ‘Golden Thread’ of data in realising the potential of the various technologies and supports the Mott MacDonald mdoel of a “Digital anatomy”-

- Digital Vision - understanding and contextualising the strategic need for a state-of-the-art digitally-led healthcare is critical if the project is to realise the potential offered by technology.
- Patient and staff experience - recognise that the hospital is considered as the healthcare provider of choice for mucjh of teh poulation by utilising patient and staff-centred digital design, while driving new models of care, thereby directly influencing and informing the digital environments created.
- Digital estate – Utilising high-level best-in-class practices and protocols with respect to Building Information Modelling (BIM), is critical, but without an appropriate interface with operational Facilities Management, the model itself has only limited value. Smart Enterprise Asset Management (SEAM) and digital twinning needs to be considered at the outset in order to ensure that this information rich environment is developed appropriately and efficiently.
- Digital, technology and innovation- is constantly evolving and therefore systems must be adaptable and open ended if new technology is to be successfully integrated.
- Culture and partnerships- acknowledges that not all healthcare providers are at a similar point in their evolution. Clients must understand the technology offered and be willing to drive through the necessary organisational changes that underpin the adoption of new technologies if they are to be successful. Digital champions, at an appropriate level within the organisation, play a key role in the success of the initiatives.
- Integration and optimisation- is only achievable if the initiatives identified above are interlinked in a holistic way, with all members of the client team, design team, construction team and staff committed to achieving the vision for a digital hospital.

# Architectural Strategy



# Architectural Strategy

## 3.1 Context

The 2016 SOC proposal and subsequent 2022 approval sought to realise the delivery of the HTP as noted in the brief and reduce the extent of "Backlog" maintenance through the demolition of a large part of the site (primarily stores and Catering) and replacement with new stores, catering. During the development of the brief and subsequent analysis of the detailed cost plan it has become clear that the budget (which was established in more the 6 years ago) is insufficient to achieve these two goals. It is also in many ways incompatible with the increased emphasis on Net Zero Carbon design, which seeks to reduce, not just carbon in use but embodied carbon too. As a result, in late November 2022, the trust and design team proposed a radical change to the original design intent and explored the feasibility of re-locating the site of the major building work from the northwest of the site (option B) to the southeast (option G)



### 3.2 Design Implications of the Hospital Site

Interaction of the design with the public spaces, other existing and proposed buildings both within and external to the campus and access routes.

#### 3.2.1 Interaction with the hospital site

The new location is very well connected and integrated into the site, utilising and strengthening much of the existing site infrastructure.

The original hospital, inevitably, was organised around the Emergency department and retaining and expanding the Emergency department ensures that the most critical linkages (to imaging and Theatres) is retained. The creation of a dedicated Acute Medicine (Assessment & short Stay Wards) adjacent to the Emergency Department and Emergency Care facilities, centred around a new entrance to the hospital, places the key critical functions of the hospital in the optimum place for time sensitive clinical care and provides a clear entrance and orientation point for effective Hospital wayfinding.



Site plan

**3.2.2 Interaction with access routes**

**Vehicular Traffic** - The location of the new main entrance, is directly opposite the major public car parking and connects into the existing hospital circulation road to create a new drop off which will afford improved access to the hospital for visitors and patients arriving by car.

The existing Ambulance Bay is expanded to increase capacity from 4 to 10 ambulance bays, all of which are protected by a canopy to improve patient transfer.

To the south of the building a discrete entrance connects directly to the central core and will allow easy access for non-emergency ambulance and patient transfer to all departments within the new building.

**Public Transport** - The site layout also envisages re-allocation of the existing layby near the existing patient tower as a cost efficient and convenient means of providing an appropriate level of access for the existing public transport links within the site.

**Cyclists** – Cycle provision at this stage has been considered to be provided on the edges of the existing car parks.

**Pedestrians** – existing pedestrian routes around the site tend to follow the vehicular routes in this location and most pedestrians within the site will have arrived via car or bus. There is very little pedestrian movement to and from Mytton Oak road to the south. However, the building is designed to provide a covered link through the creation of a ground floor overhang which will provide shelter for pedestrians all along its eastern façade and via canopy.

**3.2.3 Interaction with public spaces**

The site is semi-rural in nature, sitting as it does on the edge of the rural market town of Shrewsbury. Public spaces within the current hospital are somewhat limited with few natural gathering spaces, with a predominance of simple footpaths cutting through grassed areas. Where there has been investment in landscaping it is typically provided to allow quiet contemplation and relief, such as the recently completed Captain Tom's Garden; or for exercise, whether that be outdoor Gyms or nature and walking trails.

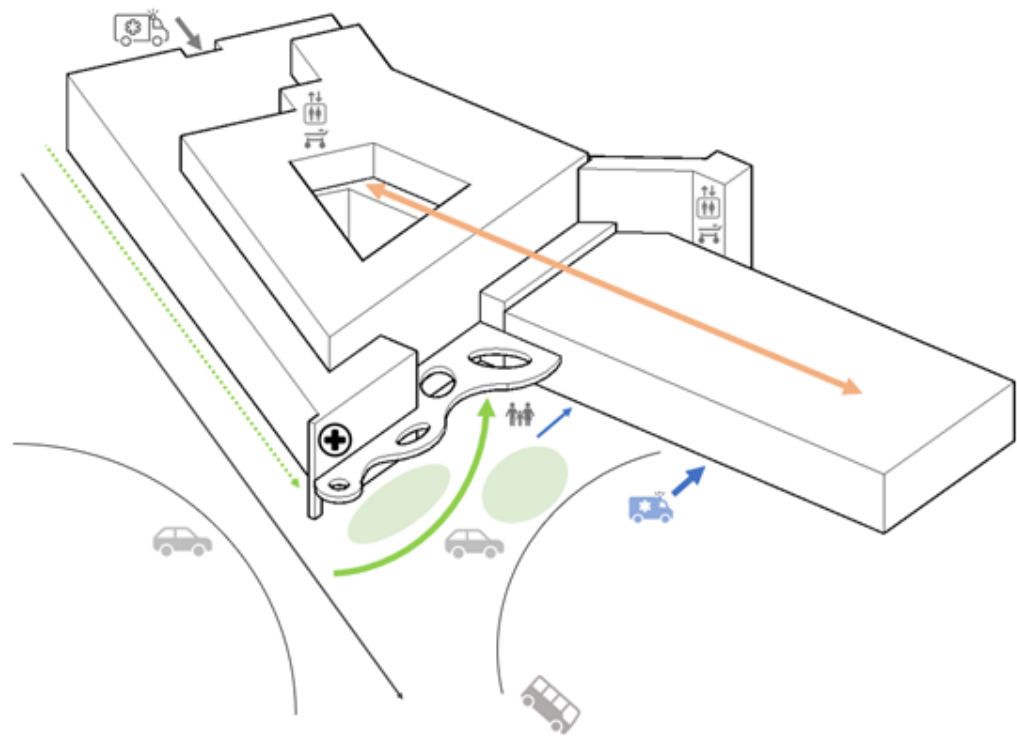
In this context the design forms two key public spaces:

**Entrance plaza** – which features an organic layout mixing hard and soft landscaping to facilitate movement and integrate the building into the existing network

**Central Courtyard** – a new large sheltered green space which can accommodate external dining from the entrance catering facilities as well as provide light and views from the bedrooms which surround it at the upper levels.

**3.2.4 Topographical issues**

The site is essentially flat, sitting at the notional level 1 (Upper Ground) of the overall site but has significant change in level at its western edge, where the ground falls away by around 3m to the lower ground level. It is therefore proposed to utilise this change in level to create a strip of heavy plant accommodation which includes switchgear etc which will also act as a retaining wall.



Cross section

3.3 Character and innovation

This is how well the design provides a coherent, legible, and stimulating solution which makes a positive contribution to the neighbouring environment and is in line with the overall values of SaTH.

3.3.1 The project facilities are interesting to look at and move around in

As noted in the concept sketches, we have sought to create an efficient building which is legible and avoids deep plan space to consistently offer patients, staff, and visitors an environment which is stimulating and plays a positive role in the health and well being of its inhabitants.

The large central courtyard is visible from the entrance and central core to help visitors locate themselves within the context of the whole hospital and new building. The existing outpatient building is incorporated into the development, via a top-lit double height space which links it to the new accommodation. It is intended to retain the existing patterned concrete cladding (cleaned up) which will provide a striking texture as the sun moves throughout the day and provides a tactile counterpoint to the new building and provide a focal point for the entrance.

To the north of the new building, the clinical accommodation is linked back to the new clinical core which sits adjacent to the Emergency Department, via a generous corridor which looks out over the main entrance.

3.3.2 There is a clear, distinctive design rationale and philosophy to the building

The site is quite constrained with the main Hospital circulation tight to the east of the site, and a secondary road forking off to the east at the southern end of the site. To the sets of the site is an emergency access road and the large change in level. To the north of the site is the existing Outpatients entrance and Emergency department, creating a roughly triangular plot.

3.3.3 An inspiring and welcoming atmosphere which express the values of SaTH

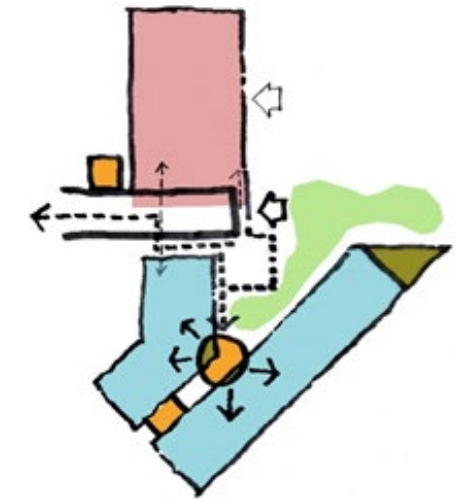
Located at the main public entrance of the site, the newbuild element of the project will form the new face of Royal Shrewsbury Hospital and is considered by the planners to be of critical importance to the success of the project. It is therefore imperative that the new building is perceived as being of high quality and embodies the key concepts of the Shrewsbury and Telford Hospital's values.

The project is unashamedly modern looking and has employed three key elements to express the above values:

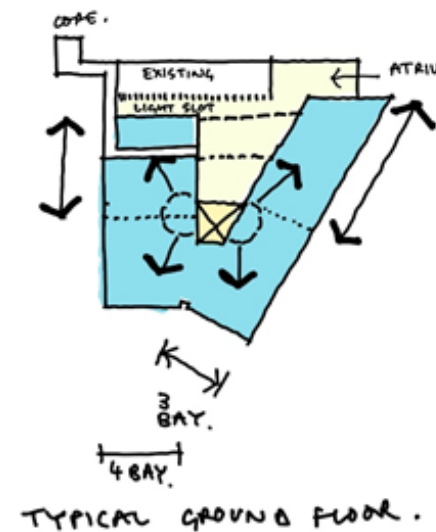
- A welcoming covered veranda is formed under the protective mass of the building, fringed with low level planting and taller trees to provide a soft caring edge to the building
- The cladding re-imagines the original concrete panels with an elegantly proportioned lighter flatter appearance and uses a high-quality stone like material to provide a logical, durable, and efficient visually interesting façade treatment
- At the entrance a series of flowing canopies and planted gardens lead visitors into a new, entrance space which features a small café with views to external terraces and a double height link to the rest of the hospital



Initial concept



Final concept



Developed Building concept



Ground floor plan

The concept illustrated above was developed around two orthogonal grids which are rotated through 30o to reflect the site geometry and allow the building to utilise efficient planning as much as possible with cores accommodating the non-orthogonal angles.

The rotated geometry allows the building to create a large central courtyard, which links to the main entrance both internally and externally via a café and sheltered terrace, to create a rational and legible building which offers a wide range of internal and external spaces to accommodate patients, visitors, and clinical staff.





### 3.4 Use

The way in which the project facilities enable the users to perform their duties and operation. The design needs to be developed to optimise the use of the project facilities considering the objectives listed below.

#### 3.4.1 The design facilitates safe, dignified, and efficient delivery of healthcare

The key components of the accommodation are arranged over 4 floors in response to the capacity of each floor and the critical adjacencies and patient traffic and privacy.

##### Ground floor

The Ground floor places the emergency department to the north of the entrance (directly adjacent to the imaging and theatres) taking advantage of the recently refurbished elements of the emergency department and expanding and remodelling the rest of the existing accommodation to provide safe and effective clinical accommodation to match the expected increase in emergency activity.

To the south of the new entrance is placed the acute medical department which works in tandem with the adjacent emergency department. The Acute Medicine department features an assessment area (closest to the emergency department) and short stay bed accommodation in the finger block to the east.

The final element of the ground floor is the gynaecology department, which is located to the southwest of the central core and adjacent to the southern entrance to the building. This location allows discreet access and egress, with separate egress for EPAS and GATU.

##### First floor

The first floor accommodates the birthing suite which is linked to the southern entrance and main entrance via the central core (which features 2no. dedicated Bed lifts as well as 2no. public passenger lifts). The birthing suite is also linked to the emergency department to the north via a new pair of bed lifts which allow direct transfer to the ground floor clinical facilities without crossing public circulation.

Directly adjacent to the Birthing suite is the Neonatal department which also has its own reception off the central core.

The final component of the first floor is a 32 Bed standard ward

which features 72% single beds and can, if required, function in tandem with the short stay ward below to support the AMU. Like the birthing suite, the 32 Bed ward has its own dedicated entrance off the core and is also linked back to the emergency department via the new dedicated bed lift to the northwest.

##### Second floor

The second floor accommodates the maternity inpatient accommodation in the eastern wing and the children's centre to the south and west.

The children's centre is divided into 3 key components

- the Children's assessment unit which is located to the north closest to the dedicated patient lifts adjacent to the emergency department
- the Daycase unit, which is also located to the north, allowing convenient access to the main theatres
- the children's inpatient accommodation, which provides access to an enclosed external terrace

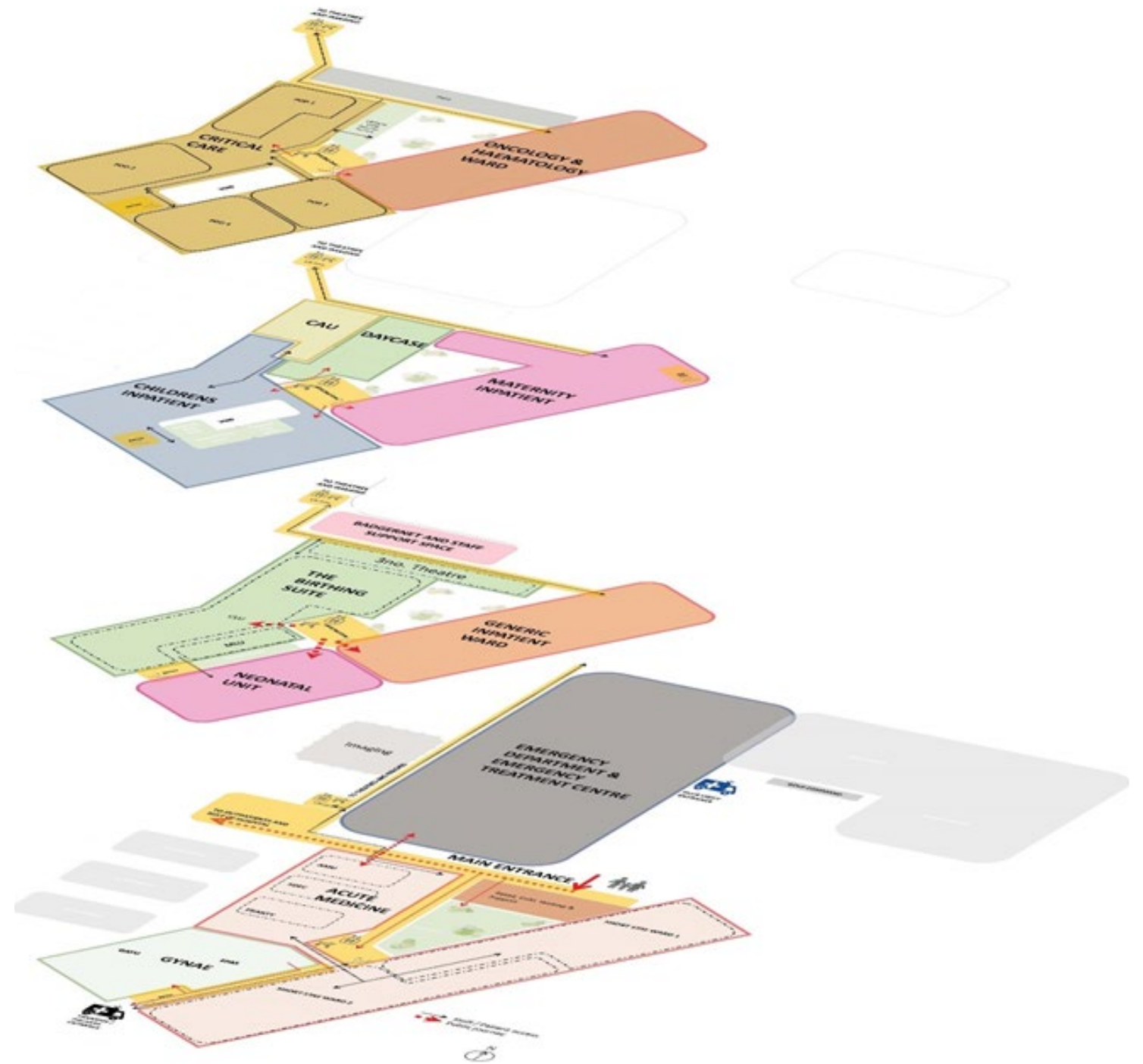
This arrangement allows a single main reception, accessed from the central core, and facilitates good clinical zoning to keep day-patients separate from inpatients.

The maternity inpatient accommodation is accessed from the central core allowing quick and efficient transport from the birthing suite below

##### Third floor

The final floor houses the Critical Care unit (which is divided into 4no. 8 bed wards) and the oncology and haematology ward (to take advantage of the high proportion of single bedded accommodation)

This is the smallest inhabited floor plate and uses this to its advantage to create patient terraces to aid clinical treatment and recovery.



Departmental adjacencies



### 3.4.2 The design optimises SaTH's ability to manage the projected clinical demand and future flexibility

The project has been designed around a standard grid which is 7.8m wide to provide the most efficient way of accommodating the high proportion of single ensuite bedrooms (based on the P22 template). This arrangement allows every bedroom to be identical, whether it is within the oncology and Haematology ward, maternity inpatient ward, children's ward, or general inpatient ward. The same principle has been applied to the 4 bed wards (also based on the P22 template) once again maximising flexibility of use between departments.

The 7.8m grid, combined with the concrete flat slab construction, also allows more extensive reconfiguration of walls and services should this be required in the future.

This flexible arrangement is supported by 2 clinical cores, as noted previously. The central core provides a high level of support for patient movement via the 2 dedicated patient lifts, which are linked to a discreet entrance to the south of the building to facilitate patient transfer via non-blue light ambulance, to all floors. The northern core is intended to be used by patients and clinical staff only, for rapid movement between the upper floors and key central facilities such as imaging and theatres, without compromising patient dignity or public movement.

The two lift cores are supported by 2 further stair cores which allow rapid movement of staff between floors – particularly the north-eastern core which links the ground floor short stay and first floor inpatient wards.



Entrance Plaza



3.5 Access

Linkages of spaces and the quality of these linkages, ease and safety of ingress and egress, universal access provisions, evacuation arrangements, vehicular access, with internal accessibility arrangements.

3.5.1 The layout of the project facilities provides universal access for all

Our design for the project provides for genuinely barrier free access following best practice and legislation. Our design aims to achieve the following as part of the design process:

- To maximize access to all parts of the development, its facilities and services for people who are patients, students, visitors, and members of staff regardless of disability and as required by local, regional, and national policy
- To ensure that appropriate standards for accessibility are met at the outset and as part of mainstream inclusive design wherever possible
- Inclusive design means designing beyond the minimum requirements of the Building Regulations to ensure that all people, regardless of age, sex or ability can use and enjoy the built environment
- The scheme will be designed to address the anticipated, substantial increase of older people in proportion to the working-age population in the near future and their needs
- To follow design guidance given in relevant British Standards and other currently published good practice guidance about meeting the needs of disabled people

The common parts of the development, including the exterior approaches, public spaces, facilities and routes between car parking spaces and public transport, are therefore designed to be as inclusive as possible.

Accessible and attractive access to adjoining pedestrian routes has been created through the use of a new public plaza at the new entrance, this accommodates the level changes to provide level thresholds with the ground floor of the building, which also includes the provision of 8 disabled car parking spaces immediately opposite the main entrance.

An accessible drop-off point is also provided within the new entrance plaza for passengers of cars, taxis, or minibuses so that walking distances are reduced. There are also two large existing patient and visitor carparks to the east of the development, and it is intended to increase the overall capacity of the site by adding car parking decks of these.

A barrier free entrance draft lobby with automated sliding doors is to be provided, avoiding the need for revolving doors and their associated difficulties for less able users.

Once inside the building, floor plates are step-free and meet the requirements of the building code. The building is relatively large, but all essential facilities are suitably distributed to minimize walking distances. The building has dual lift access to upper floors to allow access to an alternative lift should one break down.

WC facilities are provided on all levels, including entry level, in order to minimize walking distances. A changing places WC is also provided at ground floor in the entrance area.

Department travel time in minutes & Seconds	main entrance	imaging	surgery	majors	UTC	paediatrics	resus	AMU - assessment	AMU - short stay	Gynaecology	Birthing	Neonatal	Inpatient ward	Childrens assesment unit	Childrens Daycase	Childrens Inpatient	Maternity Inpatient	central staff changing	Critical Care Unit	Oncology & Haematology
main entrance	01:01	01:34	00:43	00:07	00:16	00:43	00:14	00:37	00:55	01:52	01:52	01:52	02:14	02:14	02:07	02:07	02:42	02:07	02:07	02:07
imaging	01:34	00:33	00:16	00:21	00:29	00:21	00:57	01:38	01:49	02:10	02:53	02:44	02:18	02:29	02:52	02:59	02:39	02:38	02:38	02:52
surgery	01:34	00:33	00:16	00:17	00:54	01:01	00:14	01:30	02:07	02:21	02:43	03:26	03:17	02:51	03:01	03:25	03:32	03:11	03:11	03:25
majors	00:43	00:16	00:17	00:20	00:07	00:07	01:13	01:21	01:02	02:26	03:09	03:00	02:34	02:44	03:08	03:15	02:54	02:54	03:08	03:08
UTC	00:07	00:21	00:54	00:20	00:07	00:07	00:36	00:44	01:24	01:49	02:31	02:23	02:34	02:07	02:31	02:38	02:17	02:16	02:31	02:31
paediatrics	00:16	00:29	01:01	00:07	00:07	00:07	00:07	01:06	01:24	02:10	02:53	02:44	01:56	02:50	02:52	02:59	02:39	02:39	02:52	02:52
resus	00:43	00:21	00:14	00:07	00:07	00:07	01:19	01:27	01:45	02:31	03:14	03:06	02:39	02:50	03:14	03:21	03:00	02:59	03:14	03:14
AMU - assessment	00:14	00:57	01:30	01:13	00:36	00:57	01:19	00:14	00:32	01:29	01:29	01:29	01:51	01:51	01:44	01:44	02:39	01:44	01:44	01:44
AMU - short stay	00:37	01:38	02:07	01:21	00:44	01:06	01:27	00:14	00:32	01:29	01:29	01:29	01:51	01:51	01:44	01:44	03:05	01:44	01:44	01:44
Gynaecology	00:55	01:49	02:21	01:02	01:24	01:24	01:45	00:32	00:32	01:47	01:47	01:47	02:09	02:09	02:02	02:02	03:30	02:02	02:02	02:02
Birthing	01:52	02:10	02:43	02:26	01:49	02:10	02:31	01:29	01:29	01:47	00:14	00:14	02:01	02:11	01:29	01:29	01:29	02:36	02:36	02:50
Neonatal	01:52	02:53	03:26	03:09	02:31	02:53	03:14	01:29	01:29	01:47	00:14	00:14	01:36	01:36	01:29	01:29	01:44	01:44	01:44	01:44
Inpatient ward	01:52	02:44	03:17	03:00	02:23	02:44	03:06	01:29	01:29	01:47	00:14	00:14	01:36	02:46	01:29	01:29	01:36	03:10	03:10	03:24
Childrens assesment unit	02:14	02:18	02:51	02:34	01:56	02:18	02:39	01:51	01:51	02:09	02:01	01:36	01:36	00:07	00:07	00:41	02:14	02:14	02:28	02:28
Childrens Daycase	02:14	02:29	03:01	02:44	02:07	02:50	02:50	01:51	01:51	02:09	02:11	01:36	02:46	00:07	00:07	00:31	01:10	02:24	02:39	02:39
Childrens inpatient	02:07	02:52	03:25	03:08	02:31	02:52	03:14	01:44	01:44	02:02	01:29	01:29	00:07	00:07	00:14	01:34	01:29	01:29	01:29	01:29
Maternity Inpatient	02:07	02:59	03:32	03:15	02:38	02:59	03:21	01:44	01:44	02:02	01:29	01:29	00:41	00:31	00:14	01:41	01:29	01:29	01:29	01:29
central staff changing	02:42	02:39	03:11	02:54	02:17	02:39	03:00	02:39	03:05	03:30	01:29	01:36	02:14	01:10	01:34	01:41	02:34	02:49	02:49	02:49
Critical Care Unit	02:07	02:38	03:11	02:54	02:15	02:39	02:59	01:44	01:44	02:02	02:36	01:44	03:10	02:14	02:24	01:29	01:29	02:34	02:34	00:14
Oncology & Haematology	02:07	02:52	03:25	03:08	02:31	02:52	03:14	01:44	01:44	02:02	02:50	01:44	03:24	02:28	02:39	01:29	01:29	02:49	00:14	00:14

Travel distance matrix

### 3.5.2 The project facilities are easy to move around in

A new main entrance is provided for the whole hospital with immediate access to the emergency facilities, outpatients, and acute medical services, linked to a new public plaza with enhanced disabled parking and drop off space.

This main entrance sits at the heart a rationalised hospital circulation system which creates a clearer east-west public circulation route and links the pharmacy, outpatients catering and pathology departments with the entrance, and new women's and children's accommodation to the south. This new route redefines the north-south street to the west of the emergency department as a patient zone and will significantly improve patient dignity by allowing much greater separation between public and patients, creating an effective "on stage / Off stage" dynamic.

Within the new building, the circulation is designed as an approximately triangular "donut" with 2 key vertical lift cores provided:

- A central core is provided to minimise travel distances and avoid the need to circulate through adjacent departments. This core is a shared public and clinical core which is linked at ground floor to the main entrance to the north and the discreet non-emergency ambulance entrance to the south
- An emergency core is provided to the north, beyond the major east west public circulation line, to provide direct access to emergency facilities, imaging, and theatres

This circulation pattern provides as very efficient communication space which is lower than that which might normally be expected of a building of this size and complexity.

The use of a "doughnut" creates a very legible circulation systems, with the large central courtyard acting as a reference point to orientate staff, patients, and visitors as they move around the building. The main entrance lies to the north of this space and the main vertical circulation sits to the south, at the heart of the courtyard, with views into it. This enables visitors to clearly see where they need to head if they are visiting any of the departments within the new building immediately upon arrival at the hospital, and once they are within the new core, remain connected to the entrance and able to understand which floor they are on.

### 3.5.3 The design provides for appropriate services access

There are 7 elements of service access to consider for the project – Catering; Consumable's supply; clinical supply; waste removal; building systems service; IT systems Service; and maintenance.

Catering; Consumable's supply; clinical supply, waste removal - Consultation with the estates team confirms that the building will be served from the existing stores, catering, and waste areas, via the existing hospital circulation system, with no intended external servicing required. For the upper floors, the clinical core to the north will therefore be used to deliver all catering elements, clinical and non-clinical consumables.

Waste will also be removed via this core. At ground floor level, the departments will be serviced via the public circulation which feeds the Acute Medical department, Gynaecology, and short stay wards.

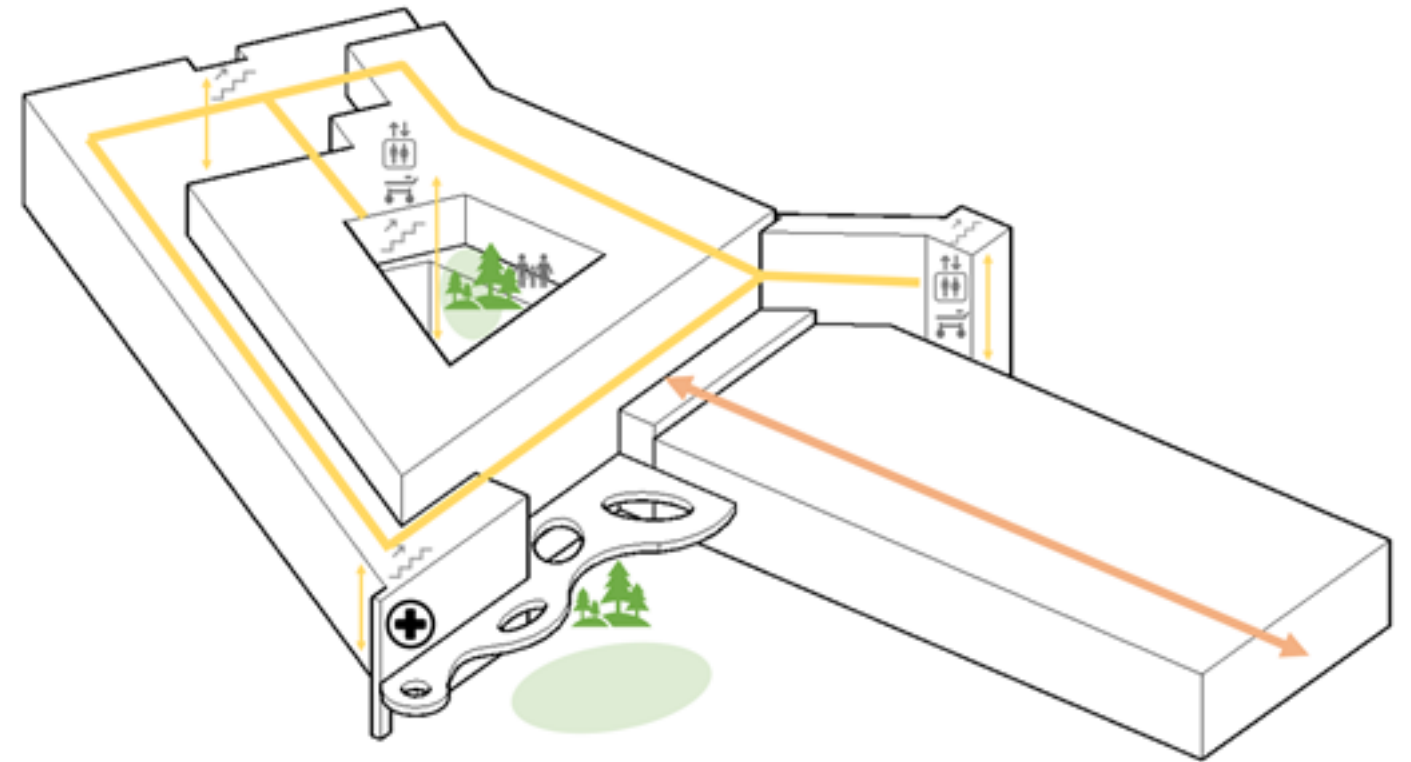
Building systems service- there are 5 distinct plant areas within the building; level 0 plant rooms; level 3 plant room; enclosed rooftop plant; roof mounted external plant; and distributed local plant. These areas allow excellent service access as follows:

- Level 0 plant- primarily houses medical gas manifolds, electrical intake, and water services. These all require external access, and this location provides a discrete area away from the public access routes, via the existing emergency services access between the existing outpatient wings and the western edge of the building
- The Level 3 plant space houses the water pumps and is accessed via the internal circulation at the northern edge of the building
- Level 4 (enclosed rooftop plant) – houses the air handling plant and is serviced by the central lift core, with one of the bed lifts extending up to this level to provide for appropriate access for maintenance personnel and small plant replacement. (Large plant replacement is facilitated by removable panels and the adjacent deck access.
- External roof mounted plant – is limited to Photo Voltaic Panels (PVPs). There is only limited-service access required to these (primarily cleaning) and this is provided by the extension of the core staircase to the roof of the plant room
- The distributed plant is mainly in the form of local Mechanical Ventilation with Heat recovery (MVHR) units. These are mounted within the ceiling voids and will be accessed locally
- IT systems Service- a central Hub Room is provided to each floor within the central circulation core, providing convenient access for servicing and distribution

Maintenance - at under 21m from typical ground level, a reach and wash system is envisaged, with MEWP access for those windows above 20m (the western elevation is 24m from the lower ground floor). The building has effective hardstanding to all elevations (either as road and pavement, pedestrian plaza or "Grasscrete") to allow traffic of MEWPS etc. further details of the access and maintenance can be found under this section in the report.

### 3.5.4 The fire planning strategy provides for ready access and egress

A full fire strategy is provided later in this report; however, the design of the building has been carefully considered within the standards set out in Health Technical Memorandum 05-02: Firecode. The principles set out in this code are based on progressive horizontal evacuation with each department having 3 exists to allow patients to be moved around the building. There are 4 cores, each treated as firefighting shafts, with two of the cores having fire evacuation lifts, and all exiting either directly to the outside or into the existing hospital streets.





### 3.6 Space

Space is concerned with the provision of effective and efficient types of space, the arrangement, quantity, quality, and interaction of the spaces with the wider environment.

#### 3.6.1 The design and layouts of the project facilities provides for the physical integration between outdoor spaces and the buildings

The design has been carefully developed to provide the key patient spaces and communal staff spaces with direct access to Daylight and views. As noted earlier, the “Doughnut” configuration creates the maximum external envelope for what is a very compact design. In addition to access to views and daylight at the perimeter, the building form has created five separate external spaces which provide positive interaction for staff, patients, and visitors.

At ground floor level a new landscaped entrance plaza has been created. The sinuous, organic nature of the paving, planters, canopy, and seating, provides a counterpoint to the rigid geometry of the new building. Welcoming visitors to the hospital. This space is linked to the semi-private internal courtyard space. Via the covered area formed beneath the first floor of the building. This covered area provides a sheltered area for the café Entrance plaza

The inner courtyard features ornamental planting, providing staff and patients with a central and easily accessible place to retreat and relax in an attractive, green setting. A combination of ground level planting and raised beds form circulation routes through the space which can also act as wandering loops. Seating will be provided adjacent to planting throughout the space and there will also be a dedicated outdoor seating area associated with the new café.

At first floor level, a small, enclosed garden provides daylight and views to the MLU delivery rooms as well as the staff and parent spaces opposite in the Neonatal ward. External space is essential for children who are in longer term treatment, and we have therefore provided 120m<sup>2</sup> of sheltered space, directly accessible to the children's oncology inpatient rooms. This space is capable of being subdivided to allow separate access for other children. The final accessible landscaped space is provided just outside the Critical Care Unit at the third floor, where the building cuts back to provide 180m<sup>2</sup> of space overlooking the central courtyard.

#### 3.6.2 High quality, effective and efficient spaces are provided

Our team has worked very hard to balance the 3 key factors which directly affect the quality of the space provided:

- Good level of Natural Light
- Good level of ventilation and temperature control
- Access to a view

Good levels of Natural Light – as noted previously, we have deliberately created a compact building which maximises its envelope using relatively narrow wings and a large courtyard. This allows us to get good levels of daylight into key public spaces, such as the new main entrance and the patient bedrooms. In the main entrance it is intended to provide curtain walling with full height opening doors to maximise views out.

In the patient bedrooms, we have deliberately located the ensuite WCs to the external wall to maximise visibility of patient's rooms for staff and although this does prevent the whole external wall from being used for window, the location of the bed combined with a tall window area, within the entrance, to spill out into, providing an area for outdoor eating. This delineation also allows the inner courtyard to be secured in the evening for added security, provides a good balance of reasonable levels of daylight across the rooms, with all perimeter rooms having windows which typically have an area of glazing greater than 15% of the floor area. These windows also provide excellent views out across the wider site or internal courtyard. It is intended to recess the windows into the façade to avoid the need for external Bris Soleil and prevent overheating and glare. Good levels of daylight are supplemented by low energy lighting to provide optimum light levels for clinical treatment and recovery.

In the deeper elements of the plans, which is typically circulation, careful modulation of lighting in these areas creates pools of quiet for relaxation for staff, patients and visitors and use of low energy efficient fittings, occupancy, and daylight sensors, ensures costs associated with lighting are kept to an absolute minimum.

Good level of ventilation – is critical for patient recovery and prevention of infection, as a consequence, this is a relatively highly serviced building. Central plant with heat recovery is combined with assisted natural ventilation (also with heat recovery) to provide effective ventilation, while remaining highly energy efficient. Optimised thermal mass reduces mechanical ventilation, for a de-engineered solution promoting wellbeing, user control and comfort.

Many clinical areas have very specific requirements for ventilation, with high levels of air filtration and temperature control. These rooms use a central mechanical ventilation system, to ensure adequate levels of ventilation and reclaim the energy released into the building systems, from occupants and infrastructure. These rooms are typically placed in the centre of the deepest parts of the plan to avoid deep service runs traversing the less heavily serviced rooms.

The southern and western wings of the building also have the more intensively ventilated areas, such as delivery rooms, neonatal cots and critical care rooms and are more prone to fluctuation in temperature due to solar gain and are therefore centrally ventilated

Where this level of servicing is not required, such as individual patient bedrooms, spaces are either naturally ventilated with a mixed mode which includes heat recovery. Common approaches to natural ventilation typically produce shallow plan ‘finger’ arrangements of buildings, which have excessively long circulation routes. However, the need for time efficient movement between departments, has driven us to adopt a much more compact and more tightly integrated building form. Rooms along the northern, and eastern edges of the building are relatively shallow and dominated by inpatient accommodation and enables mixed mode natural ventilation which is still a very low energy solution.

This approach is supported by the use of a concrete flat slab construction which allows for a clear passage of air through the rooms at high level for exhaust air.

Access to a view – as noted earlier, the building has been designed around the provision of access to views, from the careful design of communication spaces which always have views into either the central courtyard or over the wider site; to the careful placement and configuration of the patient bedrooms which allow patients to have a clear view out of their room to the wider landscape beyond; and on through to the location of staff offices and rest rooms adjacent to the inner courtyard.

However even in the deeper parts of the plan, such as where the new building connects to the existing outpatient entrance, we have sought to provide glimpses and views to the outside, via a two-storey high top lit atrium whose glazed end wall reveals the rest of the hospital beyond. This 4m wide, brightly lit space also retains views and interest for the rooms above which form the “Badgernet” facility, offices, and seminar rooms, allowing the natural intensity of light and shadow to fluctuate throughout the day. This space ensures that the adjoining rooms to have genuinely stimulating internal views without access to an external façade. 6.0 Form and Materials

Form and Materials is concerned with the quality of the Project Facilities in terms how it expresses itself in terms of its massing, appearance, and organisation.

### 3.6.3 Bedroom options

During the development of the sustainability strategy, it has become clear that the design of the single bedrooms has a fundamental impact on potential energy in use target for the building.

The design as illustrated in the stage 2 report, envisages the bathroom pods being located adjacent to the external face of the room. (The upper bedroom in the illustration right)

This "Outboard" option for the bathroom pod has significant advantages from a clinical perspective:

- Provides unhindered access to the clinical zone in the bedroom
- Provides excellent opportunities for clinical observation
- Provides a discrete "family zone" away from clinical activity

However, in spite of a low capital cost, there are compromises in terms of the environmental quality and options:

- Uneven daylight distribution
- Poor service access to sanitary installations
- Limited size and placement of window
- Reliant on comfort cooling via a chilled water system (MVHR) due to lack of openable area of facade
- Increased energy use / sqm

The alternative to this model is to locate the Bathrooms pods "inboard", adjacent to the internal circulation. This is a model commonly used in many hospital projects and tends to be favoured by contractors, engineers and estates departments, for the following reasons:

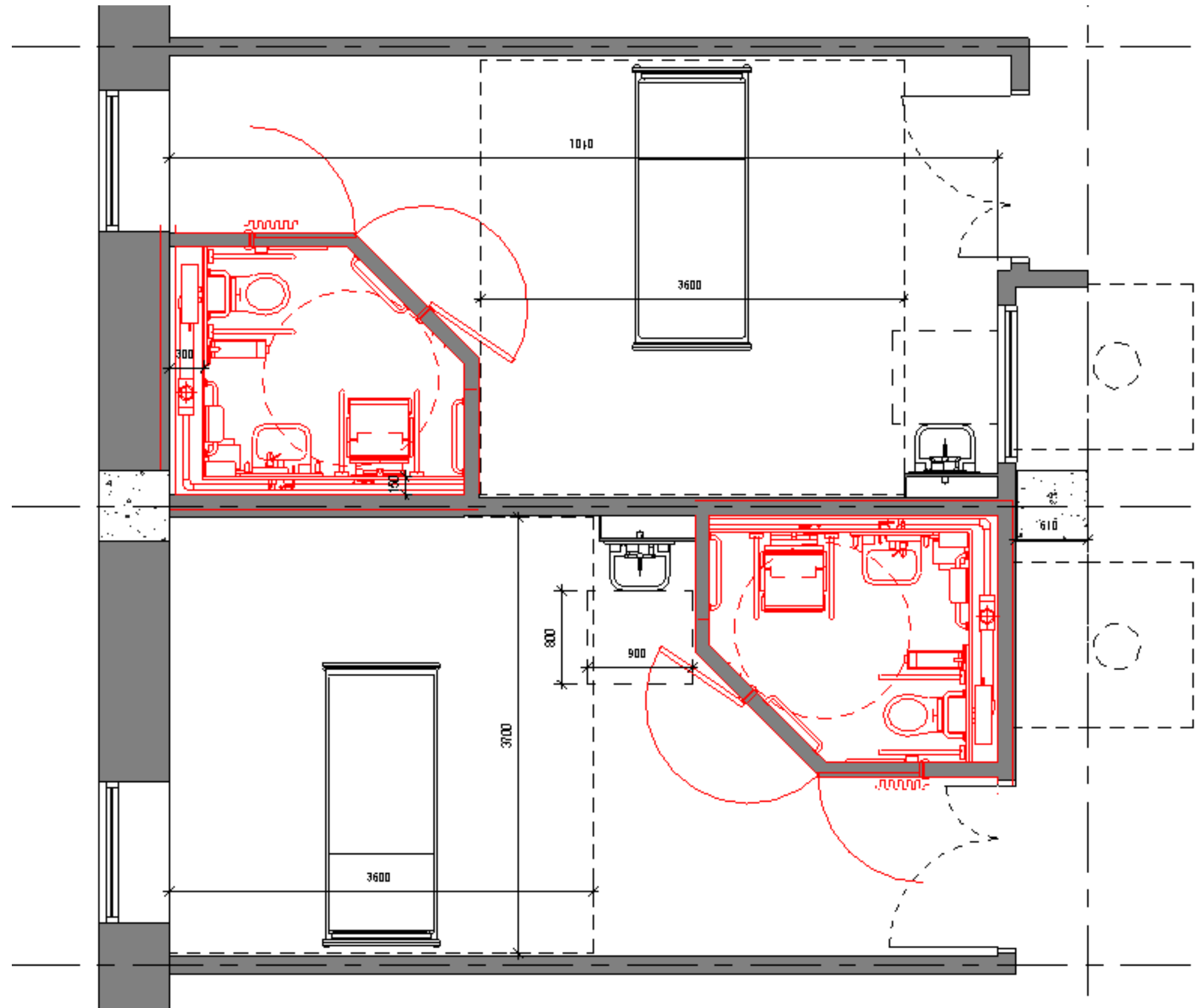
- excellent service access to sanitary installations
- multiple options for size and placement of window
- use of façade for effective natural ventilation (cooling) thereby reducing reliance on comfort cooling via a chilled water system (mechanical)
- reduced energy use / sqm

there are also advantages from a patient perspective, with better daylight distribution and views.

However, there are still drawbacks:

- Clinical observation is limited to door opening
- "Family zone" potentially interrupts access to clinical activity
- Increased capital cost (due to increased need for louvered openings to façade for ventilation, whilst still requiring cooling from MVHR units)

We will be developing the stage 3 information using "inboard" bathrooms, due to improved daylight distribution and lower energy in use.



Bedroom options



3.7 Forms and Materials

Form and Materials is concerned with the quality of the Project Facilities in terms how it expresses itself in terms of its massing, appearance, and organisation.

3.7.1 The scale, proportion and overall composition contributes positively to their surrounding environment

The existing hospital buildings are of a panelised concrete construction, somewhat in the style of the brutalist movement of the 1970's (RSH was opened in 1978). This panelised construction features aluminium windows set between heavily textured, solid concrete panels, separated at intermediate floor levels by a wide band of continuous concrete. Although concrete of this nature does not generally age well, the detailing is sufficiently competent to limit the staining and the overall appearance of the buildings whilst clearly of their time presents a consistent (if slightly dated) image of competent healthcare.

This language has been re-interpreted in the new building to provide a clean, efficient and effective new face of Healthcare for the Shrewsbury and Telford Hospitals NHS Trust. The higher floor to floor heights have allowed us to create a more vertical emphasis with elegantly proportioned panels, separated by a slimmer floor band. The panels are smooth, with a limited number of modules, but are fixed at a slight angle to the plane of the façade to create subtle changes in the light and shadow, cast on the façade. Elevation extract

Like the original aesthetic treatment, the windows are formed as a separation between panels, and are a simple, aluminium double-glazed units, glazed between floor and ceiling to maximise daylight penetration, with spandrel panels to conceal the service zone above the ceiling.

At ground floor the mass of the building is supported on slender columns behind which a sheltered walkway sits, to provide a welcoming route to access the building. The rooms behind this walkway are typically short stay multi-bed bays, and these are expressed on the façade by a dark, full height curtain wall system which is glazed above eye level to provide daylight and maintain privacy.

3.7.2 The external materials and detailing, including landscaping are of high quality

As noted above, the façade utilises a simple panel system to provide an elevation which is elegantly proportioned and relates well to the existing buildings. It is intended that this panel system will be constructed from a high-quality fibre-cementitious rainscreen board, from the Equitone "Natura" range. This is a through-coloured base board, with semi-transparent coloured finish which results in the structure of fibre cement material shining through to create a subtle, natural high-quality panel. The finished panel is both weatherproof and UV-stable. Irregularities, differences in shade and traces of the manufacturing process are to be expected and avoid the artificial regularity that surface coloured panels normally exhibit. Typical Equitone Natura panel

At this stage it is intended to "secret fix" the panels to the substrate to preserve the high-quality appearance. Windows will be a simple double glazed Aluminium framed system, with spandrel panels and louvres (to accommodate the MVHR ventilation system). The plant room at roof level will be clad in a darker insulated panel (exact panel type still to be determined)

Initial consultation with the planners suggests that as the new building sits in such a prominent location, defining a new public image for the hospital, they will be seeking a high-quality architectural response as part of the full planning submission. We believe that the treatment described above will provide such a response



Typical Equitone Natura panel



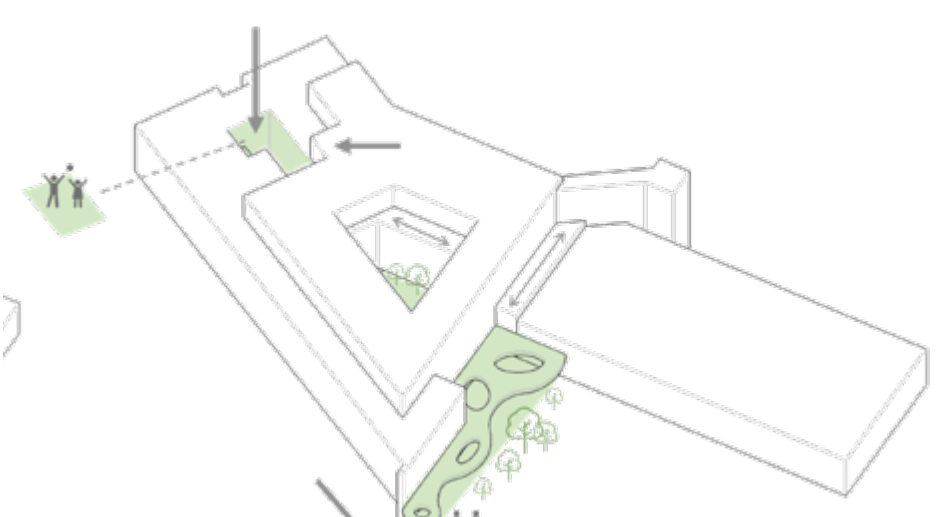
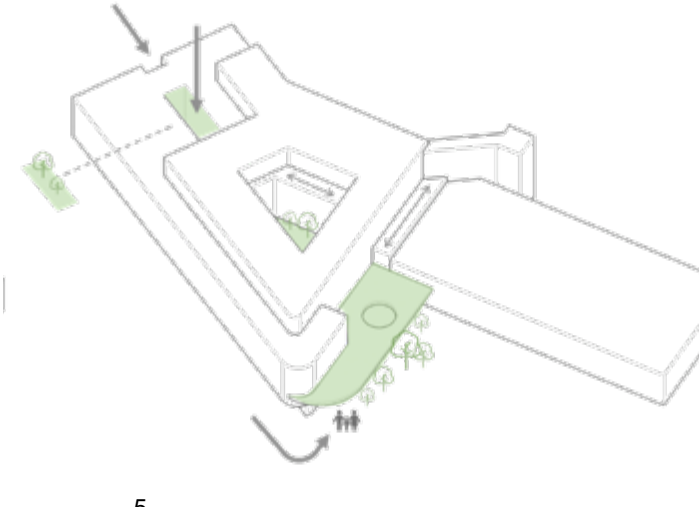
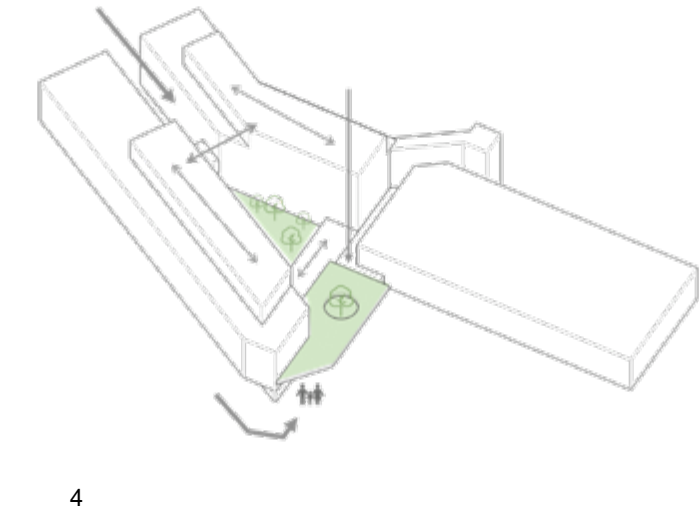
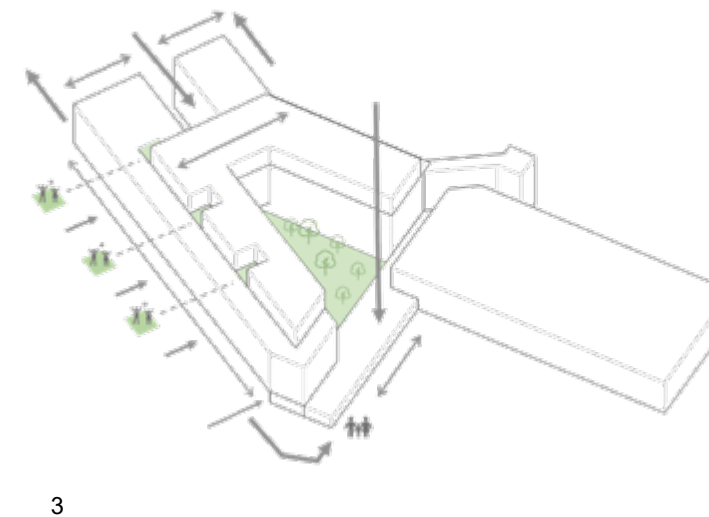
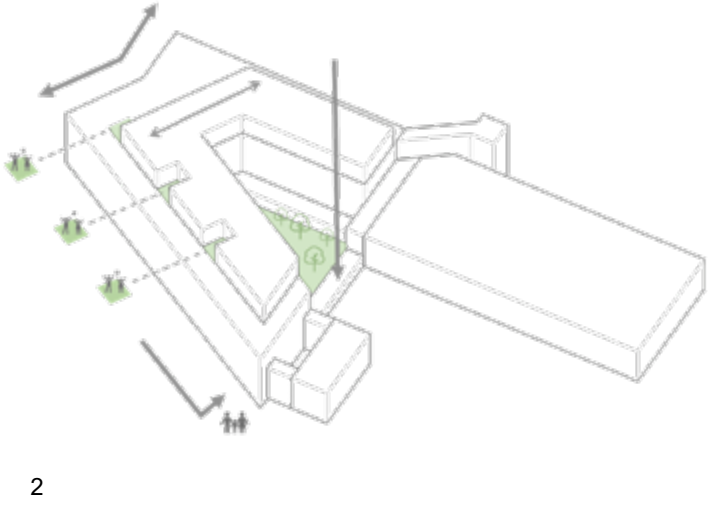
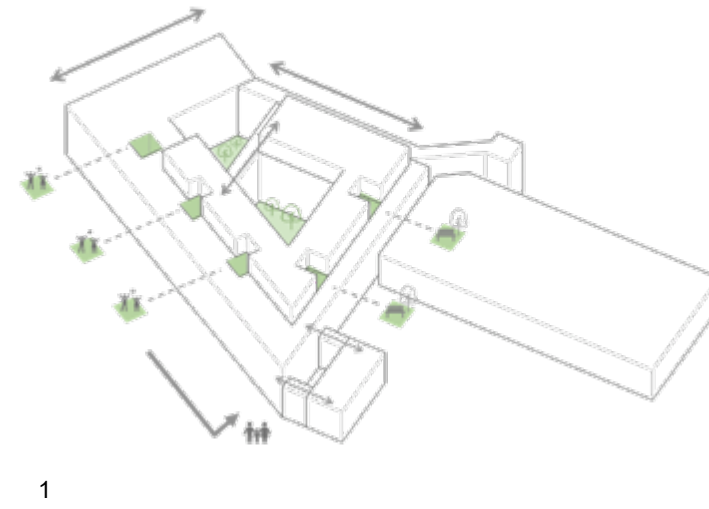
Original RSH Hospital building



Elevation studies

3.8 Design Development

The following series of diagrams demonstrate the design development of the building throughout stage 2.



The first few steps show the original circulation path coming from the top left, the evolution of the form of the building and how the mass splits into fingers.

Further development introduces the splay legs, the new main entrance decisions which leads to the development of a protective canopy.

The corner of the building by the main entrance evolved several times in order to create a welcoming signal.













LEVEL 4 ADJACENCY  
Oncology and Critical Care



LEVEL 4 ADJACENCY  
Oncology and Critical Care











### 3.9 Quality of Environment

AHR have drawn upon the quality of recently completed schemes through the teams previous Healthcare Design experience and best practice site visits of high quality clinical and inpatient environments.

#### 3.9.1 Early stage Clinical and Environmental modelling concepts

##### Creating a welcoming environment

From our experience we are aware that acute hospitals require clear wayfinding, inclusive environments, and a reassuring accessible environment.

Beyond this, there is often diverse opinions in how these spaces are to feel and looking at other sectors can assist with individual zones in relation to each unique part of the hospital whilst maintaining a joined-up approach possibly through use of interior finishes.

This can be through the operational and transitional nature of how these spaces are accessed, how long people wait in areas, what forms of staff communication occur and what the general public are expecting.

During the next stage of the design we will be exploring concepts such as integrating an airport feel for the main reception, hotel feel for inpatient environments and a playful family friendly environment for paediatrics.

Opportunities let light into the building can create engaging and vibrant areas to what are seen as simple circulation spaces. Image above shows simple geometric shapes incorporated into the roof design.

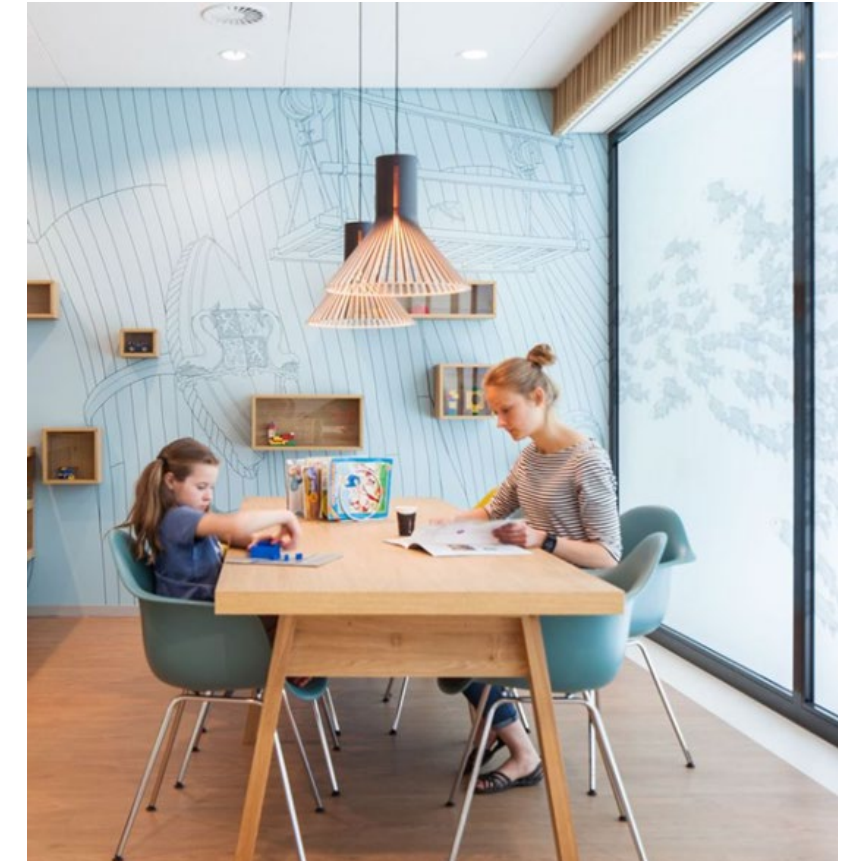
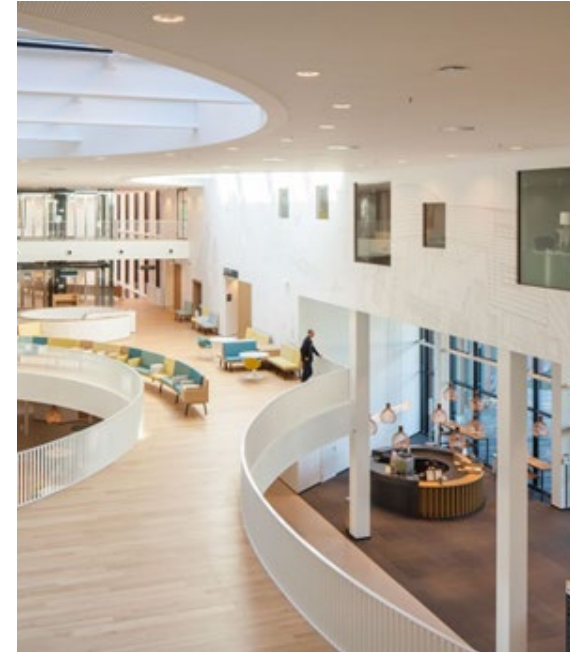
The New Ward block at Chesterfield Royal Hospital aspired for a hotel feel whilst working to a tight budget. Using a standardised rain screen cladding system and Hilton hotel size window openings ward rooms and clinical areas had plenty of views out to nature with natural light. The New Hospital at SaTH maximises views out from patient and staff areas to the local landscape and new inward-looking landscaped courtyard. There will be therapy garden terraces for paediatrics and critical care ward.

##### Observation and Releasing time to care

Outboard en-suites encourage improved observation for the patient via corridor glazed screens.

However as noted earlier, in this instance we believe that the environmental benefits are significant for inboard en-suites and that an appropriate digital strategy can provide even greater improvements in patient care and efficiency.

A releasing time to care initiative was incorporated into the design by improving patient observation which resulted in patients calling staff less as staff were more visible and patients felt more reassured. The result was freeing up time for staff as they were not responding to as many calls. Image below shows a centralised nurse base over looking patient beds. During the next design stages we will be looking into NHS initiatives and what can be incorporated





**Patient and staff areas**

Creating a healing and therapeutic environment for patients is imperative but also creating a sustainable and healthy working environment for staff is critical for the running of the hospital. We will be leaning on our experience from WELL standards and applying principals where affordable within the design to create uplifting environments for all service users. Images below show examples of clinical environments that are using high contrasting finishes with natural wood materials, clever use of lighting to create a warm and welcoming hospital.

**Circulation**

A site visit to the Phelix Platter Hospital in Switzerland demonstrated a world class inpatient environment that had rapid access to care. A deep floor plan with central utility areas were available from numerous access points with dual corridors. Having the large format windows again outboard brought plenty of light into the deep plan. The wards work in pairs with easy access between them in order to support one another at critical times with fast response between departments.

**Artwork and Wayfinding integrated within the interiors**

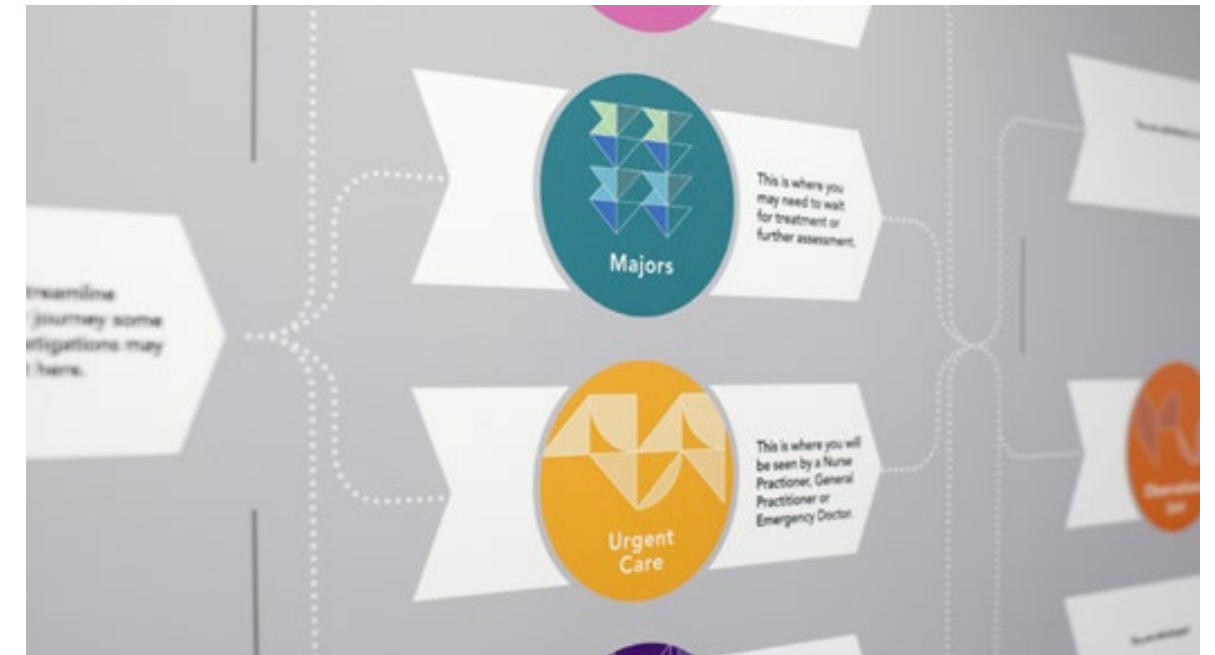
Throughout the next stage of the design process AHR will hold workshops to discuss the design and the development of the interiors including wayfinding, signage and artwork integration. There are several opportunities to integrate Artwork within the fabric of the building, such as coordinated signage panels, colour coded furniture whether this is built in or loose, window film, acoustic baffling or even printed whiteroc. We will explore these opportunities in order to work out a strategy that works within budget.

**Infection prevention**

Utility areas are centralised as far as possible with localised areas as prescribed within the functional brief with dirty utility areas close to exits. Infection prevention were consulted throughout the design process, we have carried this same approach at SATH initially until further consultation is made. Consideration of materials has started at this stage in producing an outline specification for costing purposes and all finishes selected so far from vinyl flooring to bioguard ceiling tiles will meet the standard set out in the HTM guidance.

**Digital - smart hospital considerations**

During the next design stages AHR and the MEP engineers will be supporting the Trust to evaluate the integration of smart and digital technology that will support staff in delivering care along with controlling the operability of the building. This would also work along side their aspirations to deliver improved care through new smart data systems. Future proofing the hospital to be able to tag on future smart technology is an important consideration that at RIBA stage two we have started to implement. Systems that support case studies such as the New Chase Farm Hospital in London and Karolinska Univeristy Hospital in Sweden will be examined and discussed with the Trust.





### 3.10 Security Strategy

We anticipate that the scheme will be assessed under the “secure by Design” initiative, and this will happen as part of the RIBA stage 3 design process. The security strategy looks at four specific types of threat; Terrorism; malicious damage; theft; and disruptive behaviour.

#### 3.10.1 Terrorism / threats to life

Forthcoming legislation is likely to significantly increase the duty of care on the Trust to take appropriate action to anticipate and mitigate possible terrorist acts. The nature of hospitals is such that it would be extremely difficult, eliminate, individual acts of terrorism, where devices are carried in back packs etc. However, defence against this type of attack can be undertaken through surveillance and management by site security. We will therefore agree the location of high-quality security cameras as we develop the scheme in detail. The treatment of the covered walkway is critical. It is likely that this will be well trafficked and potentially not directly overlooked (by virtue of the proposed planting strip) it is therefore proposed to have this area effectively lit and covered by security cameras.

For larger, Vehicle initiated attacks, we have considered how the building might be attacked, and provided obstacles in the form of sturdy planting and or bollards, to keep vehicles a safe distance away from the building and prevent ramming attacks. The area between the existing outpatients building and the western façade of the new building has been identified as being potentially vulnerable, and it is therefore proposed to provide a gated entrance to this area.

#### 3.10.2 Malicious damage

Is primarily concerned with vandalism and damage to the building fabric. Externally materials at ground level will be selected based on their robustness and ease of maintenance. All elements of the fabric, at all levels will be classified to meet A2-s1, d0 according to EN 13501-1.

#### 3.10.3 Theft

Opportunistic theft from rooms with an external wall (typically offices and bedrooms) will be relatively easy to accomplish through the use of window restrictors which will limit openable windows to just 100mm gap. At ground floor level the windows will be double glazed with toughened safety glass to external pane (for resilience) and laminated glazing to the internal pane (for integrity).

All external doors will be electronically locked to enable controlled access by staff, where appropriate. It is also proposed that the southern door which connects to the central core will allow remote operation (via intercom) and / or keypad operation, to allow ingress of maternity patients and ambulance staff. It is proposed that the main entrance doors are also electronically secured to facilitate emergency lockdown and out of hours access to the emergency department.

Internally, all publicly accessed departmental doors will be electronically secured to allow appropriate staff access. All staff only clinical rooms will be electronically secured.

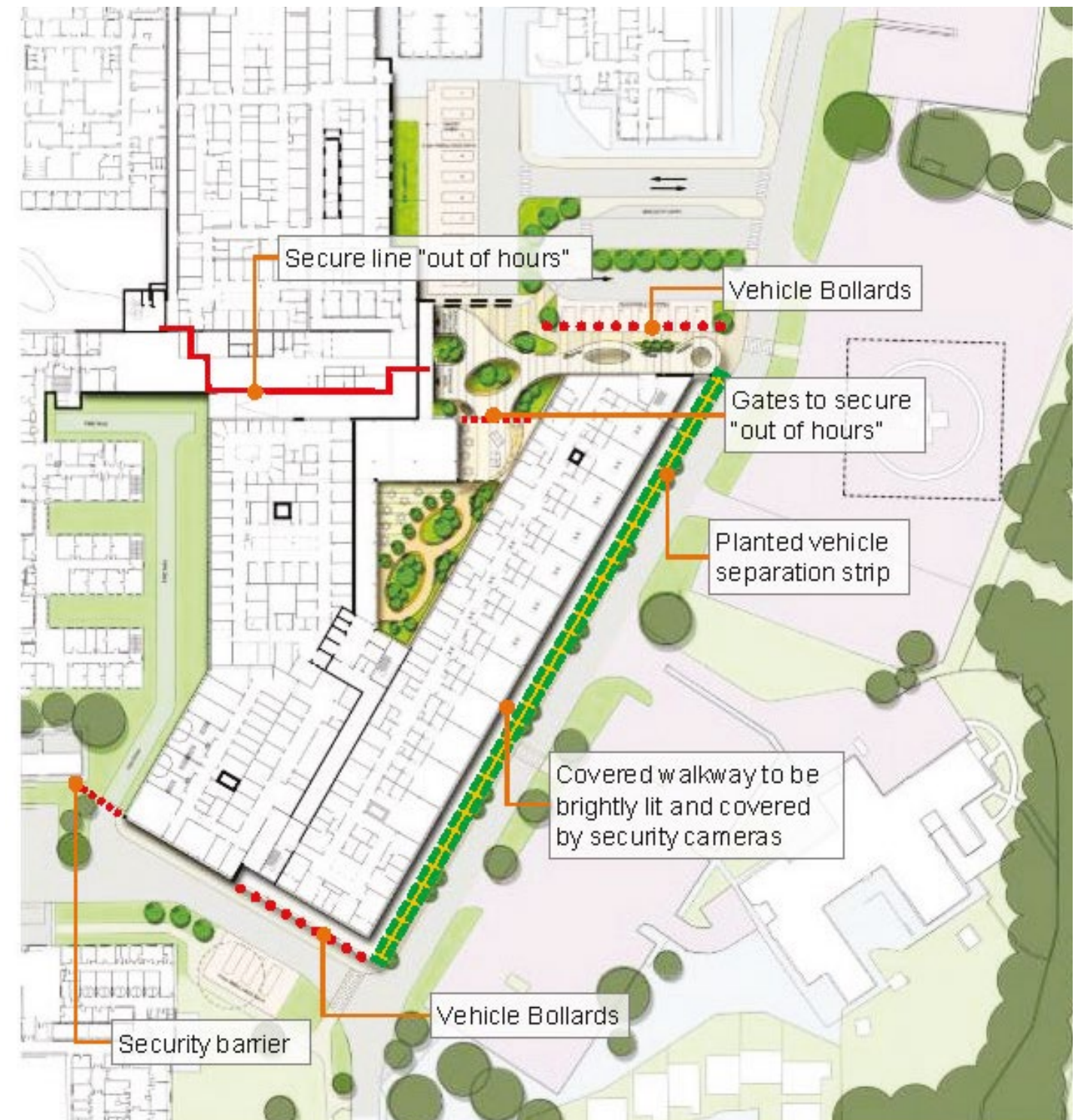
Out of hours it is proposed to secure the main central courtyard via a lockable gate/fence and to internally separate the emergency department from the main circulation via lockable doors/ screens.

#### 3.10.4 Disruptive behaviour

The general décor and treatment of waiting areas and reception desks will be designed to reduce negative stimulation and incorporate well understood and proven design principles to reduce stress and discourage poor behaviours.

The location of the security office has been considered with the site security team, and due to the existing infrastructure considerations as well as the need to have this area accessible in the event of “lockdown” it is proposed to locate it in the close vicinity of its existing position, adjacent to the emergency department.

These principles will be developed in more detail throughout the next stage of design.









3.11 Drawings and Plans

VERSION CONTROL

The Shrewsbury Telford Hospital NHS Trust  
Hospital Transformation Programme OBC

Revision				Area			Approvals	
Date	No.	Issued to	Revision	Building Gross (sqm)	Impact of Change from Previous Version	Benchmark Gross (sqm)	Author	QA
01-Dec-22	0		Estimated SoC gross area based upon Capital Costs Constraints Rev 10 (QS Estimate @ September 22 updated 1 Dec 22)	30,500.00		30,500.00	CMW	CR
			<b>Gross Hospital Area is 0.00sqm over the Benchmark</b>					
02-Dec-22	v1		OBC v1 SoA developed following User Engagement	31,917.56	increases area by 1327.56sqm		CMW	CR
			<b>Gross Hospital Area is 1327.56sqm over the Benchmark</b>					
22-Dec-22	v1		OBC v2 SoA utilised for option appraisal (Developed Option) includes recent On Costs	33,009.82	increases area by 1092.26sqm		CMW	CR
		Developed	<b>Gross Hospital Area is 2419.82sqm over the Benchmark</b>					
22-Dec-22	v2		OBC v2 SoA utilised for option appraisal (Alternative Option)	33,062.06	increases area by 52.24sqm		CMW	CR
		Alternative	<b>Gross Hospital Area is 2472.06sqm over the Benchmark</b>					
04-Jan-23			Affordability Check - Updated Target area set by Lead Consultant includes recent On Costs and a new Main Entrance			30,750.00	CMW	CR
11-Jan-23	v3		OBC v3 - Oncosis rationalised, Maternity reconfigured & Main Entrance added	31,061.29	reduces area by 2000.71sqm		CMW	CR
			<b>Gross Hospital Area is 311.29sqm over the Benchmark</b>					
19-Jan-23	v4		OBC v4 - Updated following HTP Strategic Review	30,839.38	reduces area by 221.91sqm		CMW	
			<b>Gross Hospital Area is 89.38sqm over the Benchmark</b>					

VERSION CONTROL

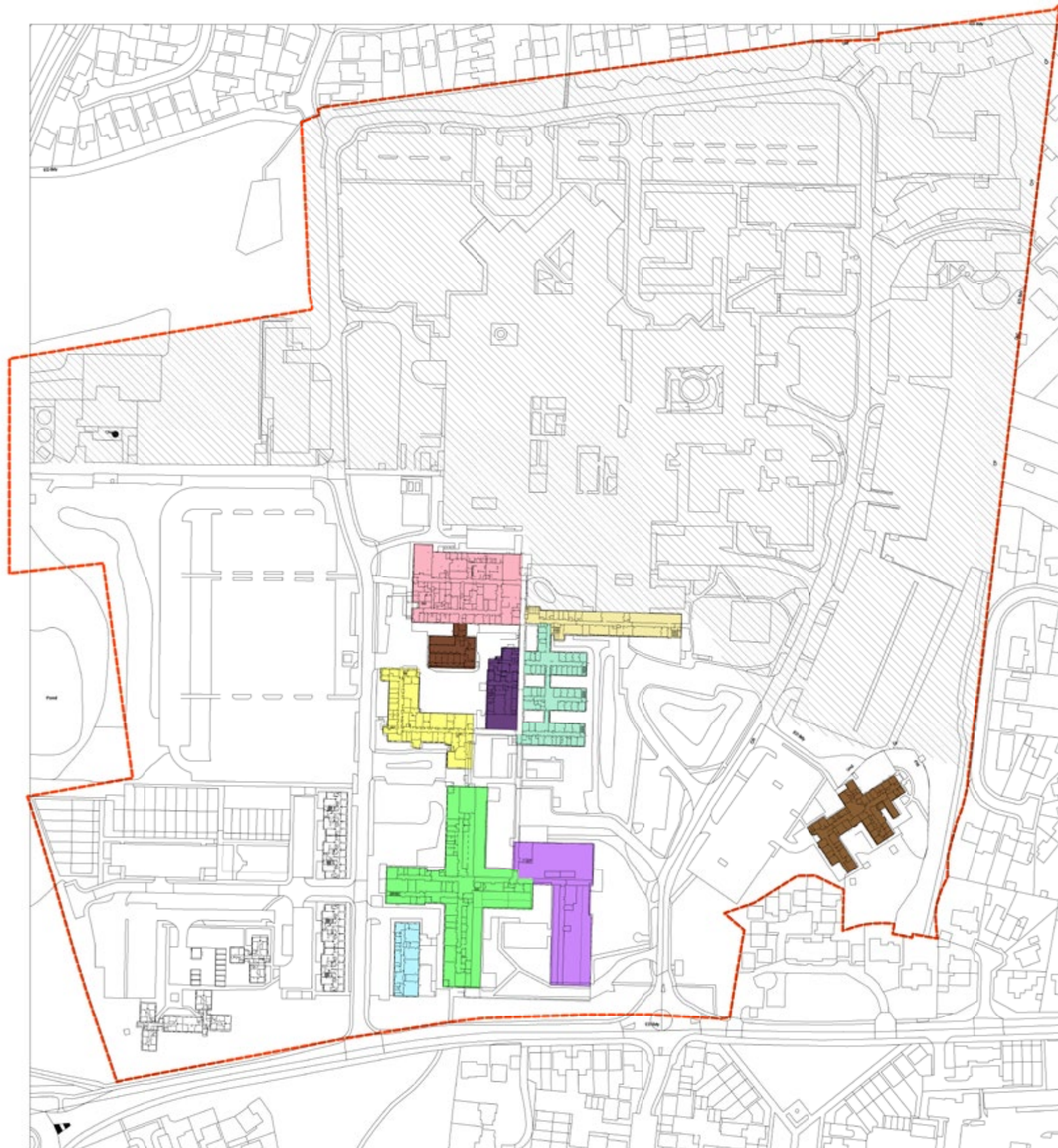
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**Department (Lv00)**

- Basement Wards
- Basement (Antenatal Clinic)
- Path Lab
- Cardiac Rehab Staff Support
- Pharmacy
- Mortuary
- Clinics 5-6-7-8
- Admin Level 0 (Medical Records)
- Mytton Oak Unit
- Nursery

Rev	Initial Issue	Date	ETU	CP
original by	ETU	18/11/22	CP	CP



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project  
Hospital Transformation Programme - Royal Shrewsbury hospital

drawing  
Level 00 - Site Wide Plan - By Department

project number  
2019.00606.006

scale  
1 : 1000 @A1

drawing number  
RSH-AHR-ZZ-00-DR-A-00002

rev  
P1

issue status  
P1

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Department (Lv01)

- Antenatal
- Boiler House
- Catering
- Escalation
- Estates
- Faculty of Health
- Fert & EPAS
- Fracture Clinic
- GU Clinic
- Hamar Centre
- Hummingbird
- Learning Centre
- Maternity Generator
- Medical Assessment Unit
- Old Finance
- OPD
- Path Lab
- Radiotherapy
- Renal
- Shropdoc
- Stores
- Theatres
- Treatment Centre

Rev	Initial Issue	Date	ETU	CP
original by	ETU	18/11/22	CP	CP
date created	18/11/22			

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project	
Hospital Transformation Programme - Royal Shrewsbury hospital	
drawing	
Level 01 - Site Wide Plan - By Department	
computer file	plot date
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project number	scale
2019.00606.006	1 : 1000 @A1
drawing number	rev
RSH-AHR-ZZ-01-DR-A-00002	P1
	issue status

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**Department (Lv02)**

- Faculty of Health
- Haematology
- OPD (Admin Level)
- Shropdoc
- S&R Trauma & Ortho Care of Elderly Urology (Ward 21)
- Treatment Centre
- Ward Block (Entrance/ Offices/ Support)

Rev	Initial Issue	Date	ETU	CP
original by	ETU	18/11/22	CP	CP

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project  
 Hospital Transformation Programme - Royal Shrewsbury hospital

drawing  
 Level 02 - Site Wide Plan - By Department

project number  
 2019.00606.006

scale  
 1 : 1000 @A1

drawing number  
 RSH-AHR-ZZ-02-DR-A-00002

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 P1

issue status  
 P1

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**Department (Lv03)**

- Cardiology  
Endocrinology  
CCU
- Oncology  
Haematology

P1	Initial Issue	18.11.22	ETU	CP
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original by		date created	by	approved by
ETU		18/11/22	CP	CP



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project  
Hospital Transformation Programme - Royal  
Shrewsbury hospital

drawing  
Level 03 - Site Wide Plan - By Department

project number  
2019.00606.006

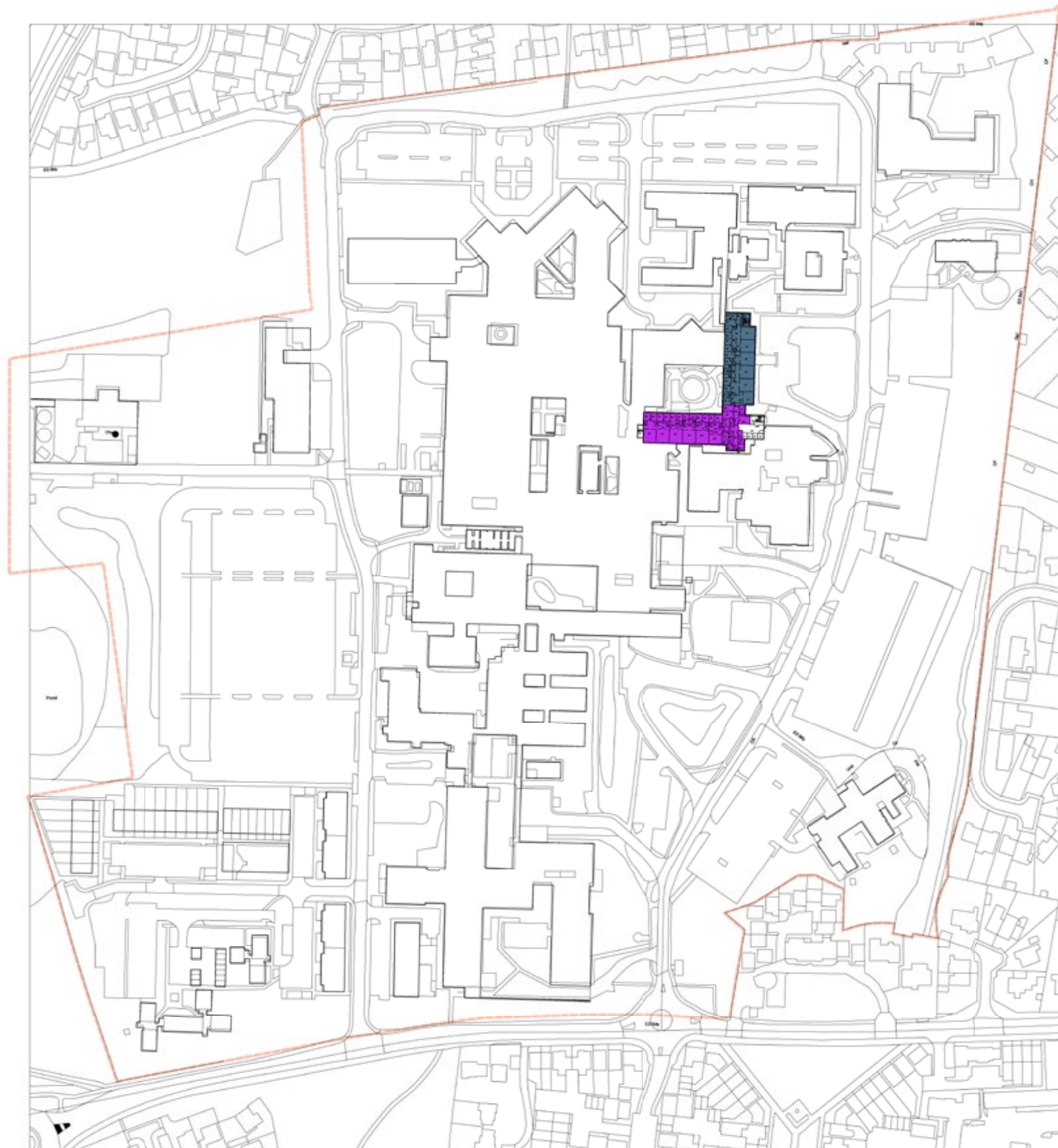
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drawing number  
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rev  
P1

issue status

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**Department (Lv04)**

- Colorectal Surgery
- Gastroenterology
- Urology
- Vascular

P1	Initial Issue	18.11.22	ETU	CP
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project  
Hospital Transformation Programme - Royal  
Shrewsbury hospital

drawing  
Level 04 - Site Wide Plan - By Department

project number  
2019.00606.006

scale  
1 : 1000 @A1

drawing number  
RSH-AHR-ZZ-04-DR-A-00002

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P1

issue status

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**Department (Lv05)**

- Nephrology
- Respiratory

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project  
 Hospital Transformation Programme - Royal Shrewsbury hospital

drawing  
 Level 05 - Site Wide Plan - By Department

project number  
 2019.00606.006

scale  
 1 : 1000 @A1

drawing number  
 RSH-AHR-ZZ-05-DR-A-00002

rev  
 P1

issue status  
 P1

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**Department (Lv06)**

■ Roof Access

P1	Initial Issue	18.11.22	ETU	CP
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ETU		18/11/22	CP	CP

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project  
 Hospital Transformation Programme - Royal  
 Shrewsbury hospital

drawing  
 Level 06 - Site Wide Plan - By Department

project number  
 2019.00606.006

scale  
 1 : 1000 @A1

drawing number  
 RSH-AHR-ZZ-06-DR-A-00002

rev  
 P1

issue status

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- Existing - Volumes - Retained (Non-Survey Model)**
- 01 Existing Unassigned Block Numbers
  - 23 Maternity
  - 24 Boiler House and Waste
  - 25A Maternity Generator
  - 25B Portacabin
  - 25C Main Generator House
  - 27 Residencies
  - 28 Path Lab
  - 29 Mortuary
  - 30 Outpatient Dept
  - 32 Aseptic Suite
  - 33 Pharmacy, EPAS, Ferts ECT.
  - 34 Catering
  - 35 X Ray
  - 38 ITU and HDU
  - 39 Stores
  - 40 Sterile Services
  - 41 Theatres
  - 42 Wards
  - 43 Estates
  - 44 Faculty of Health
  - 45 Radiotherapy and Chemo
  - 46 Myton Oak House
  - 47 Renal
  - 48 Phlebotomy
  - 49 Ward Block Extension
  - 50 Treatment Centre
  - 51 Hamar Centre
  - 52 Hummingbird Centre
  - 54 Learning Centre
  - 55 Day Nursery
  - 56 Cancer Treatment Centre
  - 57 SDEC

- Notes**
- Key**  
 - - - - - Indicates Site Boundary
- Utilities - Volumes**  
 U01 Utilities Information
- Site - Volumes**  Site - Partial Survey Model  
 00 Site Model
- Remodel - Volumes**  Single Survey Model  
 30 Outpatients Dept  
 31 Admin  
 36 A&E Remodel  
 37 Head & Neck Remodel
- Proposed - Volumes**  Shell & Core / Internal Model  
 60 Building 01 - Main HTP New Building

**Note: Block Colours in this diagram indicate combined blocks to create a volume**  
**Please Read this diagram in-line with BEP Section 3.03 for actual Project Coding of Volumes**

P4	Updated to reflect Trust Block Numbers / Alternative Option	13.12.2022	KM	GB
P3	Updated for Trust Approval of BEP / Volumes updated to suit DSSR Comments	18.11.2022	KM	KM
P2	Issued for Design Team comment	07.11.2022	KM	KM
P1	First Issue for internal AHR Comment	24.10.2022	KM	KM
Rev	Description	Date	Dr	App
			By	By
original by	date created		approved by	
K E Maddison	24.10.2022		GB	

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project	Hospital Transformal Programme - Royal Shrewsbury Hospital
drawing	BIM Execution Plan Volume Strategy Sketch

discipline file	13.12.2022
project number	2016.00000.000
scale	1 : 1000 @A1
drawing number	RSH-AHR-XX-XX-SK-A-00001
rev	P4
issue status	S4

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**Department (Lv00)**

- A&E
- Antenatal Inpatients
- Apley Clinic
- Apley Ward
- Boiler House
- Day Hospital
- Dental
- EBME
- Estates
- Fracture
- GP - XRAY2
- GU
- Hearing
- Imaging - XRAY
- Loading Bay
- Lofthouse Dental
- Macmillan
- Main Entrance
- Maternity OPD
- MAU
- Midwife
- Mortuary
- Ophthalmology
- ITU and HUD
- PAU
- Pediatric Oncology
- Pediatric Inpatients
- Pediatric Outpatients
- Pathology
- Postnatal Inpatients
- Pharmacy
- Pump House
- Rehab
- Stroke Care
- Stroke Rehab
- Surgical Day Case
- Ward Accommodation

**Departments - Proposed**

- Portable Cabins
- Temporary Staff Rooms

P1	Initial Issue	09/12/22	ETU	CP
Rev	Description	Date	Dr	App
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ETU		18/11/22	CP	CP



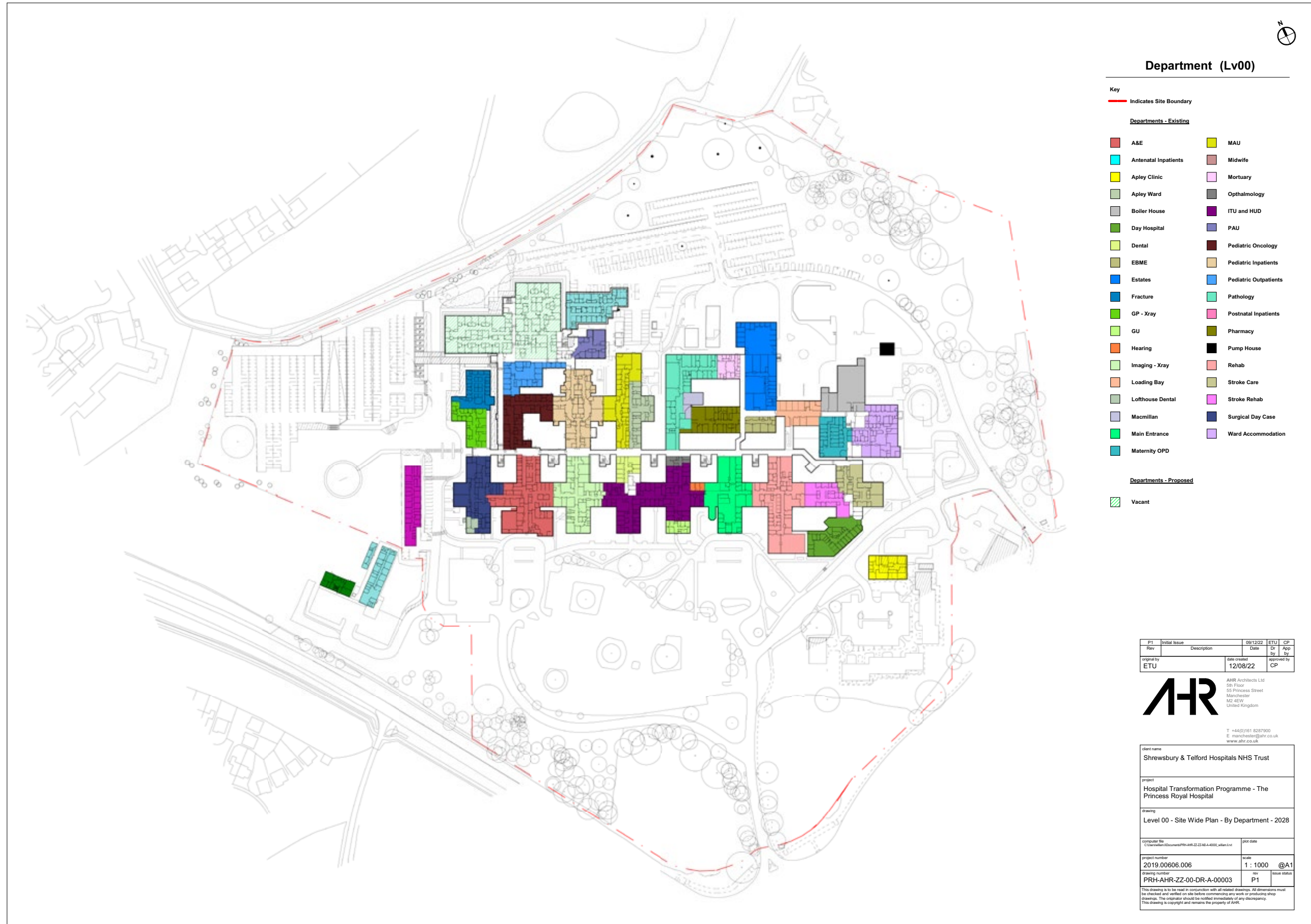
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project	Hospital Transformation Programme - The Princess Royal Hospital		
drawing	Level 00 - Site Wide Plan - By Department		
computer file	C:\Users\james\Documents\PRH-AHR-ZZ-2216-A-0000\wlan.dwg		
project number	2019.00606.006	scale	1 : 1000 @A1
drawing number	PRH-AHR-ZZ-00-DR-A-00002	rev	P1
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Department (Lv00)

- Key**  
 - Indicates Site Boundary
- Departments - Existing**
- A&E
  - Antenatal Inpatients
  - Apley Clinic
  - Apley Ward
  - Boiler House
  - Day Hospital
  - Dental
  - EBME
  - Estates
  - Fracture
  - GP - Xray
  - GU
  - Hearing
  - Imaging - Xray
  - Loading Bay
  - Lofthouse Dental
  - Macmillan
  - Main Entrance
  - Maternity OPD
  - MAU
  - Midwife
  - Mortuary
  - Ophthalmology
  - ITU and HUD
  - PAU
  - Pediatric Oncology
  - Pediatric Inpatients
  - Pediatric Outpatients
  - Pathology
  - Postnatal Inpatients
  - Pharmacy
  - Pump House
  - Rehab
  - Stroke Care
  - Stroke Rehab
  - Surgical Day Case
  - Ward Accommodation
- Departments - Proposed**
- Vacant

P1	Initial Issue	09/12/22	ETU	CP
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project	Hospital Transformation Programme - The Princess Royal Hospital
drawing	Level 00 - Site Wide Plan - By Department - 2028
computer file	C:\Users\james\Documents\PRH-AHR-ZZ-22-16-A-0000\wplan.rvt
project number	2019.00606.006
scale	1 : 1000 @A1
drawing number	PRH-AHR-ZZ-00-DR-A-00003
rev	P1
issue status	

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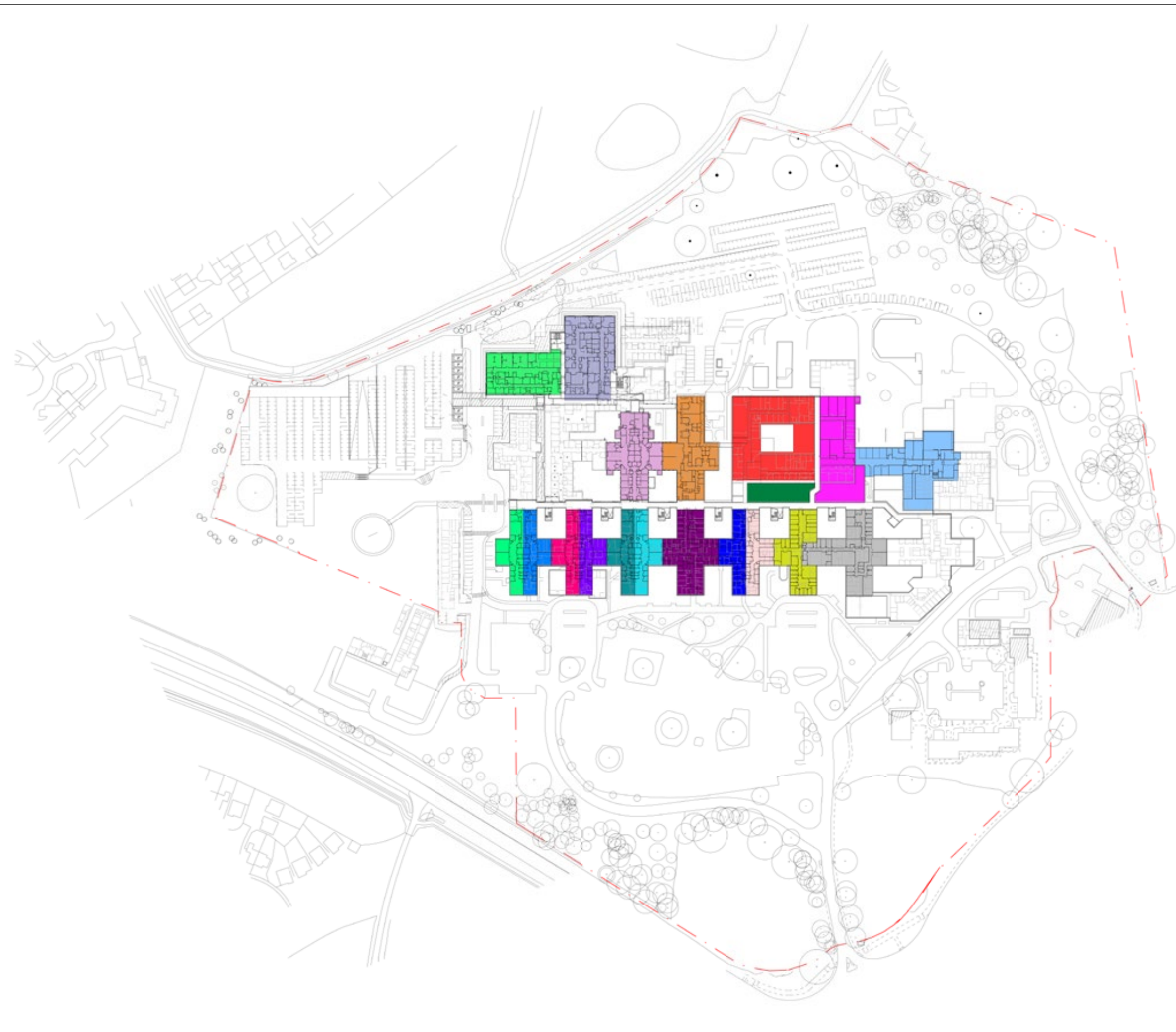


Department (Lv01)

Key  
Indicates Site Boundary

Departments - Existing

- Apley Restaurant
- Delivery Suite
- Education Centre
- Endoscopy
- Gynaecology
- Neonatal
- ITU and HDU
- Operating Theatres
- Elective Day Care
- Ward 4
- Ward 5
- Ward 6
- Ward 7
- Ward 8
- Ward 9
- Ward 10
- Ward 11
- Ward 17



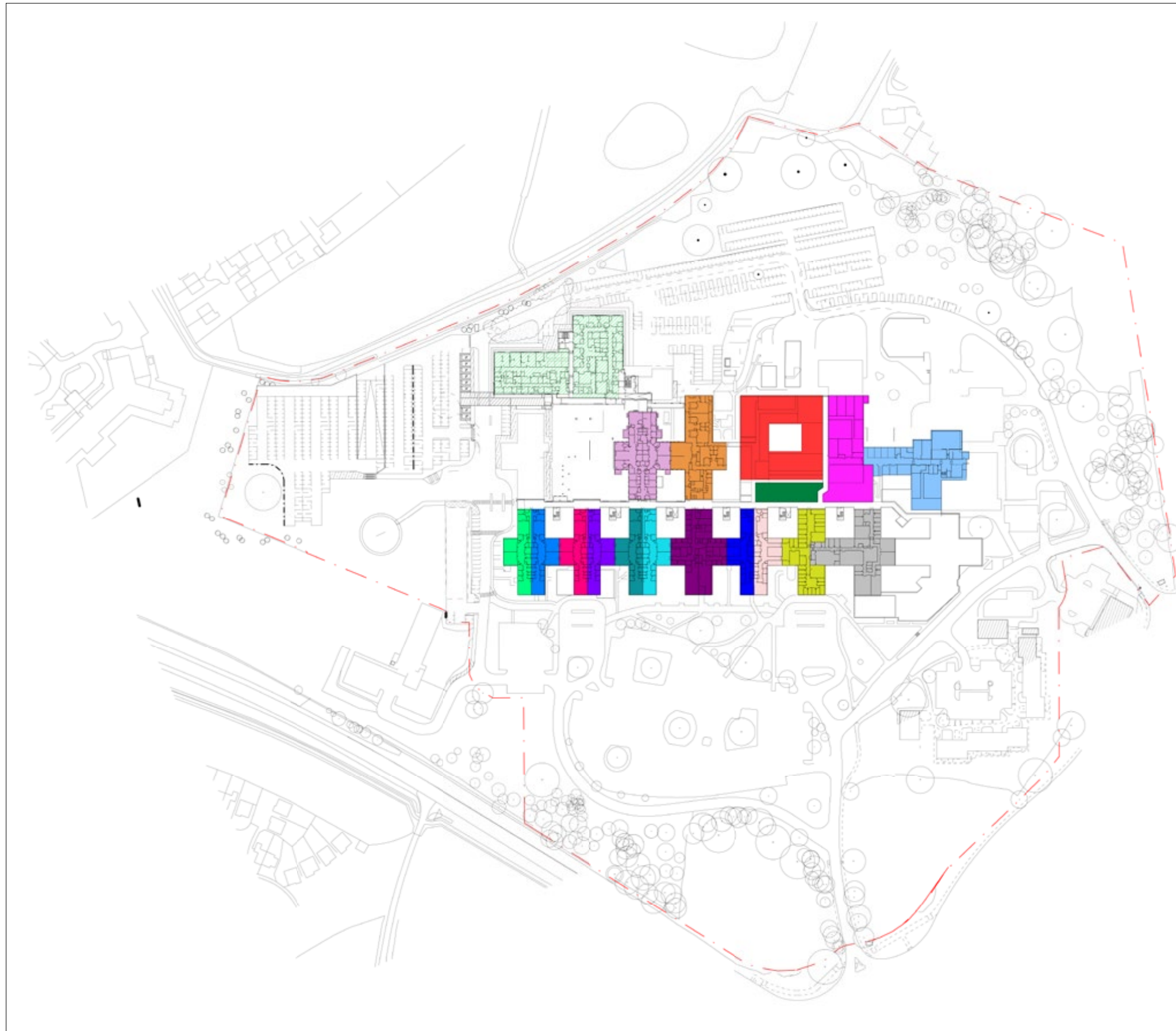
Rev	Initial Issue	Description	Date	Dr	ETU	CP
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ETU			18/11/22			CP

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project	Hospital Transformation Programme - The Princess Royal Hospital		
drawing	Level 01 - Site Wide Plan - By Department		
computer file	C:\Users\james\Documents\PRH-AHR-ZZ-2216-A-0002\wlan.dwg		
project number	2019.00606.006	scale	1 : 1000 @A1
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		issue status	

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**Department (Lv01)**

**Key**  
— Indicates Site Boundary

**Departments - Existing**

- Apley Restaurant
- Delivery Suite
- Education Centre
- Endoscopy
- Gynaecology
- ITU and HDU
- Operating Theatres
- Elective Day Care
- Ward 4
- Ward 5
- Ward 6
- Ward 7
- Ward 8
- Ward 9
- Ward 10
- Ward 11
- Ward 17

**Departments - Proposed**

- Vacant

Rev	Initial Issue	Description	Date	Dr	ETU	CP
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drawing	Level 01 - Site Wide Plan - By Department - 2028
computer file	C:\Users\james\Documents\PRH-AHR-ZZ-2216-A-0000\wlan.dwg
project number	2019.00606.006
scale	1 : 1000 @A1
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rev	P1
issue status	

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**PHASE 1**

- A. Vacate exec offices at level 1 & 2
- B. Vacate existing ward
- C. Construction of new car park

**KEY**

- Outside of scope
- Development phase

Phasing details to be developed at the next stage

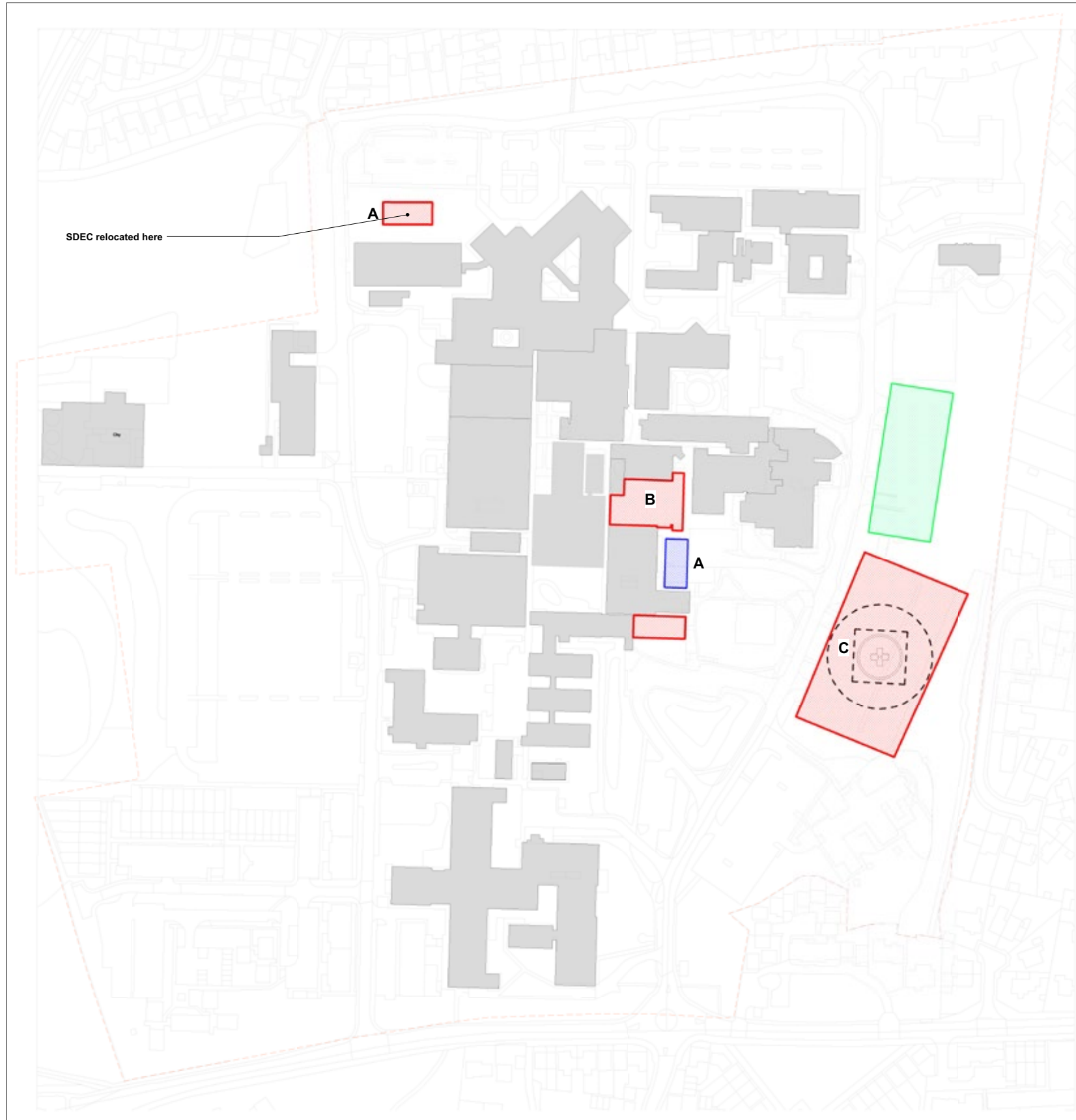
Rev	Stage 2 Issue	Description	Date	Dr	CP
original by			date created	01/23/23	approved by
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project	Hospital Transformation Programme - Royal Shrewsbury hospital		
drawing	Enabling Works - Phase 1		
computer file	C:\manchester\Documents\RSH-AHR-ZZ-XX-DR-A-09606_ahs1.rvt	plot date	
project number	2019.00606.001	scale	1 : 1000 @A1
drawing number	RSH-AHR-ZZ-XX-DR-A-09601	no	P01 S3
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SDEC relocated here → **A**

**PHASE 2**

- A. Removal and relocation of SDEC**
- B. Fit out of vacated ward**
- C. New location for Helipad created**

**KEY**

- Outside of scope
- Development phase
- Removal
- Phase complete

Rev	Stage 2 Issue	Description	Date	Dr	CP
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project	Hospital Transformation Programme - Royal Shrewsbury hospital		
drawing	Enabling Works - Phase 2		
computer file	C:\Users\wll\Documents\2019-2023\22164-4000\wllm.dwg	plot date	
project number	2019.00606.001	scale	1 : 1000 @A1
drawing number	RSH-AHR-ZZ-XX-DR-A-09602	rev	P01
		issue status	S3

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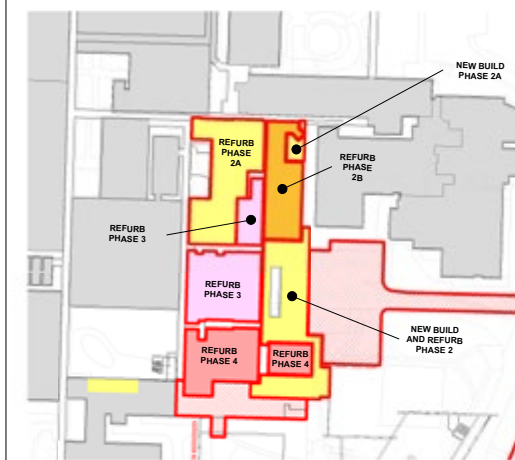


**PHASE 3**

- A. Emergency Department extension/ works
- B. Landscape works associated with Emergency Department extension

**KEY**

- Outside of scope
- Development phase
- Phase complete



- PHASE 1 Decant/vacate existing modular two storey SDEC and Offices and the existing single storey Treatment Area. Vacate Ward area in existing Head and Neck and relocate to another part of the RSH site. Vacate existing staff change to ground floor Block 31
- PHASE 2A Relocate SDEC and Treatment Area to Block 31 as temporary Fit Out move. Offices relocated to current vacant space within Hospital. Decommission existing modular SDEC and Offices and vacate site. Construct New Build Phase 2 to expand Resus and for new Paeds and new ED Reception with new Plant Room over. Amend Ambulance entrance roadway and handstanding. Fit out new Majors, Staff areas and Paeds. Maintain Blue Light access during the works.
- PHASE 2B Fit Out new Resus.
- PHASE 3A Relocate existing Majors, Resus and Paeds into Phase 2. Refurbish existing Resus bays and Minors for new RAT and CDU
- PHASE 3B Relocate Minors, UTC and CDU to new location. Decant existing UTC single storey. Refurbish existing UTC single storey for Paeds support, ED Triage and Offices.

Rev	Stage 2 Issue	Description	Date	Dr	App	CP
original by						
W/L			01/23/23			GB



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drawing	Enabling Works - Phase 3		
computer file	C:\Users\wll\Documents\2019-2023\22164-4000\wll\wll.dwg	plot date	
project number	2019.00606.001	scale	As indicated@A1
drawing number	RSH-AHR-ZZ-XX-DR-A-09603	rev	P01
		issue status	S3

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Phasing details to be developed at the next stage





Form temporary outpatient's department entrance

Waiting area facilities enhanced to accommodate relocated outpatients entrance

**PHASE 4**

**A. Works or reconfiguration of temporary Outpatients entrance**

**B. Relocated car park kiosks and community ambulance desk**

**C. Clear area for new-build**

**KEY**

- Outside of scope
- Development phase
- Removal
- Phase complete

Rev	Stage 2 Issue	Description	Date	Dr	CP
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WL			01/23/23	approved by	GB



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drawing	
Enabling Works - Phase 4	
computer file	plot date
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project number	scale
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drawing number	rev
RSH-AHR-ZZ-XX-DR-A-09604	P01
	issue status
	S3

Phasing details to be developed at the next stage

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**PHASE 5**

A. Create new generators  
 B. Construction of new-build  
 C. Landscape works associated with new-build

**KEY**

Outside of scope  
 Development phase  
 Phase complete

Phasing details to be developed at the next stage

Rev	Stage 2 Issue	Description	Date	Dr	CP
original by			13.02.23	WL	GB
WL		date created	01/23/23	Dr	App
		approved by		by	

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project	Hospital Transformation Programme - Royal Shrewsbury hospital		
drawing	Enabling Works - Phase 5		
computer file	C:\Users\j\Documents\2019-2023\22164-4000\wlan.dwg	plot date	
project number	2019.00606.001	scale	1 : 1000 @A1
drawing number	RSH-AHR-ZZ-XX-DR-A-09605	rev	P01
		issue status	S3

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**COMPLETED DEVELOPMENT**

**KEY**

- Outside of scope
- Phase complete

P01	Stage 2 Issue	13.02.23	WL	CP
Rev	Description	Date	Dr	App
original by		date created	Dr	App
WL		01/24/23	approved by	GB

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client name	Shrewsbury & Telford Hospitals NHS Trust
project	Hospital Transformation Programme - Royal Shrewsbury hospital
drawing	Enabling Works - Complete
computer file	C:\Users\wll\Documents\2019-2023\22164-4000\wll\wll.dwg
project number	2019.00606.001
scale	1 : 1000 @A1
drawing number	RSH-AHR-ZZ-XX-DR-A-09606
rev	P01
issue status	S3

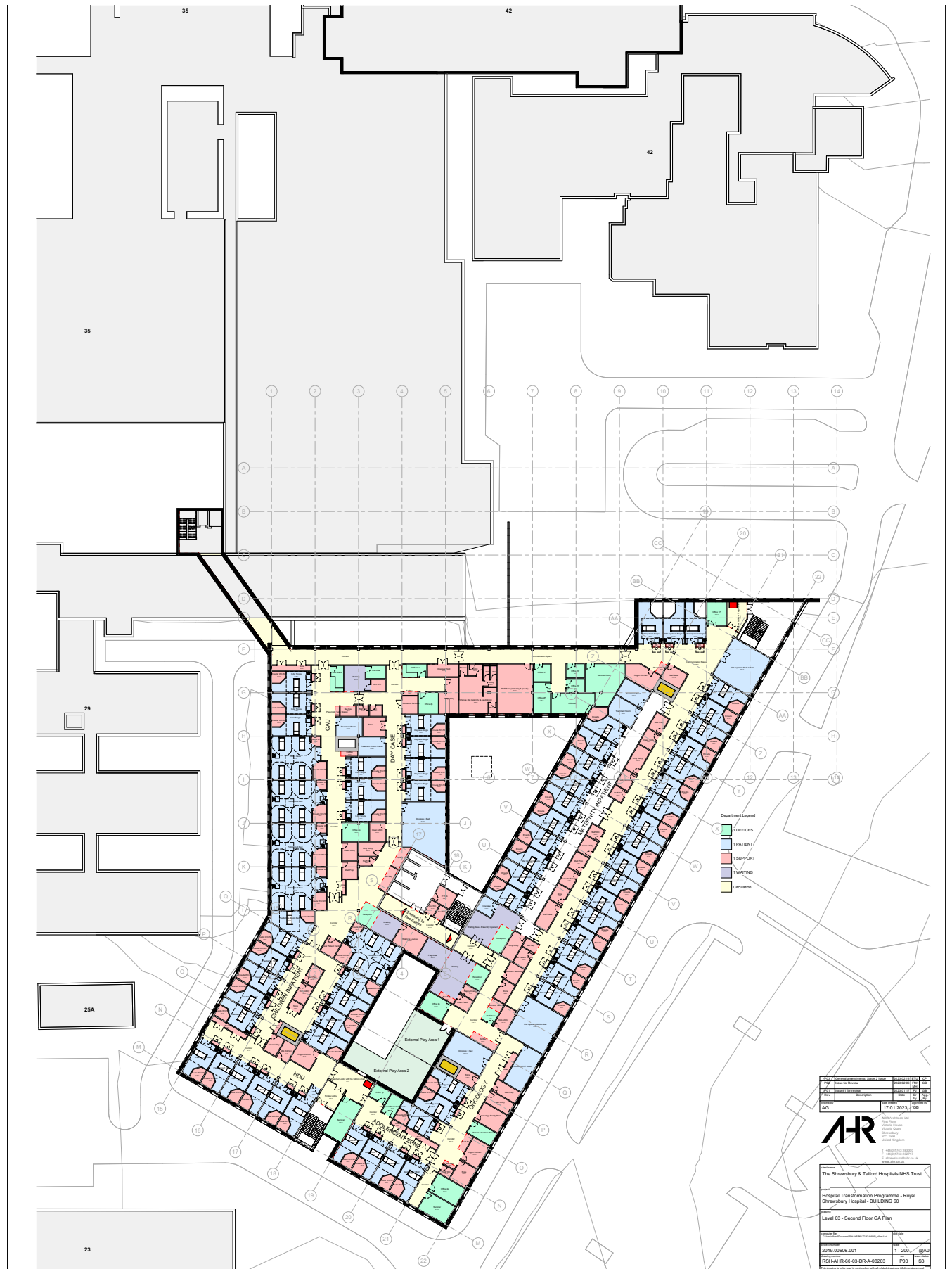
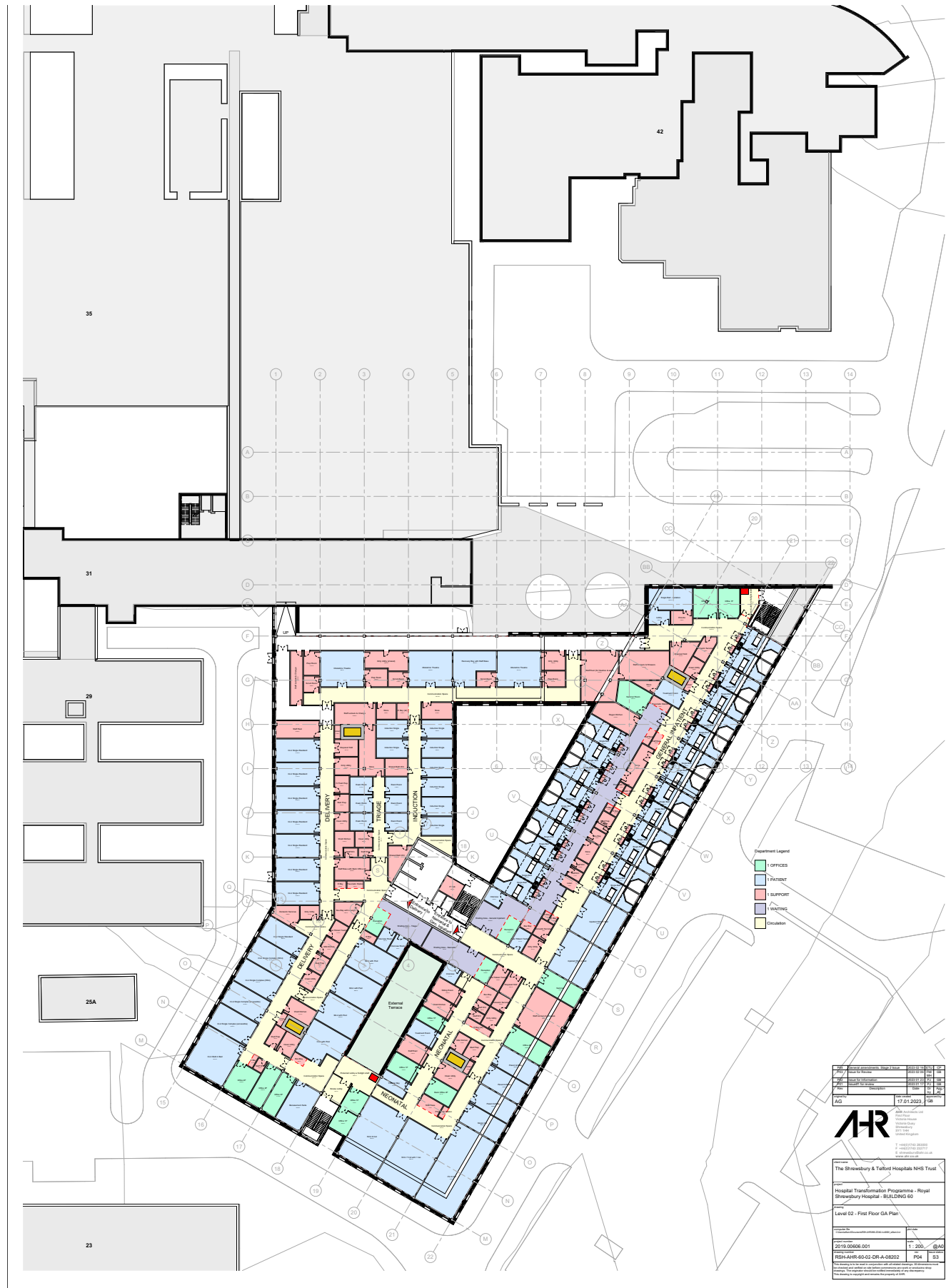
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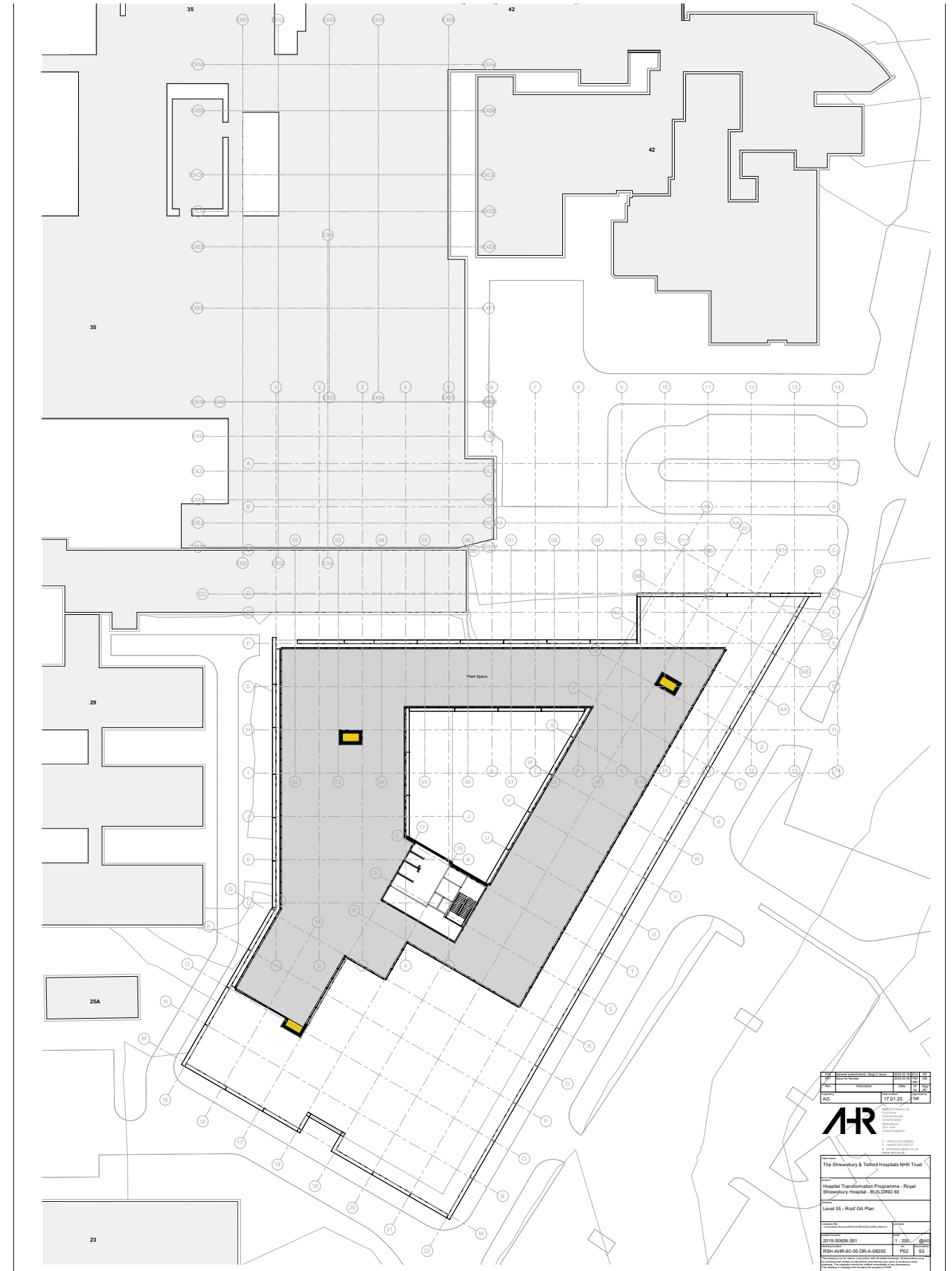
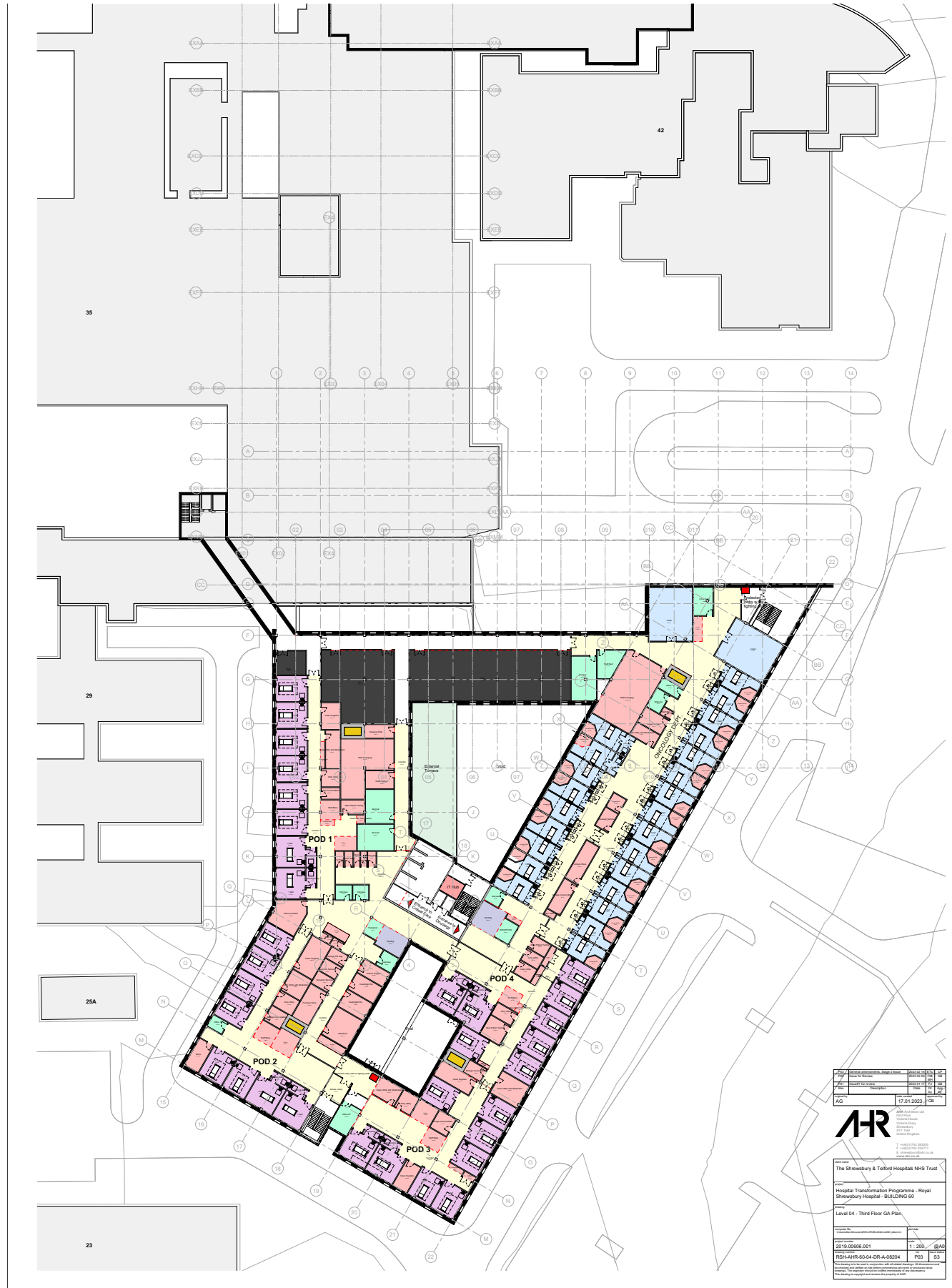
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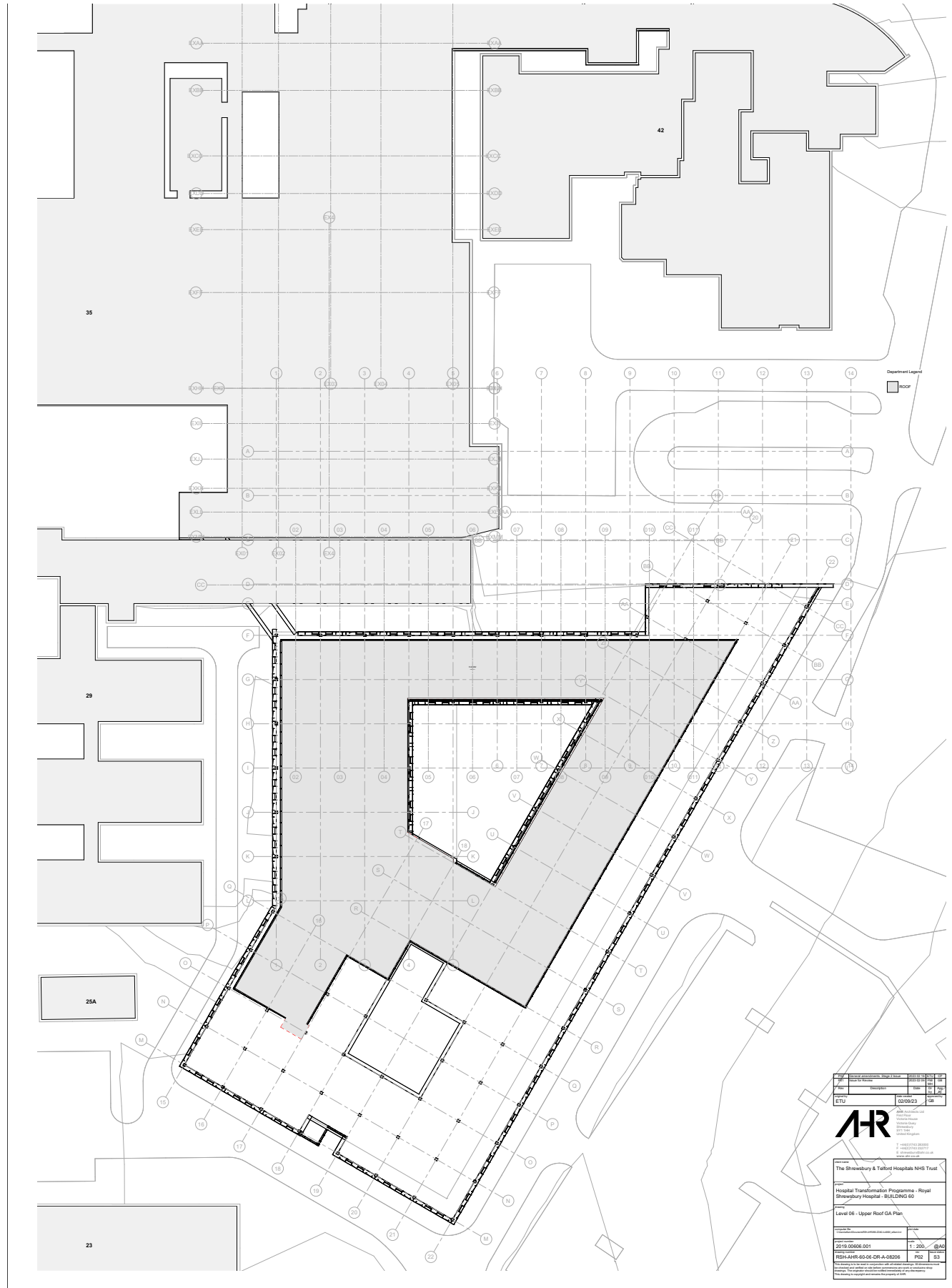








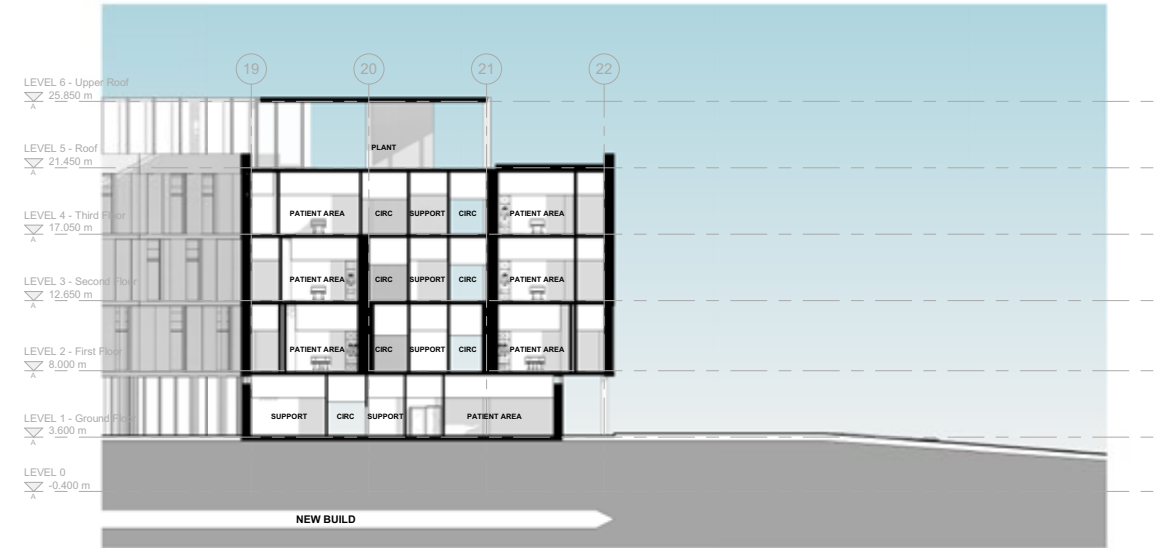




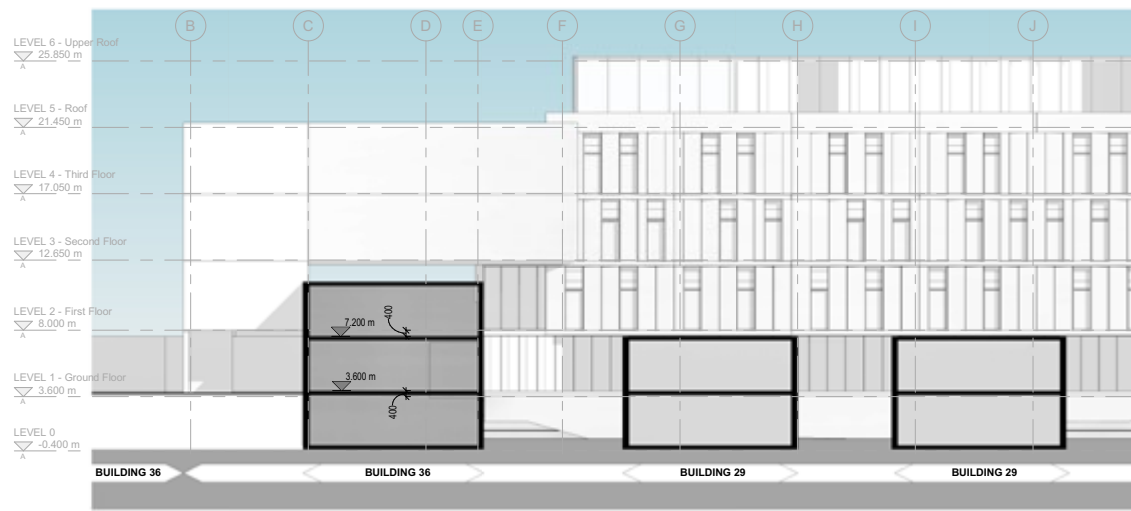




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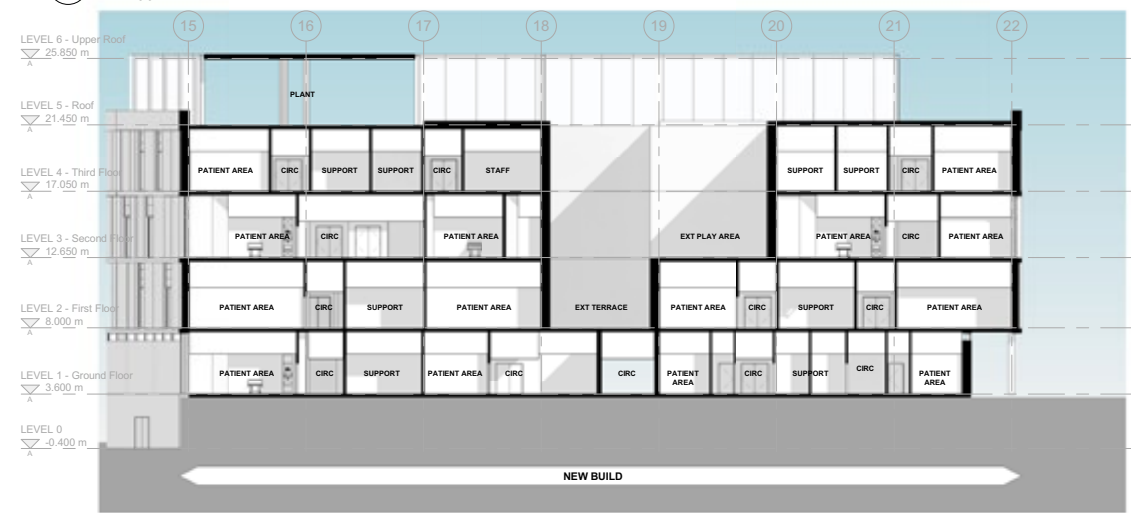
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3 Section CC  
1 : 200



4 Section DD  
1 : 200



5 Section EE  
1 : 200



Rev	Stage 2 Issue	Description	Date	ETU	CP
original by			01/10/23		
ETU				CP	

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client name	The Shrewsbury & Telford Hospitals NHS Trust		
project	Hospital Transformation Programme - Royal Shrewsbury Hospital - BUILDING 60		
drawing	Sections		
computer file	C:\shrewsbury\Documents\99-AHR-80-22-02-A-000_wlan.rvt	plot date	
project number	2019.00606.001	scale	As indicated@A1
drawing number	RSH-AHR-60-XX-DR-A-08301	rev	P01
		issue status	

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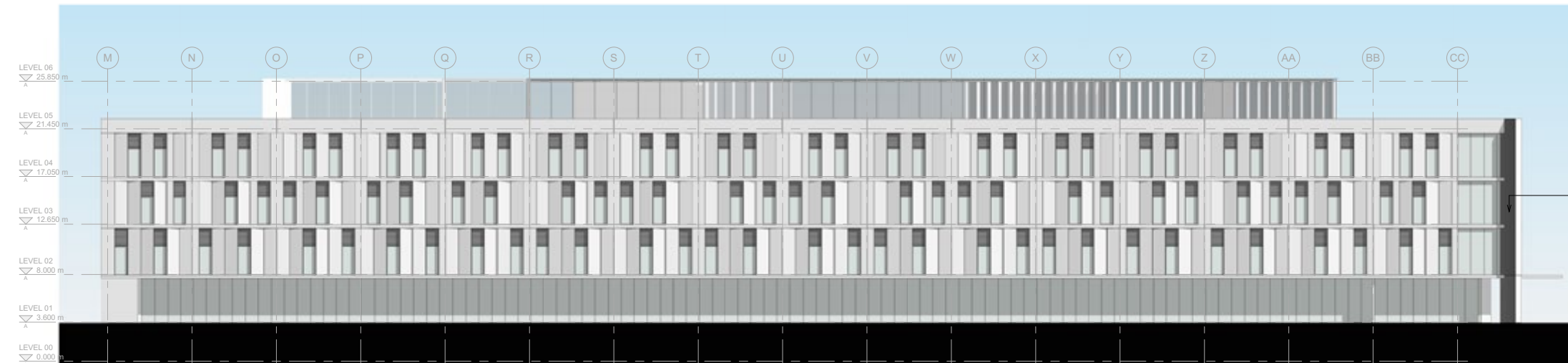
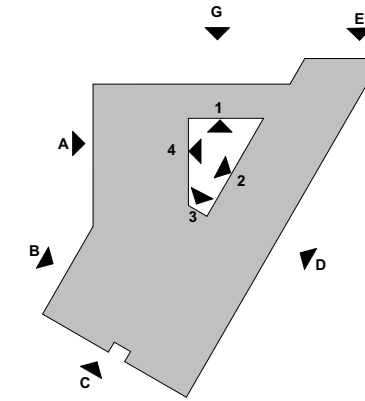




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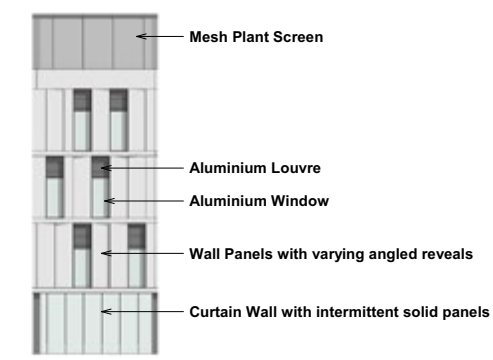
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3 Elevation C  
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Rev	Stage 2 Issue	Description	Date	Dr	App	CP
EB			01/10/23			CP

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client name  
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project  
Hospital Transformation Programme - Royal Shrewsbury Hospital - BUILDING 60

drawing  
Elevations - Sheet 1

computer file  
C:\shrewsbury\Documents\RSH-AHR-60-22-10-1-4-0001.dwg

plot date

project number  
2019.00606.001

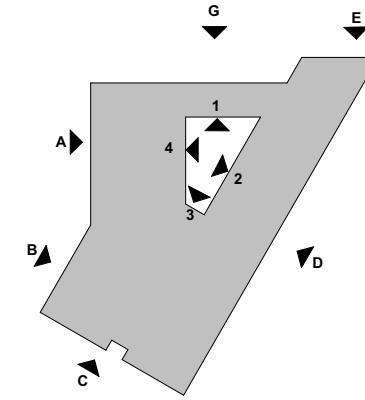
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drawing number  
RSH-AHR-60-XX-DR-A-08401

revision  
P01

issue date  
S3

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2 Elevation E  
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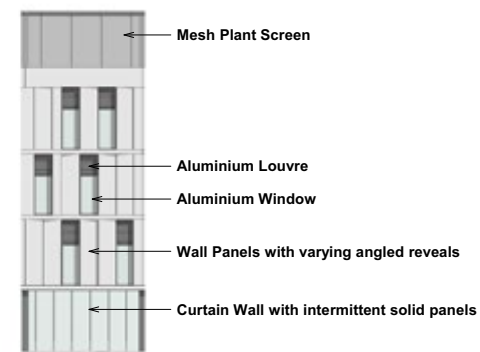
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4 Internal 2  
1:200



5 Internal 3  
1:200

6 Internal 4  
1:200



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original by			01/10/23	Dr	App
EB				CP	By

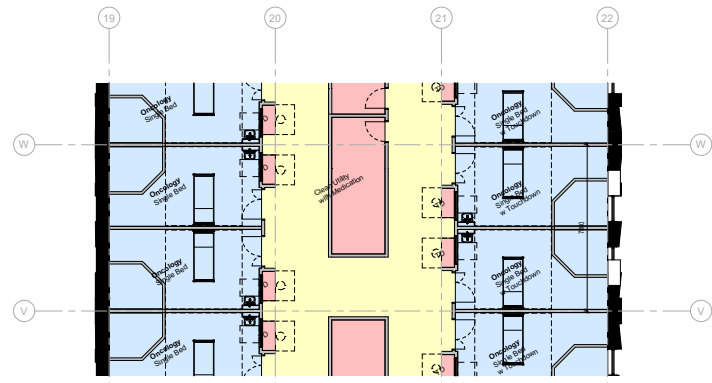


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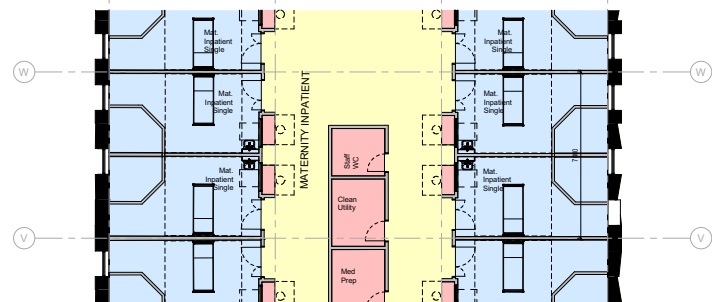
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client name	The Shrewsbury & Telford Hospitals NHS Trust		
project	Hospital Transformation Programme - Royal Shrewsbury Hospital - BUILDING 60		
drawing	Elevations - Sheet 2		
project number	2019.00606.001	scale	As indicated@A1
drawing number	RSH-AHR-60-XX-DR-A-08402	rev	P01
		issue status	S3

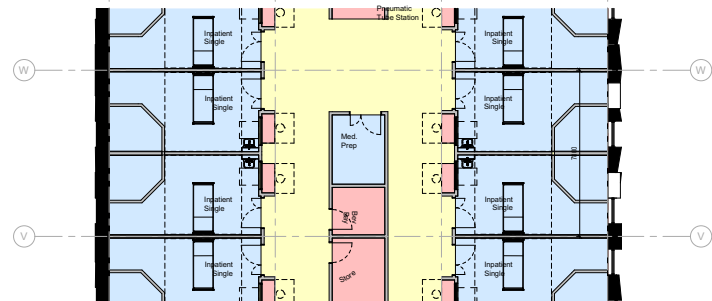
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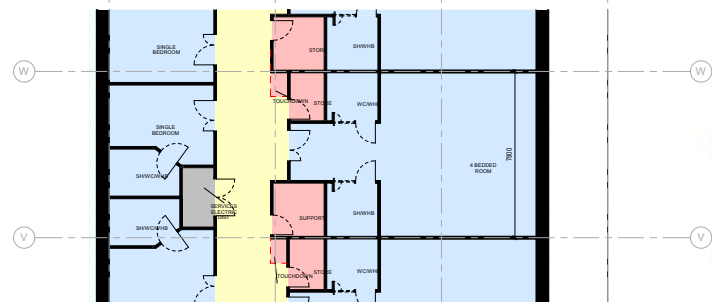
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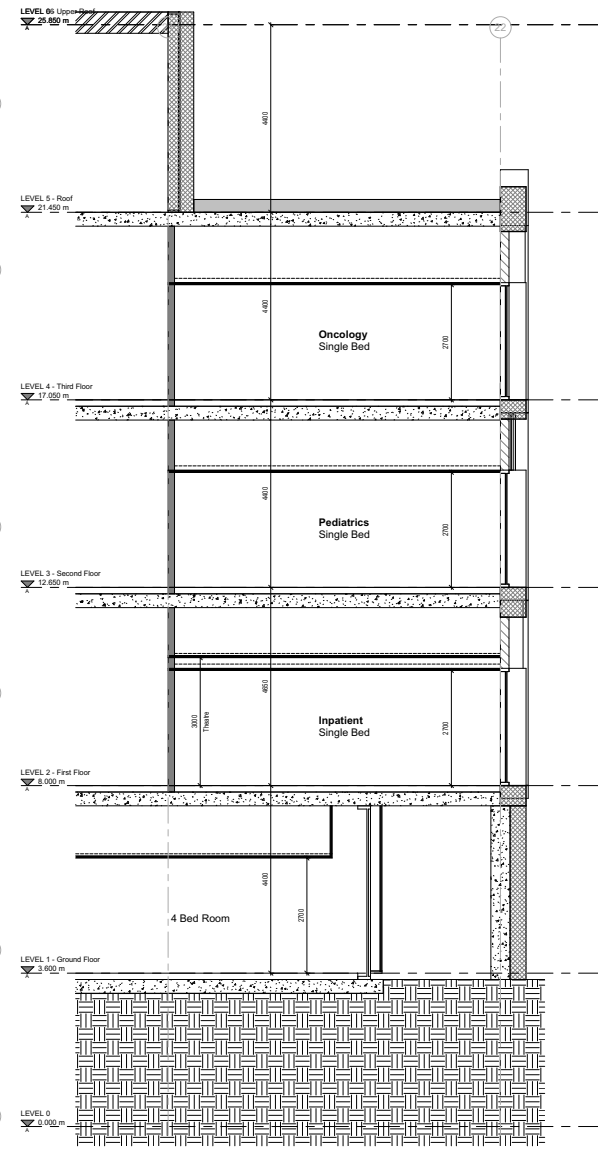
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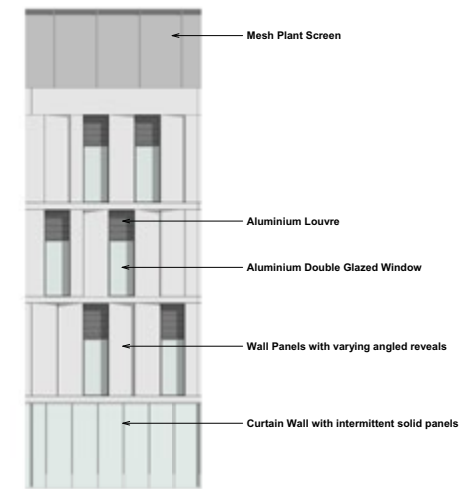
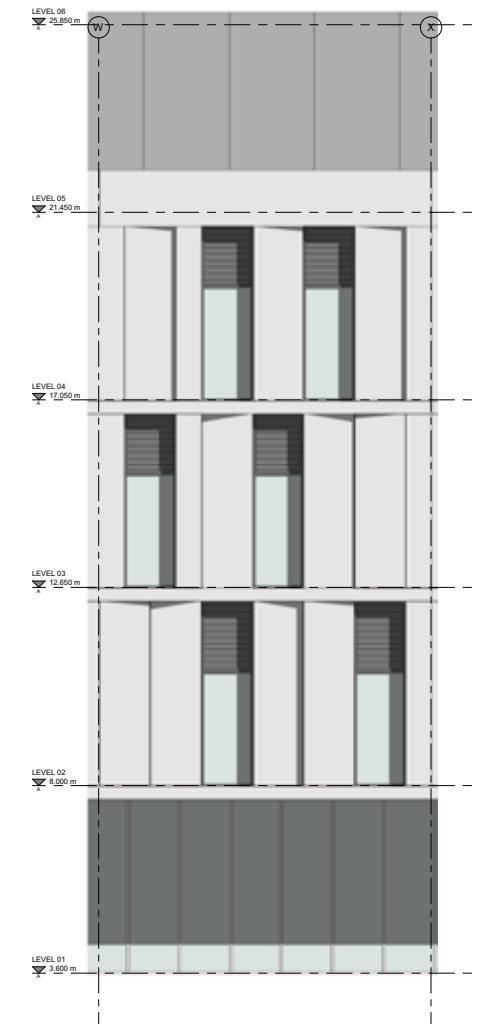
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1:100



**1 Level 01 - Layout**  
1:100



**2 Indicative Section**  
1:50



**GLAZING**  
**SINGLE BED:**  
**GLAZING - 2.86 M<sup>2</sup> / EXTERNAL WALL - 10.53 M<sup>2</sup> = 27.2%**  
**(ON THE ASSUMPTION OF 2700MM AFL)**

**NOTES**

- FACADE UNDER DEVELOPMENT - COORDINATION WITH GA LAYOUT TO BE DEVELOPED AT THE NEXT STAGE
- SOLAR SHADING UNDER DEVELOPMENT



Rev	Change / Reason	06/12/21	CP	CP
1	Issue	01/10/23	CP	CP
2	Issue	01/10/23	CP	CP

**AHR**

Architectural  
 Royal Shrewsbury Hospital - Building 60

Client Name: The Shrewsbury & Telford Hospitals NHS Trust

Project: Hospital Transformation Programme - Royal Shrewsbury Hospital - BUILDING 60

Drawing: Elevations - Bay Study

2019.0006.001 As indicated (BA)

RDH-AHR-60-XX-DR-A-08403 P01 S3





- Key**
- - - Indicates Site Boundary
  - Existing
  - New Build
  - Refurb
  - Relocated



Rev	Stage 2 Issue	Description	06.02.23	WL	GB
original by			Date	Dr	App
ETU			02/01/23	CP	CP



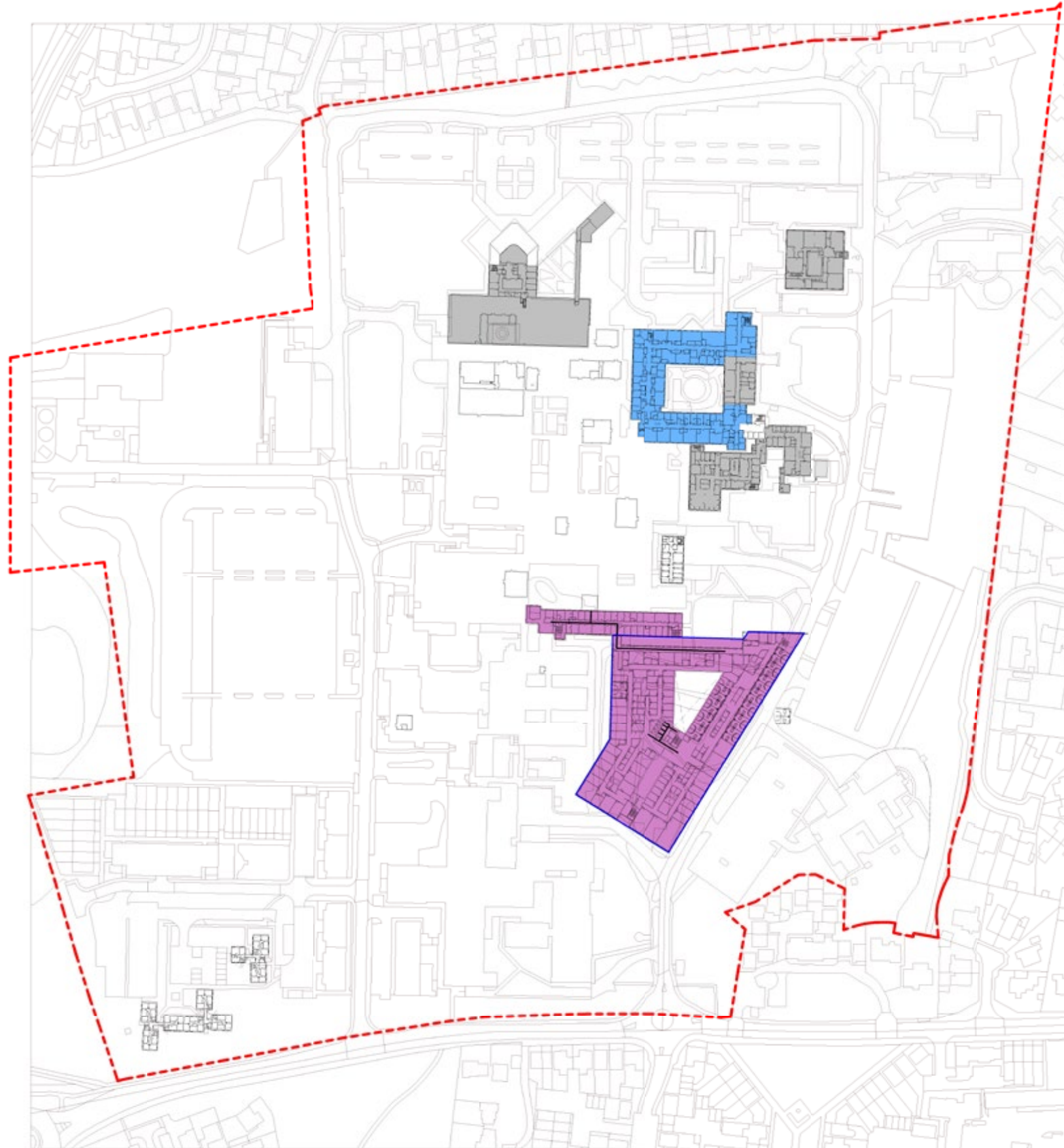
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client name	
Shrewsbury & Telford Hospitals NHS Trust	
project	
Hospital Transformation Programme - Royal Shrewsbury hospital	
drawing	
Level 01 - Site Phasing	
computer file	plot date
C:\Users\etun\Documents\2019-00606\2019-00606-0000.dwg	
project number	scale
2019.00606.006	1 : 1000 @A1
drawing number	rev
RSH-AHR-ZZ-01-DR-A-06600	P01
	S3

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Key  
— Indicates Site Boundary

- Existing
- New Build
- Refurb
- Relocated



Rev	Stage 2 Issue	Description	06.02.23	WL	GB
original by			Date	Dr	App
ETU		site created	02/03/23	CP	CP

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client name	Shrewsbury & Telford Hospitals NHS Trust
project	Hospital Transformation Programme - Royal Shrewsbury hospital
drawing	Level 02 - Site Phasing
project number	2019.00606.006
drawing number	RSH-AHR-ZZ-02-DR-A-06600
scale	1 : 1000 @A1
rev	P01
issue status	

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Key	
	Site Boundary
	Existing
	Proposed New Build Footprint



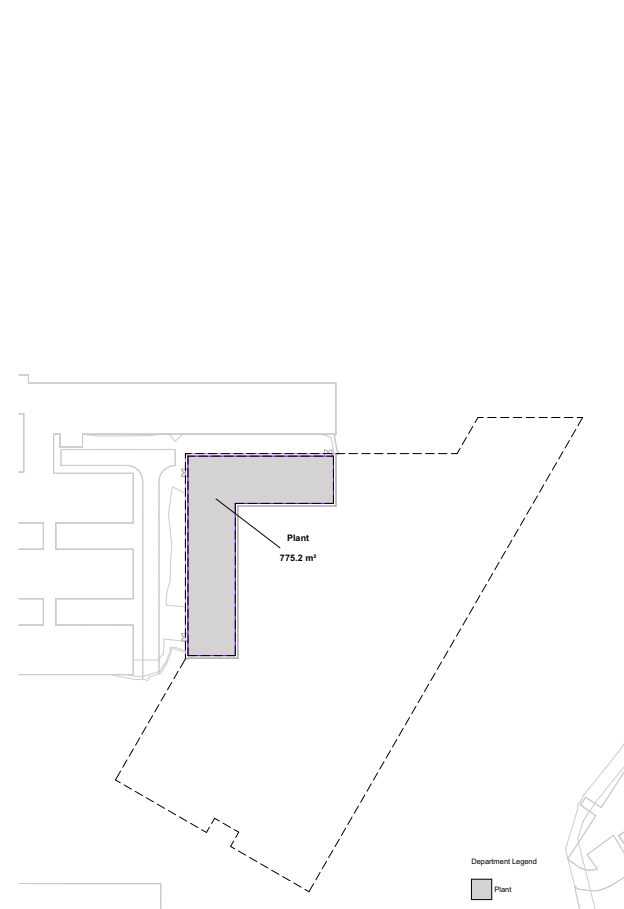
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original by				Dr	App
ETU		Site created	02/06/23	CP	CP

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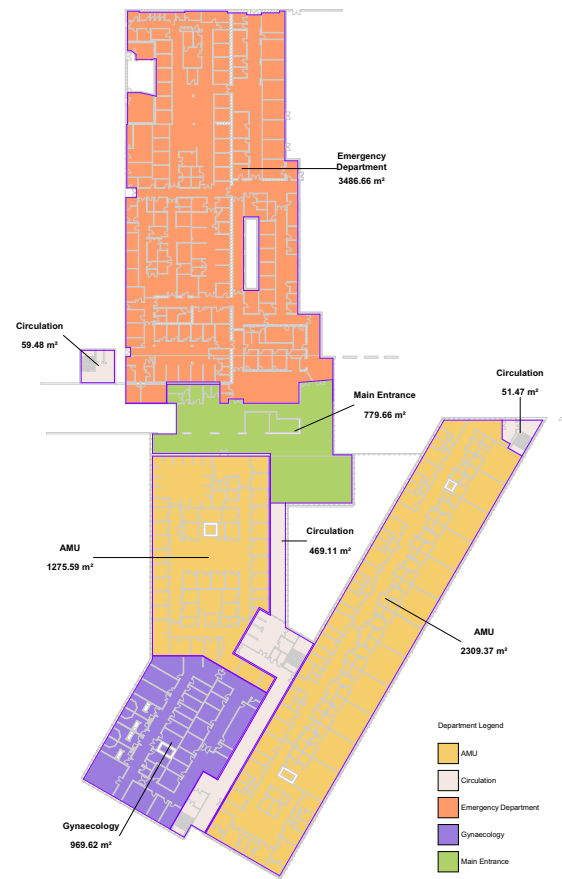
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client name	Shrewsbury & Telford Hospitals NHS Trust		
project	Hospital Transformation Programme - Royal Shrewsbury hospital		
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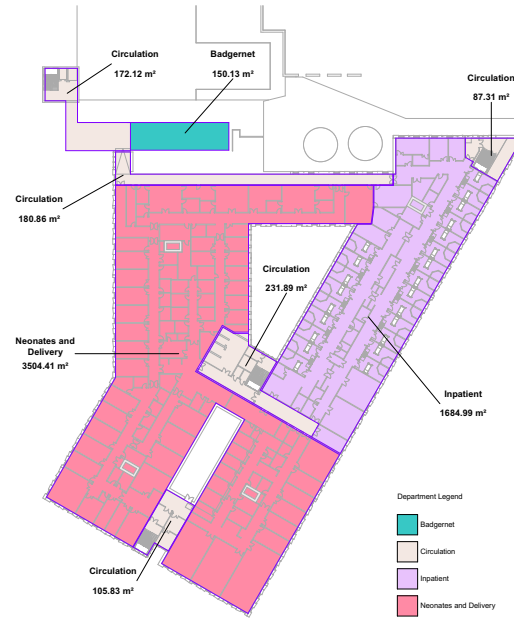
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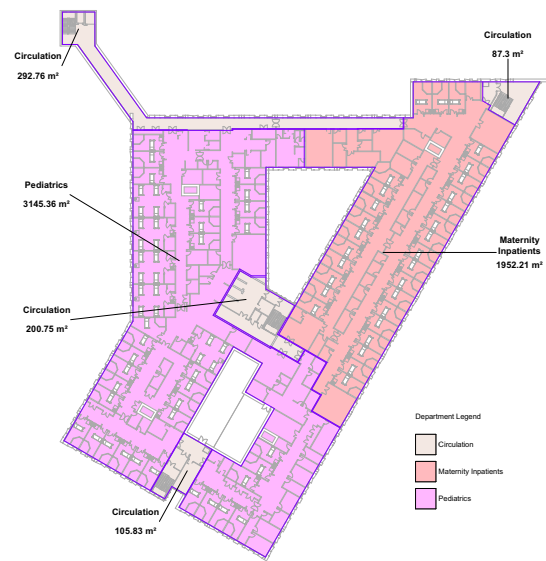
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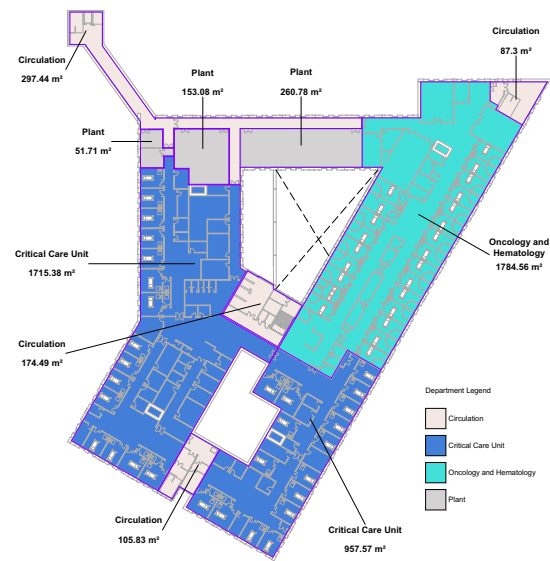
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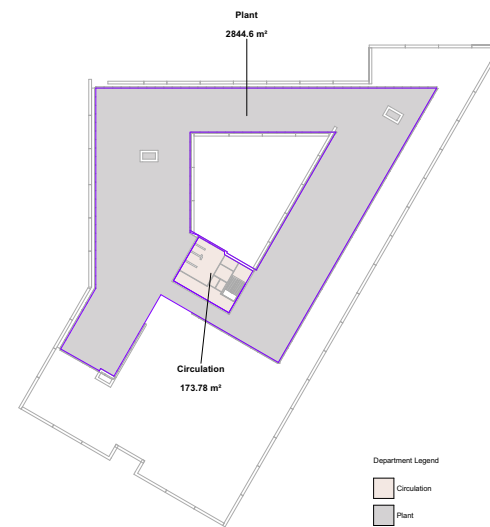
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1:500



3 LEVEL 03  
1:500



4 LEVEL 04  
1:500



5 LEVEL 05  
1:500

Level	Department Name	Area
LEVEL 01	AMU	1275.59 m²
LEVEL 01	AMU	2309.37 m²
		3584.96 m²
LEVEL 02	Badgemet	150.13 m²
		150.13 m²
LEVEL 01	Circulation	469.11 m²
LEVEL 02	Circulation	180.86 m²
LEVEL 02	Circulation	231.89 m²
LEVEL 02	Circulation	105.83 m²
LEVEL 03	Circulation	292.76 m²
LEVEL 03	Circulation	200.75 m²
LEVEL 03	Circulation	105.83 m²
LEVEL 04	Circulation	297.44 m²
LEVEL 04	Circulation	105.83 m²
LEVEL 04	Circulation	174.49 m²
LEVEL 05	Circulation	173.78 m²
LEVEL 01	Circulation	59.48 m²
LEVEL 02	Circulation	172.12 m²
LEVEL 01	Circulation	51.47 m²
LEVEL 02	Circulation	87.3 m²
LEVEL 03	Circulation	87.3 m²
LEVEL 04	Circulation	87.3 m²
		2853.53 m²
LEVEL 04	Critical Care Unit	957.57 m²
LEVEL 04	Critical Care Unit	1715.38 m²
		2672.96 m²
LEVEL 01	Emergency Department	3486.66 m²
		3486.66 m²
LEVEL 01	Gynaecology	969.62 m²
		969.62 m²
LEVEL 02	Inpatient	1684.99 m²
		1684.99 m²
LEVEL 01	Main Entrance	779.66 m²
		779.66 m²
LEVEL 03	Maternity Inpatients	1952.21 m²
		1952.21 m²
LEVEL 02	Neonates and Delivery	3504.41 m²
		3504.41 m²
LEVEL 04	Oncology and Hematology	1784.56 m²
		1784.56 m²
LEVEL 03	Pediatrics	3145.36 m²
		3145.36 m²
LEVEL 04	Plant	260.78 m²
LEVEL 05	Plant	2844.6 m²
LEVEL 00	Plant	775.2 m²
LEVEL 04	Plant	153.08 m²
LEVEL 04	Plant	51.71 m²
		4085.36 m²
		30684.43 m²

Rev	Revised	Description	Date	By	App
1	1	01/23/23		CP	

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Client Name: The Shrewsbury & Telford Hospitals NHS Trust

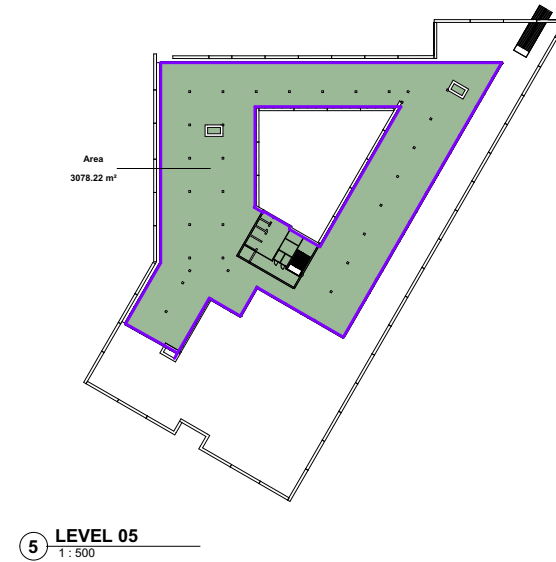
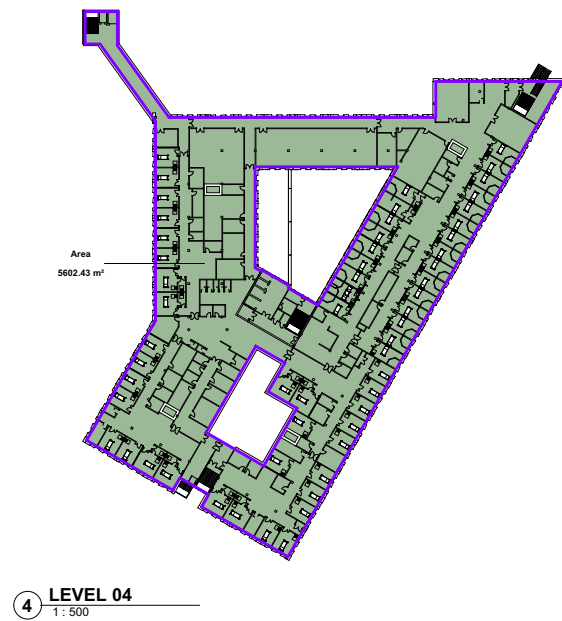
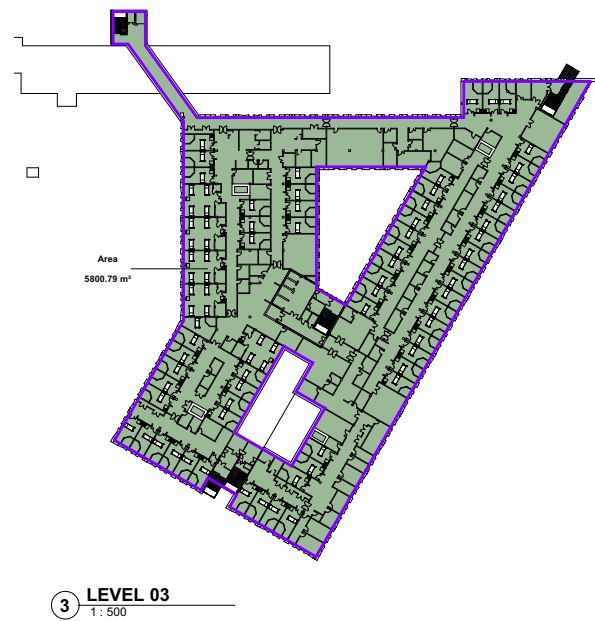
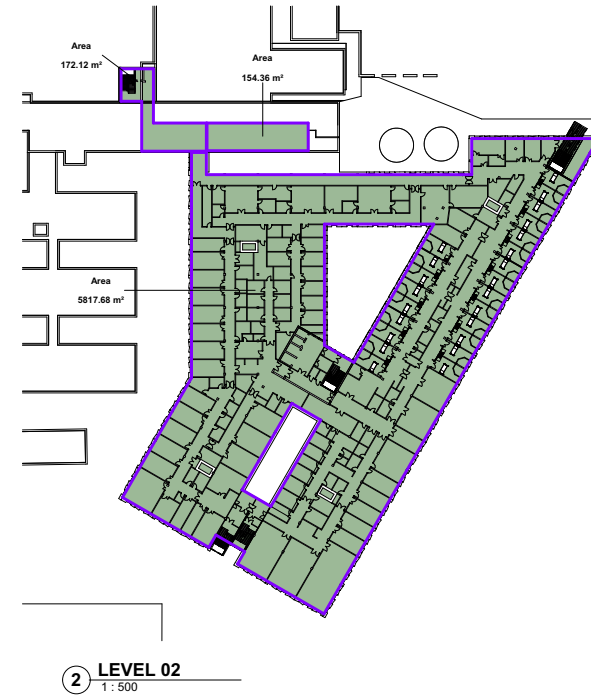
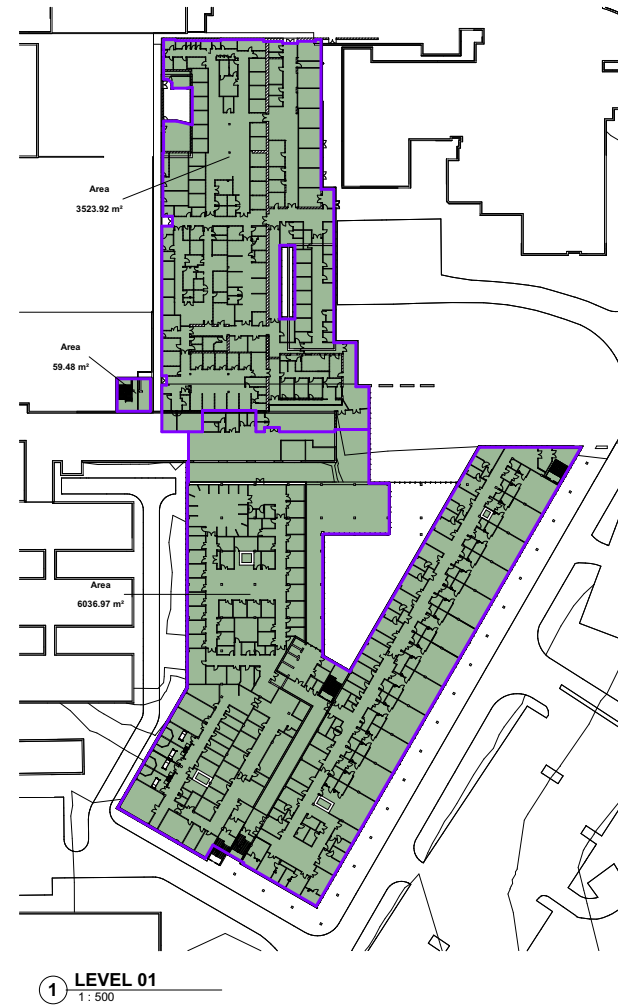
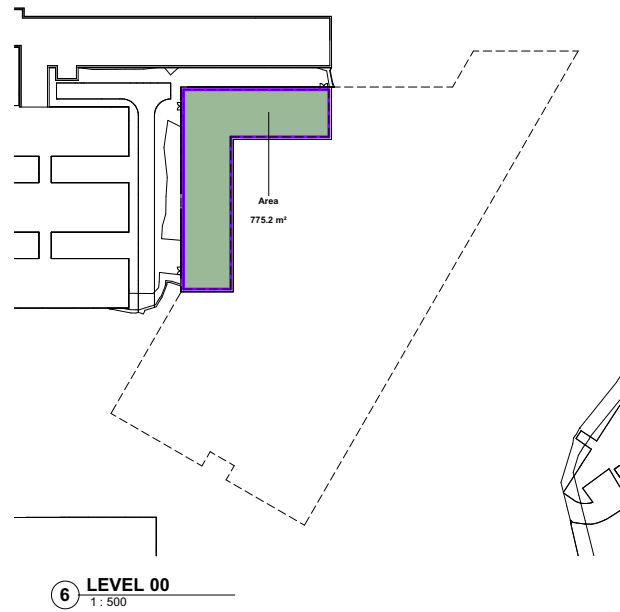
Project: Hospital Transformation Programme - Royal Shrewsbury Hospital - BUILDING 60

Drawing: Departmental Area Plans

Project No:	2019.0006.001	Scale:	1:500	Sheet No:	@AA
Drawing Title:	RSH-AHR-60-XX-DR-A-08211	Date:	11/23/23	Author:	CP

Approved by: [Signature]





Gross Internal Floor Area	
Level	Area
LEVEL 00	775.2 m <sup>2</sup>
LEVEL 01	6036.97 m <sup>2</sup>
LEVEL 01	59.48 m <sup>2</sup>
LEVEL 01	3523.92 m <sup>2</sup>
LEVEL 02	5817.68 m <sup>2</sup>
LEVEL 02	172.12 m <sup>2</sup>
LEVEL 02	154.36 m <sup>2</sup>
LEVEL 03	5800.79 m <sup>2</sup>
LEVEL 04	5602.43 m <sup>2</sup>
LEVEL 05	3078.22 m <sup>2</sup>
	31021.16 m <sup>2</sup>

Rev	Description	Date	By	App
01	Issue for CP	01/19/23	CP	CP



Client Name		The Shrewsbury & Telford Hospitals NHS Trust	
Project		Hospital Transformation Programme - Royal Shrewsbury Hospital - BUILDING 60	
Drawing		GIFA Plans	
Drawing No	2019.0006.001	Scale	1: 500 @A0
Revision No	RSH-AHR-60-XX-DR-A-08210	Rev	PH1 S3

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## 3.12 Modern Methods of Construction Strategy

### 3.12.1 Introduction

Modern Methods of Construction (MMC) is a wide term, embracing a range of offsite manufacturing and onsite techniques that provide alternatives to traditional building and forms part of the Government's recent policy (2017) for future construction in the public sector.

In line with the Government 2019 statement - 'Presumption in Favour of MMC' DHSC and NHSEI assume that all schemes start out as MMC.

In addition to enabling a reduced on-site component assembly time, due to off-site factory production to a pre-agreed quality standard, MMC also reduces the size of on-site construction teams, disruption to site, health & safety risk and post completion defects. MMC can also help in overcoming a skills shortage in the construction industry and should also result in a reduction in project time and cost whilst improving safety and quality throughout the whole of an assets life.

The government's Infrastructure and Projects Authority (IPA) guidance 'Transforming Infrastructure Performance' (2017) also refers to MMC as 'smart construction' defined under the following three categories which covers a range of techniques with greater levels of activity taking place off site and increased levels of standardisation, underpinned by digital design and engineering.

- **Manufactured:** whilst not widely used this offers the greatest opportunities to improve delivery efficiency and boost productivity. This approach enables high levels of customisation by developing and using standard components and assemblies.
- **Volumetric:** e.g., fully fitted modules.
- **Components:** e.g., standardised design elements (WC/shower 'pods', pre-assembled bed head services etc).
- **Traditional construction:** e.g., methods that are relatively unproductive, with projects individually designed and constructed with little consistency in either the design solution or construction method, even for similar projects.

### 3.12.2 Targets

The Team recognises the significant contribution that MMC (as defined by various UK Construction bodies and in the UK Construction Strategy) makes to multiple strategic agendas for the Construction Industry and Health Sector, including but not limited to:

- Reducing the size of on-site construction teams
- Reducing disruption to operational sites
- Reducing health & safety risks
- Enabling a reduced on-site component assembly time
- Achieving off-site factory production to a pre-agreed quality standard
- Fewer post completion defects
- Overcoming skills shortages
- Enhancing productivity in the construction industry
- Reducing carbon emissions associated with the construction and contributing to the wider net-zero carbon goal

As a matter of principle, the project has adopted an "MMC first" approach when considering the built form strategy for all of the constituent projects within the wider redevelopment programme.

It should however be noted that the viability of MMC is dependent on the principles of 'supply and demand', and whether the volumes associated with a particular programme are sufficient for the supply chain to invest in the necessary manufacturing and logistical implications. In simple terms the adoption of standardisation and modularisation is, in the majority of cases, subject to site specific conditions and considerations.

### 3.12.3 Key Elements

#### Key Benefits of MMC

- Safer – Less people working on construction sites
- Quicker – Majority of work done offsite in parallel with preceding works
- Better quality – Manufactured in a controlled environment with an established QA process. The Construction Playbook refers to 'greater predictability and lower maintenance costs'
- Greener - Lower Greenhouse Gas (GHG) emissions
- Embed Digital Technology – Better managed digital outputs are more likely to provide a solid base for effective management and retention of the 'Golden Thread' of Building Information

#### Consequences

- Design - Earlier engagement of detailed design
- Procurement - Longer lead in times
- Information Sharing – Shared components and model data across sector
- Early Manufacturer Engagement – MMC elements to be developed with supply chain

#### Roles and Responsibilities

Shrewsbury and Telford NHS Trust (SaTH)  
SaTH will support and encourage the adoption of MMC through the application of this strategy and through market engagement, when permitted

#### Construction Partner:

The Construction partner will take an 'MMC first' approach to design, design-in practicable MMC solutions based on the latest market practices and undertake regular update/review of the 'MMC Tracker' throughout design.

#### Early engagement with Tier 1 contractors and supply chain

As part of normal market engagement and programme development 'best practice', the early engagement of the Tier 1 construction market and associated supply chain is identified as being a vital element in sharing knowledge and engaging the market with the range of MMC related concepts and approaches that are being considered and developed within the programme.

As the design progresses through conceptual stages the 'market' would normally be invited to attend a soft market briefing session wherein outline 'strategies' that might include design principles, potential opportunities for the standardisation of elements of

design, opportunities for 'just in time' delivery, logistical constraints and opportunities would be shared and debated with the market place. As part of this discussion the supporting supply chain would advise on the concepts, their viability, minimum volumes required, lead times on materials and building elements and possible output rates that in turn would need to be considered within the planning and programming phases.

### 3.12.4 Strategy

Standardisation and repeatability are at the heart of any MMC strategy. In the context of MMC, standardisation is the process of making something conform to a standard, which reduces reinvention and with it the number of different permutations in delivery and use. To realise benefits, standardisation is used to drive repetition. This requires rationalisation to ensure "one size fits many", reducing the number of different dimensions needed to enable greater reuse and repetition of individual components.

To this end, the team have sought to standardise conventions and frameworks (planning grids, room naming, care pathways, requirements) and repeat solutions (grids, MEP distribution, clusters, room layouts, dimensions, geometries). At this stage (OBC) it is intended to use the following definitions:

- Repeated rooms = proportion of standard spaces repeated
- Repeated clusters = proportion of standard spaces with repeated standard adjacencies (V&H)
- Dimensions = proportion of fit out using standard parameters (e.g. grids, internal walls, risers)

A lack of standardisation means reinvention and wasted effort, and manifests as increased costs when offsite or manufactured solutions are sought. Getting standard designs that can be repeated right at the outset enables an economy of scale not possible without. Evidence from Procure21+ indicates standardisation and repetition of selected rooms leads to 11% cost savings with improved patient outcomes.

To deliver MMC, SaTH has utilised the NHP criteria as a guide to implementing the strategy. This involves 3 measured criteria:

- **Delivering MMC** – which provides improved project design and decision making; supports a successful MMC adoption and improvement across the industry; and utilises Pre-manufactured Value (PMV) as a vehicle to increase opportunities within the supply chain.
- **Project Standardisation** - Repeatable rooms/components – which improves product and process integration and simplifies them; provides consistency of design and continuous improvement of spaces; improves cost certainty; reduces waste; and provides increased flexibility.
- **Project standardisation** - Shell & Core design parameters- which improves predictability of the project in terms of cost, quality, and programme; improves efficiency of design and optimisation for offsite solutions; and enables optimised logistics and supply chain integration.

## 3.12.5 Implementation

### Delivering MMC

1. Presence of MMC strategy and its application within the design
2. MMC maturity level (measure of enablers)
3. % pre-manufactured value (PMV)

The use of a standardised design on its own is not sufficient to deliver MMC. The Team has therefore considered other key enablers of MMC and has sought to facilitate them to build and refurbish facilities in the most efficient way possible. Under the NHP criteria, Projects are expected to provide evidence of a project specific MMC strategy which has had a material impact on the design and comply with the set objective tests (requirements). Whilst this project does not fall under this framework, there are clearly benefits in being able to measure this and the '6 principal pillars' identified in the NHP documentation provide a useful guide to set up such measurement. These 6 pillars also shape the implementation of the strategy.



### MMC strategy and its application within the design

#### Value - how we have defined value to incentivise the right application of MMC

This project has had a difficult journey getting to OBC and the scope and ambition of the project has been updated several times as a consequence. However, the core objectives and key requirements have remained consistent:

- Provide a renewal of the SaTH estate which will be perceived as high quality by the local population and create a sustainable healthcare infrastructure
- Provide a solution which can be delivered with a high degree of certainty and speed
- Provide an extensive range of clinical spaces which can adapt to a rapidly changing clinical landscape
- Deliver the project within stringent cost parameters

The MMC solution should therefore be capable of the following:

- Implementation without significant developmental costs
- Have a proven track record of delivery and programme
- Have a high degree of repeatability
- Be low maintenance
- Have sufficient flexibility to allow for constant change

**Digital – how we are structuring, using, and sharing our information to enable the right application of MMC**

Building Information Management (BIM) is a key component of our strategy, creating an information rich model which can be utilised by the contractor for design development and manufacture and by the FM team to assist in the maintenance and operation of the infrastructure. A Common Data Environment (CDE) is in the process of being implemented by SaTH to facilitate the rapid and accurate transfer of information. This is all captured in the Bim Execution Plan (BEP)

**Design – How we are developing and assessing options to maximise the use and benefits of MMC**

A "Shell and core" model has been embraced to allow for ongoing development of the clinical brief without impacting on the construction methodology. This model is supported by a simple 7.8m x 7.8m grid which provides the optimal span for framed solution and provides an efficient grid for the most common room type in the plan – a pair of single bedrooms.

The design of these bedrooms is consistent throughout the building and utilises colour and a range of "add on" details to allow an individual character to be applied to customise the room type for adult inpatient, maternity inpatient, short stay, oncology, and paediatric use. This approach will be extended as the design develops to reduce the number of room volumes and types of similar spaces required in the project.

The standardised grid allows for the adoption of a predominantly "off-site and near site Pre-manufacturing solutions", from simple Category 5 (Pre-Manufacturing – Non-structural assemblies and sub-assemblies), through Category 4 (Pre-Manufacturing – Additive Manufacturing) and right up to Category 2 (Pre-Manufacturing – 2D primary structural systems).

Whilst it may be possible to utilise Category 1 (Pre-Manufacturing – 3D primary structural systems) we have found in that it is difficult to deliver a complex building of the type envisaged in this project within the cost parameters established.

The façade has been developed with a very limited set of components which can be configured in numerous ways to create visual interest in the building and accommodate a range of environmental solutions such as windows, louvres, and highly insulated panels to respond to the requirements of the enclosed rooms.

The MEP and Structural solutions are being developed to enable MMC through the use of flat soffits which will accommodate modularised service racks.

**Delivery model – How we are setting the right conditions to maximise the use and benefits of MMC**

It is intended to utilise the P23 contractor's framework which has been developed to ensure collaboration and innovation is a key part of the contractors working arrangements. The tender process will specifically target and value MMC as a key selection criterion.

**Production – How we are considering production to maximise the use and benefits of MMC**

As with the approach to delivery, the ability of the contractor to demonstrate end to end production processes covering manufacturing assembly etc will be a key element in their selection. The current design team has direct experience of design for manufacture and is developing an information rich model which can be developed with the contractor to support direct manufacture.

**Into use – How we are considering the operational phase in relation to MMC**

The design team is fully committed to supporting the contractor and users in the hand over from production to use. Once again tendering documentation will emphasise the importance of "soft Landing" and will score the response accordingly.

**3.12.6 MMC Maturity (Measure of Enablers)**

As noted previously, whilst it is not a requirement of funding, it is desirable for the MMC strategy and its implementation to demonstrate success. The NHP defines this as Achieving a Maturity score of at least 2 in each pillar, and this will be our target.

Of particular interest will be the Pre-manufactured Value (PMV) to provide a framework for measuring progress and target MMC opportunities in supply chain platforms, products, systems and services, and site activities. PMV, expressed as a %, is used to identify the proportion of manufactured components within an overall construction project cost. PMV is intended to identify the extent at a package level (NRM level 1) to identify opportunities for improvement to which projects are implementing construction methods that reduce site labour and the intensity of preliminaries.

Increased PMV should demonstrate improvements in areas such as predictability, productivity, reduced waste, improved quality and performance, logistics, reduced costs, increased social impact and improved Health and safety on projects. MMC includes various methods which increase PMV, which can be divided into seven categories, defined in the government's MMC framework. Whilst developed for housing, it remains useful in healthcare. The combination of the MMC categories and PMV helps provide targeted measures to which iterative improvements can be applied across project lifecycle.

At OBC, SaTH aim to report an overall PMV% level (which can be calculated as a percentage of Premanufactured value (£) divided by gross construction cos) of over 60%

**Delivering MMC**

As a baseline, SaTH aim to demonstrate a level of standardisation and repeatability across all functional spaces and components. The site is an irregular one constrained on 2 sides by existing roads and on the other 2 sides by existing buildings, to form a triangular shape. However, the design team has worked hard to create a regular grid which has limited deviations from the orthogonal form to help support modularisation.

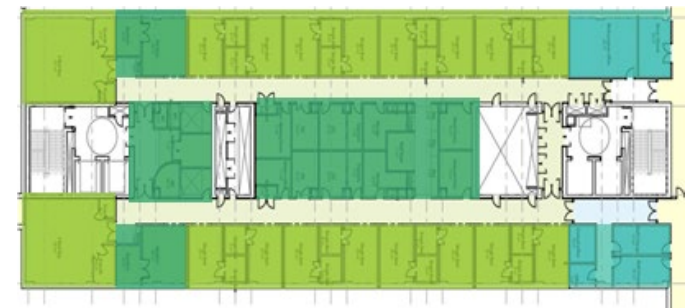
SaTH will provide the following in support of its MMC objectives:

- Creation of a programme-wide SoA which is inclusive of standardised components, evidenced with adoption of standard rooms data sets

- A target of 80% of standardised repeated rooms on a project basis. Assessed by standard rooms as a proportion of quantity of rooms (net department). SaTH will also provide examples of typical standardised rooms expected; inpatients, outpatients, dirty utilities, toilets etc as 1:50 layouts
- A target of 80% of standardised repeated primary assemblies (bathroom pods / bedhead walls / door sets / major FFE assemblies, integrated plumbing systems etc.)

It should be noted that a significant portion of the works include refurbishment and remodelling (approximately 2000sqm), and this area will adopt a common approach and standardisation principles, where possible, however it is likely to have more constraints and therefore we will be concentrating our approach on the use of a high level of 'standardised repeated primary assemblies' such as electrical fittings, sanitary appliances etc.

This Repeatability will be broken down into key typologies and will be demonstrated using colour layouts, as shown below. The number of each room type will also be reflected into the SoA

**3.12.7 Project standardisation shell and core design**

Except for the refurbished areas of the project, SaTH will provide evidence of the following to comply with the objective tests (requirements):

Standardised, repeatable MEP systems: SaTH will use standard MEP systems defined by space/ room/ cluster spatial in use requirements. MEP systems are a direct answer to end user requirements of the individual spaces and once defined, treated as a standard solution that is repeated.

Standardised repeated approach to floor-to-floor heights and corridors: SaTH has identified three types of floor-to-floor heights based on technology level:

- Medium – 1.05m ceiling zone, 2.7m floor to ceiling and 4.4m Floor to Floor
- High – 1.0m ceiling zone, 3.0m floor to ceiling and 4.65m floor to floor
- Plant – 4.5m floor to soffit

Standardised repeated structural grid: SaTH has utilised a standard, common approach to structural grids across the project, of 7.8m x 7.8m, minimising the use of abnormal or unnecessarily variable spatial grids. The building form is based on the standard grid wherever possible.

Standardised repeated assemblies: SaTH is developing fixed building systems and aiming to repeat these with as little variation as possible. This includes external façade panels, internal walls, risers, MEP distribution, roof elements. This will be greatly influenced by the shape and size of the building; a more regular and uniform shape is preferable.

**3.12.8 Conclusion**

The project is currently at RIBA Stage 2, but the foregoing indicates that SaTH has already prepared the ground well and this will allow the team to develop the project to the next level detail, with a high degree of confidence that a high (measurable) degree of MMC adoption can be economically adopted.



### Vehicular and Pedestrian Circulation

A fundamental element of the landscape design is to rationalise vehicular and pedestrian circulation around the hospital site. Whilst the vast majority of patients and staff will arrive at the site in a vehicle, there must also be due consideration for those arriving on foot in the form of appropriate circulation within the site. Pedestrian routes connecting bus-stops, car-parks and the building entrance should be clearly defined and safe.

Where practical, parking bays and drop-off areas have been located as close to the main entrance as possible. Where this is not possible due to existing site constraints, priority has been given to accessible spaces and for drop-off areas which can be used by those less able to walk. The main turning loop adjoining the plaza serves these users, providing a direct link to the canopy and the building's main entrance.

### Entrance Plaza

The creation of a new entrance plaza provides an opportunity to improve the site's legibility and enhance the building's main entrance as part of a clear wayfinding strategy. The generous external space will act as a confluence for visitors approaching from different parts of the site, leading visitors through an attractive landscaped plaza and offering clear decision points to direct them to the correct entrance. A new entrance canopy will support this strategy, projecting out from the building and coordinating with the landscape features below to read as one element.

### Ambulance, Patient Parking & Public Transport

The existing A&E ambulance parking area will be extended and improved as part of the proposals, increasing the number of bays and providing additional protection from the elements via a new canopy. Additional parking provision for three ambulances will also be made to the south of the site, in front of the Copthorne Building.

General patient & staff parking provision will remain on the opposite side of the main access road in the existing parking area to the east.

It is proposed that the bus stop will be located to the existing layby outside the Lingen Davies Centre. From here, patients will take a short walk of around 50m to the new entrance plaza.

### Helipad

The existing Helipad will be displaced as part of the proposals. A number of options are being considered for its relocation, however, the current proposals indicate it will be positioned over the existing car park footprint to the east of the main entrance. Here, it could sit on a deck above the existing parking provision and maintain a direct physical link to the building. Other options being considered may require a short internal transfer for patients via ambulance from the helicopter to the building.

### Cycle Parking

Due to an upward trend in the use of pedal cycles, allowances should be made for increased cycle parking demand in the future. Although the exact requirements have not yet been established, an area of covered cycle parking has been indicated to the south of the site a short ride from the main hospital site entrance, adjacent to the Copthorne Building.

### Courtyard

The communal courtyard has been positioned centrally within the building. This maximises access to views of green space for patients and staff and allows more light into the core of the building. The courtyard will act as a social hub within the new facility, allowing patients, staff and visitors to relax in a sheltered garden space. The courtyard will be designed to offer year-round horticultural interest and will present a variety of seating areas for social gatherings and more personal, contemplative occasions.

### Planting Strategy

The planting strategy will respond to the architectural proposals and serve a number of functions to support a clear wayfinding strategy. Avenue tree planting along the main access road will create a rhythm along the building's east elevation and provide a visual cue towards the entrance plaza to the north. Planting in this areas will also afford privacy to ground floor rooms and help to control solar gain within the building.

Within the entrance plaza planting will be used to soften the approach and direct pedestrian movement towards entrance points. Raised planter beds will be located beneath cut-outs in the canopy allowing light to penetrate and providing space for trees to grow. The planters will be positioned to channel movement and assist with wayfinding whilst also providing outdoor seating adjacent to entrances.

Car park areas will be planted with robust, low maintenance species and where practical incorporate rain garden elements and/or swales to capture surface water run-off. Tree planting will be used for structure, screening and to reinforce pedestrian routes.

Planting within the courtyard will be more ornamental in its aesthetic, providing staff and patients with a central and easily accessible place to retreat and relax in an attractive, green setting. A combination of ground level planting and raised beds form circulation routes through the space which can also act as wandering loops. Seating will be provided adjacent to planting throughout the space and there will also be a dedicated outdoor seating area associated with the new café.

### Hard Landscape Strategy

The hard landscaping strategy will seek to further reinforce wayfinding by defining a clear hierarchy of materials across the hospital site. Higher quality materials will be focussed in key public areas such as the entrance plaza and within the central courtyard. Elsewhere, paving to car-parks and footpaths will reflect the hospital's existing palette of materials. Where practicable, areas of permeable paving will be introduced to parking pays to assist with the SuDS design and treatment of surface water drainage.

Paving materials and street furniture will be robust, attractive and coordinate with the architectural design to maintain a common language across the scheme.

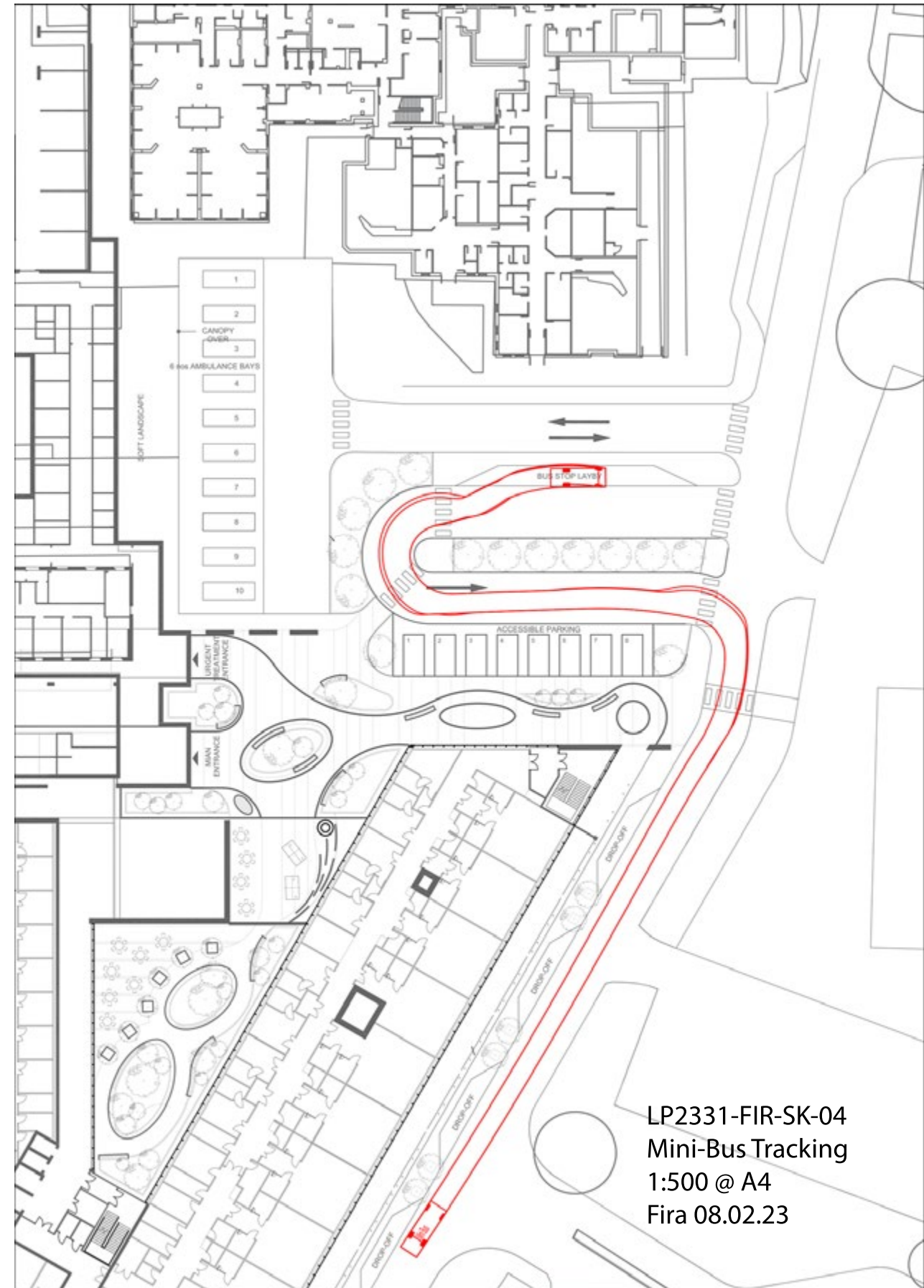
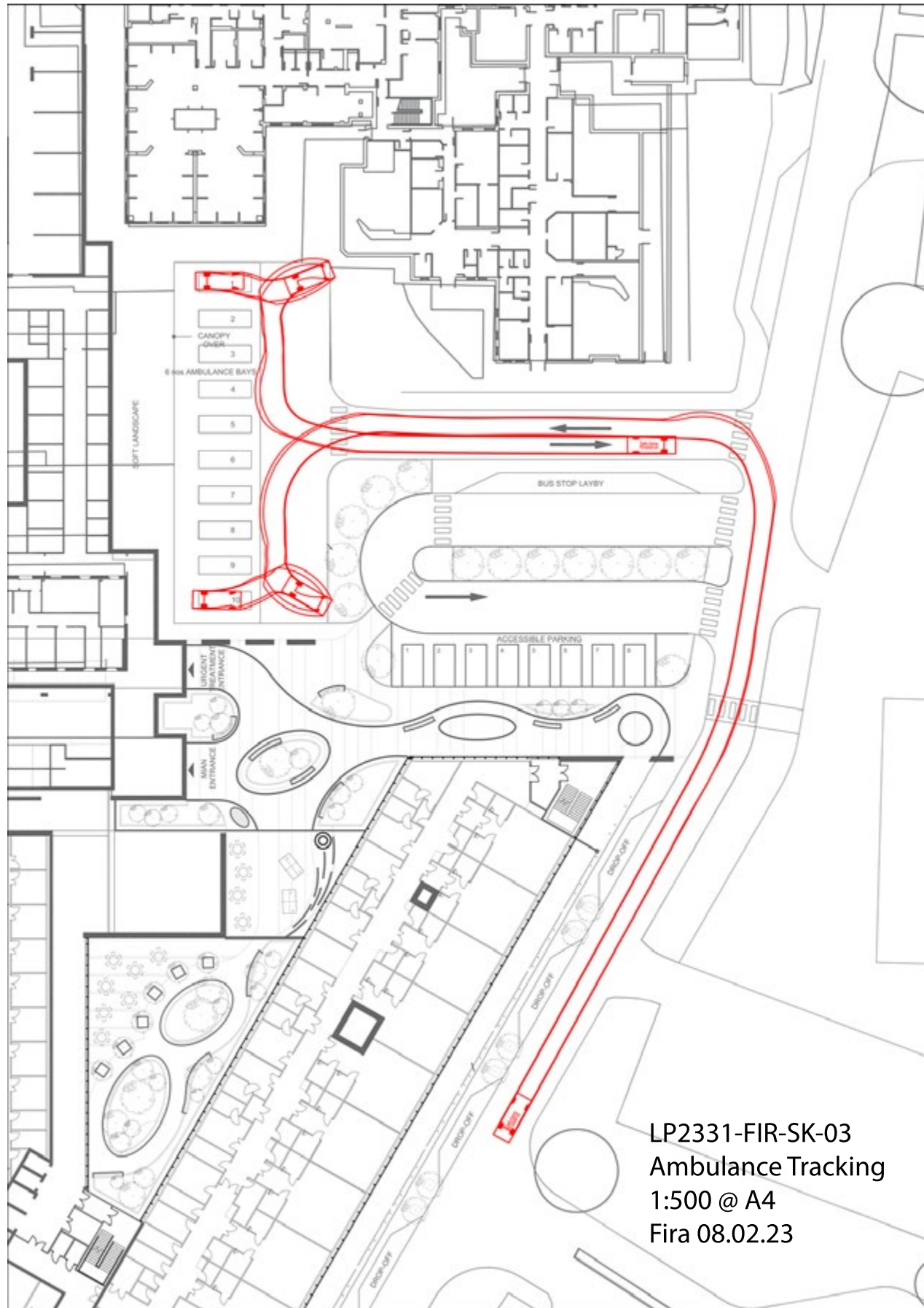
### SuDS

A sustainable urban drainage strategy will be developed with the Client and the engineering team as the project progresses. This is likely to incorporate a variety of design elements including areas of permeable paving, rain gardens and swales to control the rate of surface water run-off. Underground attenuation tanks will be provided as appropriate to better manage the release of stored water back into local watercourses. Any drainage proposals will need to be considered within the context of the hospital's wider drainage strategy.

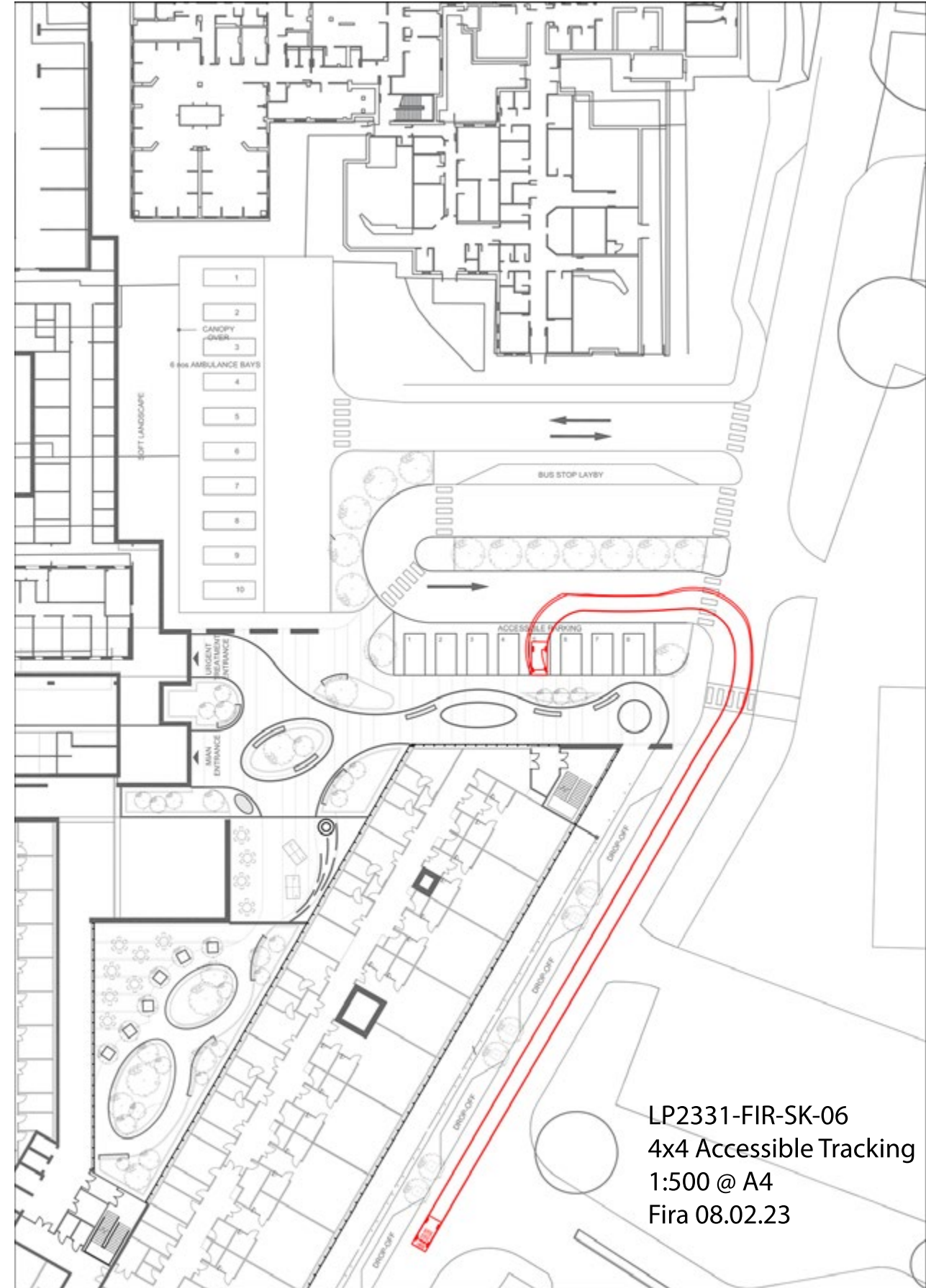
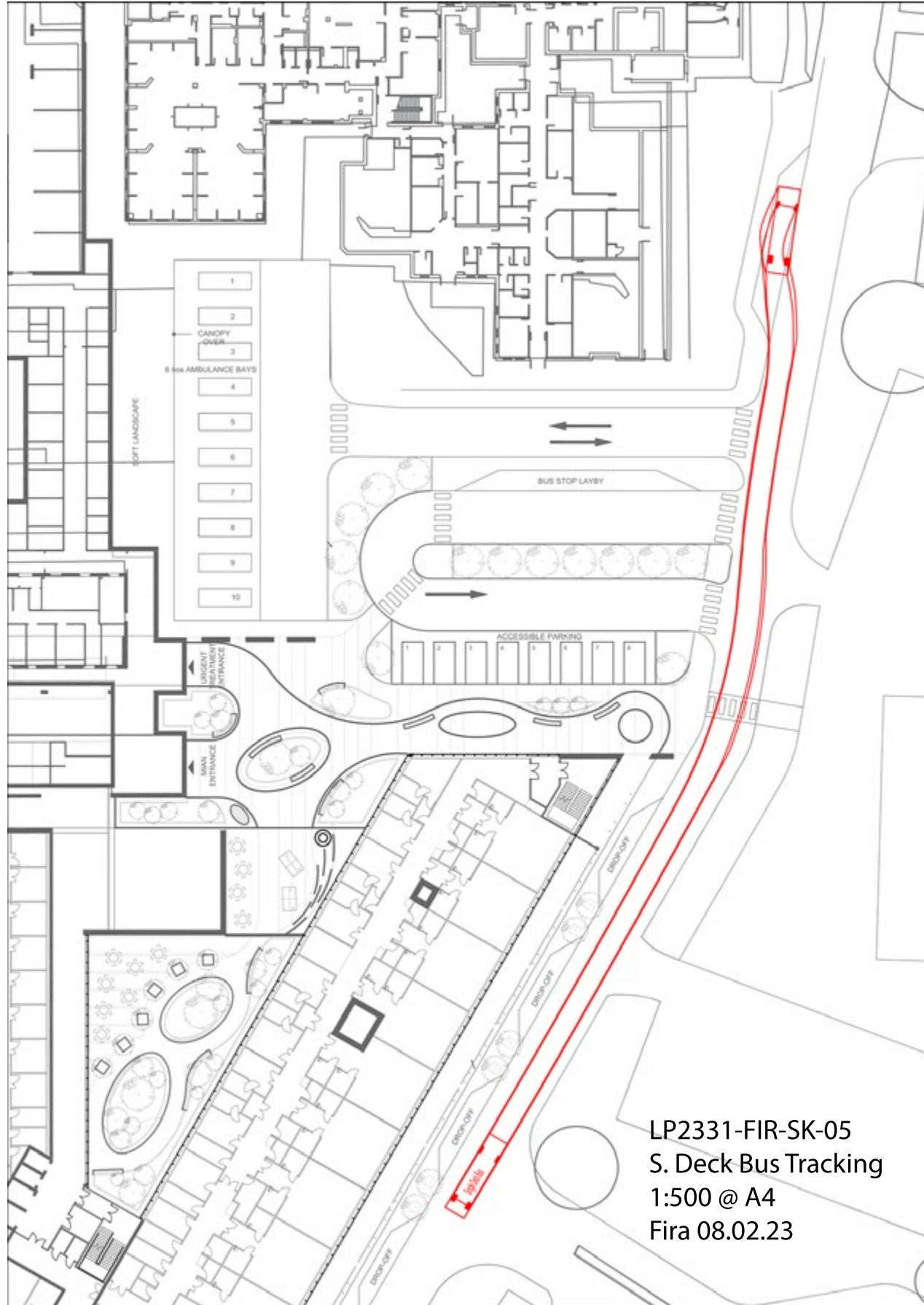
### Biodiversity Net Gain

As the landscape proposals develop there will be a range of options to consider which can contribute to biodiversity net gain both in and around the building. As part of the architectural proposals there will be opportunities to implement brown and green roof systems within the main building's roofscape. The entrance canopy also presents a valuable opportunity to improve both the SuDS and biodiversity credentials of the scheme through incorporation of a sedum roof system.

Within traditional landscaped areas the specification of species-rich seed mixes and considered plant selection can also have a significant impact. The inclusion of elements such as hibernacula, bug hotels and areas of plants for pollinators will also be considered in more protected areas of the site. The current proposals start to highlight opportunities for improving biodiversity net gain and these will be investigated further as the design progresses.







# Traffic and Transport Assessment

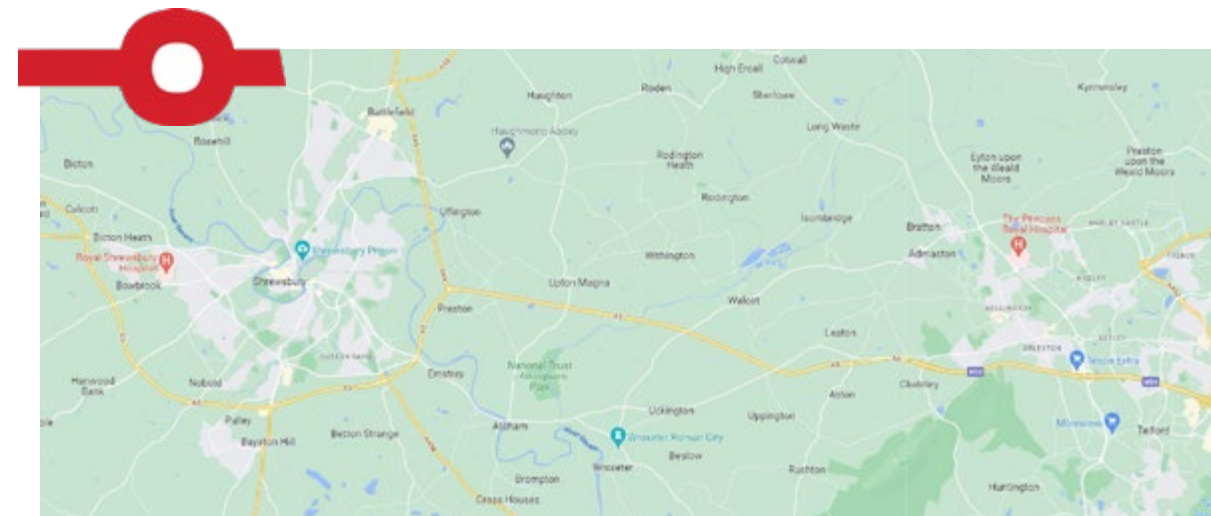
# Traffic and Transport Assessment

Shrewsbury and Telford Hospital Transport  
Study 2022  
Reference number GB01T22H00

31/01/2023



## TRANSPORT STUDY



## SHREWSBURY AND TELFORD HOSPITAL TRANSPORT STUDY 2022

TRANSPORT STUDY

### IDENTIFICATION TABLE

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**TABLE OF CONTENTS**

<b>1.</b>	<b>INTRODUCTION</b>	<b>5</b>
<b>1.1</b>	<b>BACKGROUND</b>	<b>5</b>
<b>1.2</b>	<b>REPORT STRUCTURE</b>	<b>5</b>
<b>2.</b>	<b>EXISTING CONDITIONS</b>	<b>6</b>
<b>2.1</b>	<b>CONTEXT</b>	<b>6</b>
<b>2.2</b>	<b>ROYAL SHREWSBURY HOSPITAL</b>	<b>6</b>
<b>2.3</b>	<b>PRINCESS ROYAL HOSPITAL</b>	<b>17</b>
<b>3.</b>	<b>STAFF POSTCODES</b>	<b>27</b>
<b>3.1</b>	<b>ROYAL SHREWSBURY HOSPITAL</b>	<b>27</b>
<b>3.2</b>	<b>PRINCESS ROYAL HOSPITAL</b>	<b>28</b>
<b>4.</b>	<b>SUMMARY AND CONCLUSIONS</b>	<b>31</b>
<b>4.1</b>	<b>SUMMARY</b>	<b>31</b>

**LIST OF FIGURES**

Figure 1.	RSH Site Location	6
Figure 2.	RSH – Collision Data	8
Figure 3.	RSH Unallocated Parking Observation 1	9
Figure 4.	RSH Unallocated Parking Observation 2	10
Figure 5.	RSH Unallocated Parking Observation 3	11
Figure 6.	RSH Unallocated Parking Observation 4	12
Figure 7.	RSH Cycle Parking	14
Figure 8.	RSH Accessibility Map	16
Figure 9.	PRH Site Location	17
Figure 10.	PRH – Collision Data	19
Figure 11.	PRH Unallocated Parking Observation 1	20
Figure 12.	PRH Unallocated Parking Observation 2	21
Figure 13.	PRH Unallocated Parking Observation 3	22
Figure 14.	PRH Unallocated Parking Observation 4	23
Figure 15.	PRH Cycle Parking	24
Figure 16.	PRH Accessibility Map	26
Figure 17.	RSH Postcode Map	27
Figure 18.	RSH Postcode Map w/ Bus Routes	28
Figure 19.	PRH Postcode Map	29
Figure 20.	PRH Postcode Map w/ Bus Routes	30

**LIST OF TABLES**

Table 1.	Current Staff Parking Charges	13
Table 2.	RSH Bus Service Summary	15
Table 3.	RSH Rail Service Summary	15
Table 4.	PRH Bus Service Summary	25
Table 5.	PRH Rail Service Summary	25



**1. INTRODUCTION**

**1.1 Background**

1.1.1 SYSTRA Limited has been commissioned by AHR Architects, on behalf of the Shrewsbury and Telford Hospital NHS Trust (SaTH) to provide a review of baseline conditions for the Royal Shrewsbury Hospital (RSH) and the Princess Royal Hospital (PRH) sites.

**1.2 Report Structure**

1.2.1 This Transport Study Report identifies the existing transport situations at both hospital sites and within the vicinity of the sites.

1.2.2 This Transport Study is structured as follows:

- **Section 2** - Review of the existing conditions at the sites and surrounding transport networks. In particular this focuses on the accessibility of the site by non-car means and the prevalence of public transport services, whilst also understanding demand for car parking at the sites;
- **Section 3** – Review of staff home postcodes to understand where staff are a travelling from to both sites;
- **Section 4** - Summary of the findings of the Transport Study.

**2. EXISTING CONDITIONS**

**2.1 Context**

2.1.1 This chapter examines the baseline conditions at each site, which have been highlighted both through desk-based analysis, and observations undertaken during site visits to each respective site as set out below:

- RSH – Thursday 1<sup>st</sup> December 2022, 9:30am
- PRH – Thursday 1<sup>st</sup> December 2022, 11:00am

2.1.2 The notes made during the sites visits are recorded in Appendix A.

**2.2 Royal Shrewsbury Hospital**

2.2.1 The RSH is located approximately 2.5km west of Shrewsbury Town Centre, and forms the Shrewsbury Site of the SaTH. The site is situated within the residential area of Bowbrook, toward the west of Shrewsbury’s urban-rural fringe.

Figure 1. RSH Site Location



**Access**

2.2.2 Access to the site can be achieved via the northern arm of the Mytton Oak Road (B4386) / Toronto Avenue roundabout and the priority junction of Evolution Road / Mytton Road, both of which are located along the site’s southern perimeter.

2.2.3 The site is served internally by Evolution Road and Edgcombe Way to the southwest, and an unnamed access road, which encircles the main buildings of the hospital and is accompanied by a substantial provision of allocated parking spaces around the sites perimeter.

**Local Highway Network**

**Mytton Oak Road (B4386)**

2.2.4 Mytton Oak Road (B4386) provides connections from the site, westwards towards the A5, which in turns provides linkages north towards Oswestry and east towards Telford. East of the site, Mytton Oak Road becomes Copthorne Road which provides a route towards the centre of Shrewsbury. In the vicinity of the hospital site the road is subject to a 30mph speed limit. Footway provision is continuous along each side of the road, and is lit throughout.

**Road Safety**

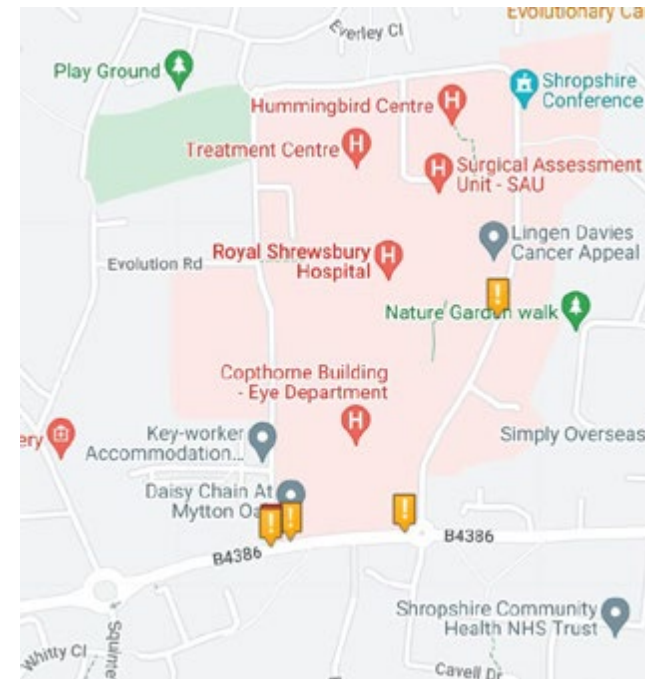
2.2.5 Collision data for the local highway network has been analysed for the period between 2017 and 2021, to determine if there are any clusters or trends which could potentially be exacerbated by increases in traffic at the site.

2.2.6 The Department for Transport (DfT) Crash Map database has been used to analyse the collisions near to the site. The collisions have been categorised as ‘slight’, ‘serious’ and ‘fatal’. Definitions from the Crash Map website are as follows:

- **Slight injury** - An injury of a minor character such as a sprain (including neck whiplash injury), bruise or cut which are not judged to be severe, or slight shock requiring roadside attention. This definition includes injuries not requiring medical treatment.
- **Serious injury** - An injury for which a person is detained in hospital as an "in patient", or any of the following injuries whether or not they are detained in hospital: fractures, concussion, internal injuries, crushing, burns (excluding friction burns), severe cuts, severe general shock requiring medical treatment and injuries causing death 30 or more days after the accident. An injured casualty is recorded as seriously or slightly injured by the police on the basis of information available within a short time of the accident. This generally will not reflect the results of a medical examination, but may be influenced according to whether the casualty is hospitalised or not. Hospitalisation procedures will vary regionally.
- **Fatal injury** - A collision which caused fatality.

2.2.7 The figure overleaf identifies the collisions over the most recent five-year period in the vicinity of the site. A total of five collisions occurred within the study area between 2017 and 2021 consisting of one ‘serious’ collisions, and four ‘slight’ collisions.

Figure 2. RSH – Collision Data



2.2.8 A cluster of collisions has been identified at the Evolution Road junction which connects to the hospital, including the only ‘serious’ accident.

2.2.9 Additionally, one ‘slight’ accident occurred within the internal road network of the hospital, which involved a collision between a car and pedal cycle, resulting in a slight injury to the cyclist.

2.2.10 Therefore, it can be concluded that with only a few collisions occurring within the vicinity of the site, that the highway network operates in a safe manner.

**Car Parking**

2.2.11 Demand for parking at RSH is very high, including at both staff and visitor car parks, with incidences of unallocated parking found across most car parks at the site.

2.2.12 At RSH, there are more measures to discourage unallocated parking than at PRH. Double yellow lines along internal access roads were coned to limit overflow parking, whilst grass verges and footways were typically surrounded by cones, fences or high kerbs. However, despite the measures provided, it was observed that more unallocated parking occurs at RSH than at PRH.

**Outpatient Parking –Visitor Parking**

2.2.13 Car Parking for Outpatients, located to the east of the site is provided for disabled users only. This is split into two sections of parking, which includes car parking directly outside the Main Outpatients Entrance to the north and a rectangular car park to the south, which is also referred to as ‘Car Park 2’. At the time of the site visit, 3 free spaces were recorded at the northern section and 1 free space at the southern section.



**Mytton Oak Centre – Visitor Parking**

2.2.14 The majority of parking for visitors is located to the east of the site, in three separate car parks. The most southern car park (Car Park 1), for the Mytton Oak Centre, comprises a total of 101 spaces, 3 of which were free at the time of the site visit, in which all three were disabled spaces. There were incidences of unallocated parking on double yellow lines, footways and verges at this car park.

**A&E Department – Visitor Parking**

2.2.15 The second of the three visitor car parks (Car Park 3), located opposite the Accident & Emergency Department and Helipad, comprises a total of 190 spaces. At the time of the site visit, no free spaces were observed in this car park. There were however incidences of unallocated parking on double yellow lines at this car park.

Figure 3. RSH Unallocated Parking Observation 1



**Ward Block – Visitor Parking**

2.2.16 The third car park, Ward Block comprises a total of 195 spaces, none of which were free at the time of the site visit.

**Ward Block – Staff Parking**

2.2.17 The northern section of the Ward Block Car Park includes a provision for 61 staff vehicles. 1 free space was observed at the time of the site visit, in which this space was disabled only. Moreover, there were incidences of unallocated parking on double yellow lines at the car park.

**Northern Car Parks – Staff Parking**

2.2.18 Approximately 356 spaces are provided for staff to north of the main hospital site, formed of the Treatment Centre (218) and Learning Centre Car Parks (138). The car park was partly closed at the time of the site visit but it was observed that 3 free spaces were recorded at the car park, all of which were disabled only, along with incidences of unallocated parking, predominantly on grass verges.

Figure 4. RSH Unallocated Parking Observation 2



**Northern Car Parks – Visitor Parking**

2.2.19 Approximately 40 spaces for visitors are provided to the north of the site, in two small car parks adjacent to the Treatment Centre. No free spaces were recorded at the time of the site visit.

**West Car Parks – Staff Parking**

2.2.20 The main staff car park is situated to the west of the site, off Evolution Road, and is comprised of 530 spaces, including 22 car parking spaces, which are favourably located closest to the main hospital buildings. At the time of the site visit, no free spaces were observed, which correlates with high incidences of unallocated parking on footways and verges witnessed.



Figure 5. RSH Unallocated Parking Observation 3



**Additional Parking and Comments**

2.2.21 Additional minor car parks situated across the remainder of the site were busy, yet typically well managed. However, there were observations of unallocated parking recorded outside the Lingen Davies Centre and Maternity & Children’s Unit, with vehicles parked on hatched lines and verges at these locations.

Figure 6. RSH Unallocated Parking Observation 4



**Charging and Fees**

2.2.22 There is a tiered charging system for visitors on site offering a ranges of rates according to the length of stay:

- Blue Badge Holders: Free
- 0-20 minutes: Free
- 20 minutes to 2 hours: £3.50
- 2 hours to 3 hours: £4.50
- 3 hours to 4 hours: £5.50
- 4 hours to 5 hours: £6.50
- 5 hours up to 24 hours: £8.50

2.2.23 Prior to the COVID-19 Pandemic, members of staff were able to purchase a staff parking permit through payroll. However, these permits were removed during the pandemic and have not been reintroduced by the Trust. The table overleaf illustrates the former staff parking charges dependent on their employment type.



**Table 1. Current Staff Parking Charges**

LEVEL OF EMPLOYMENT	£ PER ANNUM(MONTH)
Band 1-3	£90 (£7.50)
Band 4-5 F1/F2	£144 (£12)
Band 6-7	£216 (£18)
Band 8 a-c	£288 (£24)
Band 8d, 9 non A4C	£360 (£30)
Medical Registrar	£288 (£24)
Medical Consultants	£360 (£30)

2.2.24 To improve the existing parking demand at both hospital sites, the Trust should consider reintroducing staff parking permits/fees as per the above table, in which currently without these parking charges, high levels of single occupancy vehicle travel is being encouraged to the sites.

2.2.25 Additionally, one way to improve usage of the staff car park would be through greater parking enforcement. In reference to the SaTH website, the following rules apply:

- All vehicles must be parked within the marked bays only.
- No parking on double yellow lines or yellow cross-hatched boxes.
- No parking on the grass.
- Only holders of a blue registered disabled badge are allowed to park in the designated disabled parking spaces. They must display their blue badge.
- Any vehicle parked on the Trust's sites that causes an obstruction for emergency vehicles risks being damaged and will be issued with a Parking Charge Notice.
- The owner of any vehicle that causes damage to Trust property will be liable for the full cost of repair/reinstatement of the damaged property.
- Anyone who parks in breach of the rules is liable to be issued, without warning, with a Parking Charge Notice by CP Plus on behalf of the Trust.

**Non-Motorised Users**

2.2.26 The site is reasonably well connected internally for NMUs and is generally well lit, with signage provided and well-placed for users.

**Pedestrians**

2.2.27 Tactile paving is present on Mytton Oak Road which runs directly to the south of the site. Moreover, pedestrian refuge crossing zones, along with a signalled pedestrian crossing point are situated to the west of the main entrance on Mytton Oak Road. Pavements, crossing points and tactile paving also exist throughout the hospital grounds, providing good access for pedestrians.

**Cyclists**

2.2.28 Local traffic free cycle routes exist to the south and west of the site. National Cycle Route 81 also runs along the north-east of the site as a traffic free. The cycle routes provide strong connections to the centre of Shrewsbury.

2.2.29 Cycle shelters were also available on site, all of which accommodated bicycles at the time of the site visit. The largest and most widely used cycle shelter is situated adjacent to the main staff car park. This contains 'Sheffield Stands' with the ability to accommodate 18 bicycles. At the time of the site visit, 3 bicycles were parked in this shelter.

**Figure 7. RSH Cycle Parking**



**Public Transport**

**Bus**

2.2.30 There are six bus services within close proximity of the RSH as detailed in the table below. Services 11, 74, 552/553 and 558 go directly into the site.

**Table 2. RSH Bus Service Summary**

ROUTE	DAYTIME FREQUENCY	EVENING FREQUENCY
X5 – Oswestry to Telford via Shrewsbury	1 p/h	No evening services
11 – Shrewsbury to Gains Park	3 p/h	2 p/h
12 – Shrewsbury to Cophthorne	1 p/h	No evening services
74 – Shrewsbury to Llanfyllin	3 services	No evening services
X75 Shrewsbury to Rhayadar	6 services	No evening services
552/553 – Shrewsbury to Bishops Castle	1 p/h	No evening services
558 - Shrewsbury to Montgomery	4 services	No evening services

**Rail**

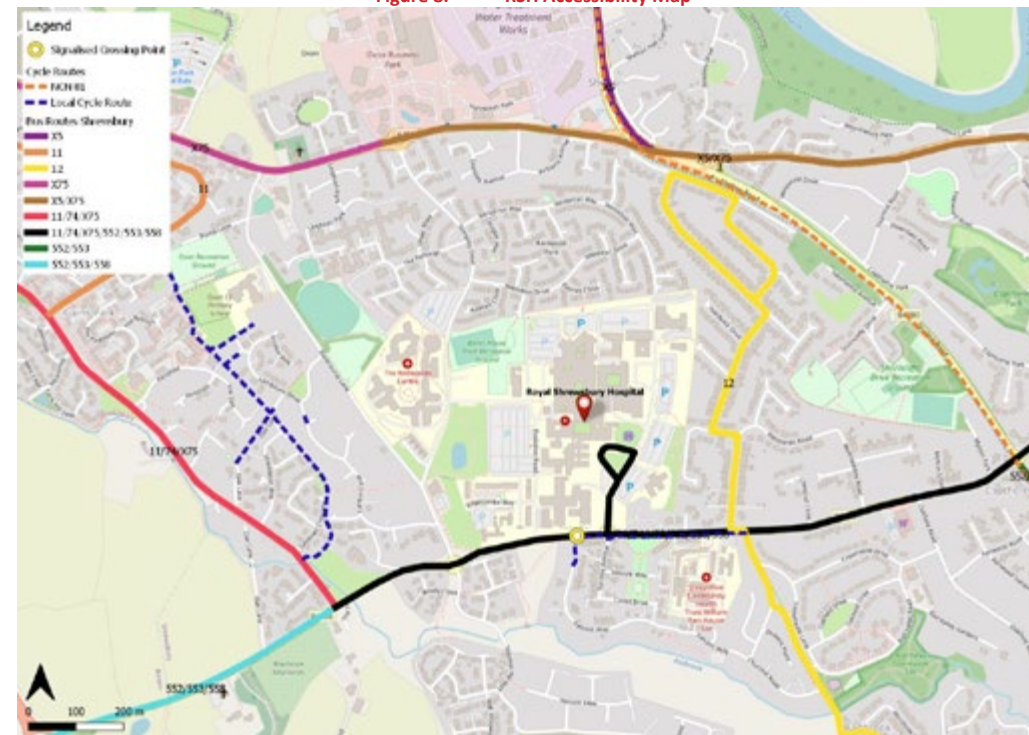
2.2.31 Shrewsbury Train Station is the closest to the RSH, approximately 10 minutes by car and 40 minutes via walking. Table 3 provides a summary of direct rail services from Shrewsbury Train Station.

**Table 3. RSH Rail Service Summary**

ROUTE	DAYTIME FREQUENCY	EVENING FREQUENCY
Shrewsbury - Aberystwyth	1 every 1-2 hours	1 p/h
Shrewsbury – Cardiff	1-2 p/h	1-2 p/h
Shrewsbury - Carmarthen	1 every 2 hours	No evening services
Shrewsbury - Crewe	1-2 p/h	1-2 p/h

Shrewsbury - Holyhead	1p/h	1-2 p/h
Shrewsbury - Llanelli	1 every 30 – 90 minutes	No evening services
Shrewsbury - Manchester	1 p/h	1 p/h
Shrewsbury – Swansea	1 every 30 – 90 minutes	No evening services
Shrewsbury – Wolverhampton	2 p/h	2 p/h

**Figure 8. RSH Accessibility Map**



**2.3 Princess Royal Hospital**

2.3.1 The PRH is located in Apley, approximately 5.5km northwest of Telford Town Centre. It forms the Telford site of the SaTH, providing a range of acute hospital services, mainly for people from Telford, Shropshire, and mid Wales. Apley is a suburban residential area, on the edge of Telford’s rural-urban fringe.

Figure 9. PRH Site Location



**Access**

2.3.2 Access to the site can be achieved via the priority junction with Grainger Drive and the northern arm of the Apley Roundabout which serves Whitchurch Drive, Apley Avenue and Grainger Drive. Upon visiting the site free-flowing traffic conditions were observed at each of the access points to the site.

2.3.3 The site is served internally by an unnamed access road, which encircles the main buildings of the hospital and is accompanied by a substantial provision of allocated parking spaces around the perimeter of the buildings.

**Local Highway Network**

**Grainger Drive**

2.3.4 Grainger Drive is a single-carriageway road, subject to a 30mph speed limit. The road provides a link through the residential areas of Apley and Leegomery towards Leegate Avenue.

2.3.5 In the vicinity of the hospital site, footway provision is continuous along each side of the road, and is lit throughout.

**Whitchurch Drive**

2.3.6 Whitchurch Drive provides connections south from the site towards M54 Junction 6 and also Telford Town Centre via Lawley Drive, B5072 and West Centre Way. North of the site the road connects with the A442 which provides connections to Sleaford, Crudgington and areas further afield.

2.3.7 The section of the road in the vicinity of the site is predominantly rural in nature and subject to a 30 mph speed limit. Footway provision is continuous along one side of the road and is lit throughout.

**Road Safety**

2.3.8 Collision data for the local highway network has been analysed for the period between 2017 and 2021, to determine if there are any clusters or trends which could potentially be exacerbated by increases in traffic at the site.

2.3.9 The Department for Transport (DfT) Crash Map database has been used to analyse the collisions near to the site. The collisions have been categorised as ‘slight’, ‘serious’ and ‘fatal’. Definitions from the Crash Map website are as follows:

- **Slight injury** - An injury of a minor character such as a sprain (including neck whiplash injury), bruise or cut which are not judged to be severe, or slight shock requiring roadside attention. This definition includes injuries not requiring medical treatment.
- **Serious injury** - An injury for which a person is detained in hospital as an "in patient", or any of the following injuries whether or not they are detained in hospital: fractures, concussion, internal injuries, crushing, burns (excluding friction burns), severe cuts, severe general shock requiring medical treatment and injuries causing death 30 or more days after the accident. An injured casualty is recorded as seriously or slightly injured by the police on the basis of information available within a short time of the accident. This generally will not reflect the results of a medical examination, but may be influenced according to whether the casualty is hospitalised or not. Hospitalisation procedures will vary regionally.
- **Fatal injury** - A collision which caused fatality.

2.3.10 The figure overleaf identifies the collisions over the most recent five-year period in the vicinity of the site. A total of five collisions occurred within the study area between 2017 and 2021, all consisting of ‘slight’ collisions.



Figure 10. PRH – Collision Data



- 2.3.11 A cluster of collisions has been identified at Apley Roundabout which provides one of the accesses to the site.
- 2.3.12 Additionally, one of the accidents occurred within the internal road network of the hospital, which involved a collision between a car and pedestrian, resulting in a slight injury to the pedestrian.
- 2.3.13 Therefore, it can be concluded that with only a few collisions occurring within the vicinity of the site, that the highway network operates in a safe manner.

**Car Parking**

- 2.3.14 Demand for parking at PRH is very high, including at both staff and visitor car parks, with incidences of unallocated parking found across most car parks at the site.
- 2.3.15 As mentioned previously, at RSH, there are more measures to discourage unallocated parking than at PRH, including cones, high kerbs and fences to stop parking on grass verges and footways. However, despite the measures provided, it was observed that more unallocated parking occurs at RSH than at PRH.

**Main Entrance – Staff and Visitor Parking**

- 2.3.16 The majority of visitor parking on site is located immediately south of the main entrance to the hospital. The car park can accommodate a total of 356 vehicles, with an additional 6 disabled spaces. This includes approximately 140 spaces to the western side of the car park which are allocated for staff only.

- 2.3.17 At this time of visit, a section of to the east of the car park was closed due to redevelopment. In regard to the remaining section of the car park that was open, no free spaces were observed within the car park, in which there were incidences of unallocated parking on grass verges and over marked lines recorded.

Figure 11. PRH Unallocated Parking Observation 1



**A&E Department Entrance – Staff Parking**

- 2.3.18 To the west of the staff and visitor car park, adjacent to the hospital's emergency entrance, a further 48 spaces are allocated for staff parking. A total of 1 free space was recorded at this location, with instances of parking on grass verges observed.

**Women & Children's Ward – Visitor Parking**

- 2.3.19 A second major area of visitor parking is located to the west of the site, adjacent to the Women and Children's Ward (WCW), which comprises a total of 121 spaces. During the time of visit, 1 free space was recorded at this location, along with incidences of unallocated parking.



Figure 12. PRH Unallocated Parking Observation 2



**Women & Children’s Ward – Staff Parking**

2.3.20 To the west of the WCW Visitors Car Park, there is a second major area of staff parking, which comprises approximately 249 spaces. Upon visiting the site, approximately 16 free spaces were observed at this location, with some incidences of unallocated parking.

**Northern Car Park – Staff Parking**

2.3.21 The main element of staff parking is situated to the north of the site, with a total of 320 spaces. At the time of the site visit, approximately 8 free spaces were recorded and incidences of vehicles parked outside of formal parking bays were recorded.

**Eastern Car Parks – Staff and Visitor Parking**

2.3.22 To the east of the site, there are two small car parks. The first being adjacent to the Wrekin Midwifery Unit, which is for staff parking only, and the second being adjacent to the Bickerstaff Endoscopy Unit, which is a visitor’s car park. These two car parks comprise of approximately 58 spaces, all of which were in use at the time of the site visit. At this location, incidences of unallocated parking were also recorded.

Figure 13. PRH Unallocated Parking Observation 3



**Apley Clinic – Staff & Visitor Parking**

2.3.23 Located to the southeast of the site, Apley Clinic provides 17 spaces for visitors, all of which were in use at the time of the site visit. There were incidences of unallocated parking at this location, with three vehicles parking on footways.

**Accommodation Parking – Staff Parking**

2.3.24 Accommodation parking, also located to the southeast of the site, recorded two free spaces at the time of the site visit, with around 7 incidences of unallocated parking on grass verges recorded.

**Additional Parking and Comments**

2.3.25 Additional minor car parks situated across the remainder of the site were also busy and unallocated parking was recorded, including outside the Mallins Health Centre and the Eye Clinic, with vehicles parked on footways and verges at these locations.



Figure 14. PRH Unallocated Parking Observation 4



**Charging and Fees**

2.3.26 Parking charges at PRH are identical to those at the RSH. The details of these parking charges can be found in sections 2.2.22 and 2.2.23.

**Non-Motorised Users**

2.3.27 The site is relatively poorly connected internally for Non-Motorised Users (NMUs). Whilst the area is generally well lit, footway and cycleway provision is intermittent, making the site feel disjointed. The issue is exacerbated further by the lack of clear onsite signage, which hinders wayfinding for NMUs.

**Pedestrians**

2.3.28 Tactile paving is present on both sides of Grainger Drive near to the main entrance on Whitchurch Drive roundabout, however it is missing at the eastern entrance to the site to allow crossing of the junction. A signalled crossing point is present close to the hospital's eastern entrance, as well as to the north west of the main entrance on Whitchurch Drive roundabout, as depicted by Figure 16.

**Cyclists**

2.3.29 Local traffic free cycle routes surround the hospital site in all directions. The routes provide good links into the centre of Wellington and also connect to National Cycle Route 81, which offers a wider connection to Telford.

2.3.30 Bicycle shelters are provided at the site, located adjacent to the hospitals main entrance, adjacent to the WCW, and adjacent to the Bickerstaff Endoscopy Unit.

Figure 15. PRH Cycle Parking



**Public Transport**

**Bus**

2.3.31 The hospital has a bus station near to the main entrance, which receives a number of services from Telford Town Centre, Shrewsbury, Wellington and Leegomery, which are detailed below.

**Table 4. PRH Bus Service Summary**

ROUTE	DAYTIME FREQUENCY	EVENING FREQUENCY
4 – Leegomery – Madeley	5 p/h	2 p/h
15 – Telford – Arleston	1 p/h	No evening services
16 – Telford – High Ercall	3 services	No evening services
17 – Shrewsbury – Princess Royal Hospital	5 services	No evening services
17a - Shrewsbury to Newport	4 services	No evening services

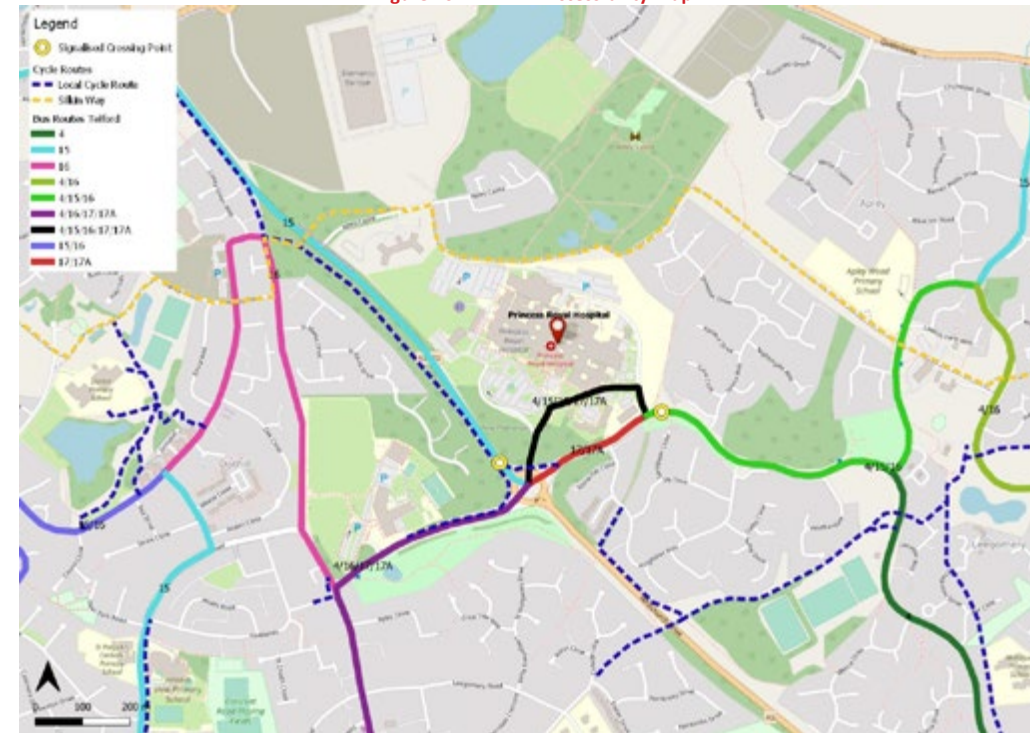
**Rail**

2.3.32 The closest train station to the site is Wellington which is approximately a 24 minute walk. Telford Train Station is situated approximately 5.8km southeast of the site. Both stations are located on the Wolverhampton to Shrewsbury line. A summary of services from Wellington Station is outlined below:

**Table 5. PRH Rail Service Summary**

ROUTE	DAYTIME FREQUENCY	EVENING FREQUENCY
Wellington – Aberystwyth	1 every 2 hours	1 every 2 hours
Wellington – Birmingham New Street	2 p/h	2 p/h
Wellington – Birmingham International	1 p/h	1 p/h
Wellington – Shrewsbury	2 p/h	2 p/h
Wellington – Holyhead	4 services	No evening services

**Figure 16. PRH Accessibility Map**





**3. STAFF POSTCODES**

**3.1 Royal Shrewsbury Hospital**

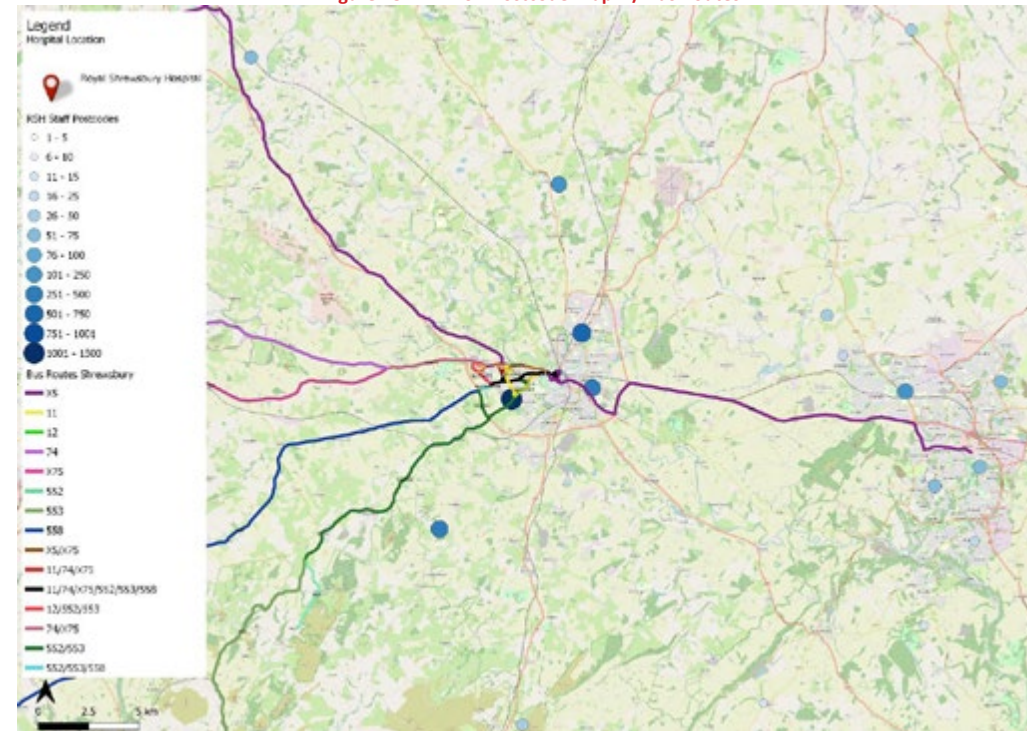
- 3.1.1 The postcode districts of staff who work at RSH have been mapped to illustrate the areas employees are most likely to travel from. These are illustrated in Figure 17 below.
- 3.1.2 Despite staff living across the UK, the majority of staff working at RSH travel locally, and live within SY (Shrewsbury) and TF (Telford) postcode areas. The district in which most staff live within is SY3, which accounts for 1035 staff. This district incorporates the west of Shrewsbury town centre and is also the district in which RSH is located.
- 3.1.3 Following this, SY1 is the second most common district for RSH staff to live in, which accounts for 598 staff. This district incorporates Shrewsbury town centre and areas to the north-west of the town.

Figure 17. RSH Postcode Map



- 3.1.4 Bus routes which serve RSH have been illustrated alongside staff postcodes to understand if there are any districts with a high density of staff living within them, which are not currently connected to the hospital by public transport. These are shown in Figure 18.
- 3.1.5 The map illustrates that SY1 and SY4 to the north of Shrewsbury town centre and SY5 to the south of Shrewsbury have very poor public transport connections and could be improved.

Figure 18. RSH Postcode Map w/ Bus Routes



**3.2 Princess Royal Hospital**

- 3.2.1 The postcode districts of staff who work at PRH have also been mapped to illustrate the areas employees are most likely to travel from. These are illustrated in Figure 19.
- 3.2.2 Similarly to RSH, whilst there are staff living across the UK, the majority of staff working at PRH travel locally, and live within SY (Shrewsbury) and TF (Telford) postcode areas. The district in which most staff live within is TF1, which accounts for 802 staff. This district incorporates a large area north-west of Telford town centre and the M54, and is also the district in which PRH is located.
- 3.2.3 Following this, TF2 is the second most common district for PRH staff to live in, which accounts for 361 staff. This district incorporates an area north-east of Telford town centre and the M54.



Figure 19. PRH Postcode Map

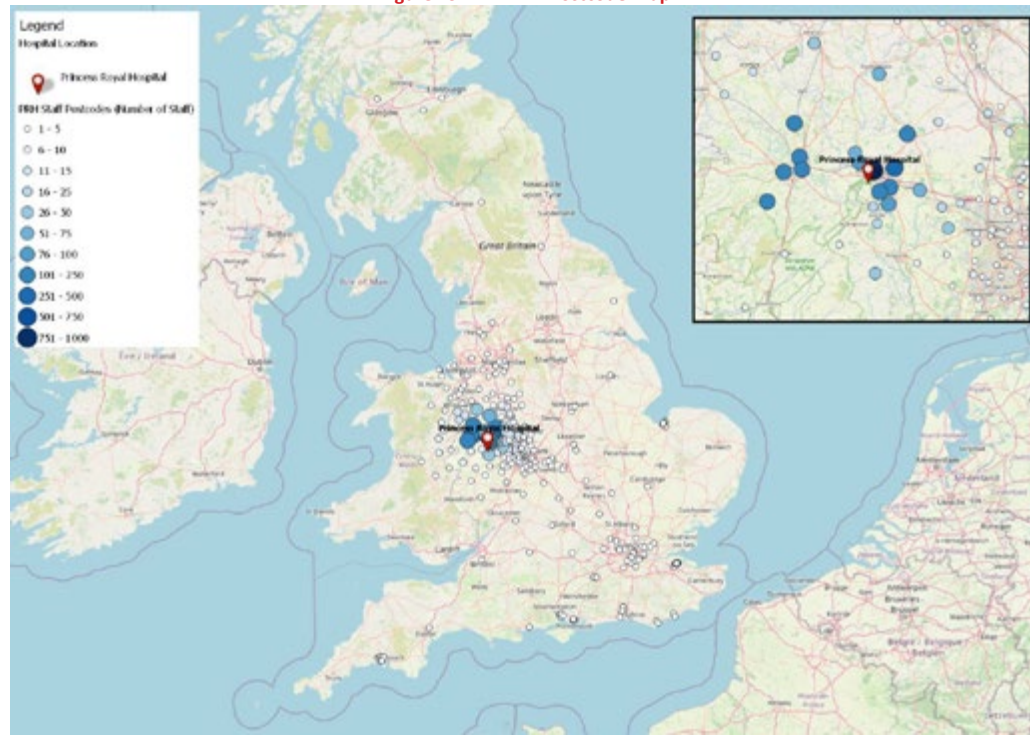
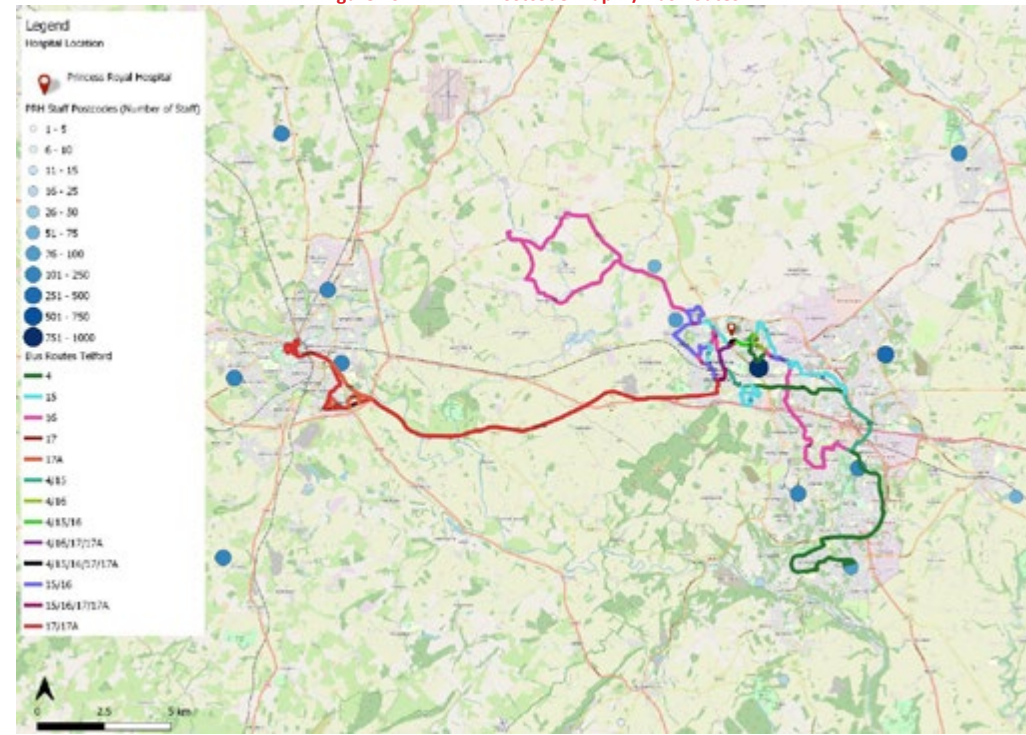


Figure 20. PRH Postcode Map w/ Bus Routes



- 3.2.4 Bus routes which serve PRH have been illustrated alongside staff postcodes to understand if there are any districts with a high density of staff living within them, which are not currently connected to the hospital by public transport. These are shown in Figure 20.
- 3.2.5 The map illustrates that TF2 and TF10 to the north-east of Telford could be better served by public transport, as well as SY1, SY4 and SY5 district areas in Shrewsbury.

## 4. SUMMARY AND CONCLUSIONS

### 4.1 Summary

4.1.1 This Transport Study provides a review of baseline conditions for the Royal Shrewsbury Hospital and the Princess Royal Hospital sites.

4.1.2 The sites are situated in good locations in terms of sustainable access opportunities and benefit from a range of sustainable transport and travel links within the immediate area. Whilst internal walking and cycling connections could be improved at Princess Royal Hospital, external cycling provisions are good at both sites, with a number of existing nearby low-traffic, arterial routes.

4.1.3 Additionally, both sites are served by several bus services, which call directly into the hospital sites, however, many of the services do not run into the late evening. Furthermore, based on staff home postcodes, there are some districts which are poorly served by public transport and could be improved. Finally, the sites are located close to rail stations, which provide onward connections to key towns and cities.

4.1.4 Demand for parking at both hospital sites is incredibly high, with incidences of unallocated parking found across most of the car parks at the two sites. Whilst there were more measures to discourage unallocated parking at RSH, this didn't stop staff and visitors parking unauthorised.

4.1.5 Moreover, whilst parking charges have fractionally increased for visitors, this hasn't reduced demand for parking at either of the two sites. Furthermore, this is exacerbated as a result of not reintroducing parking permit charges for staff following the COVID-19 pandemic, which encourages single occupancy vehicle travel to the sites.

4.1.6 Overall, the study has revealed that three key improvements should be considered by the Shrewsbury and Telford Hospital Trust:

- Reintroduction of staff parking permits/fees;
- Better management and enforcement of car parking at the sites; and
- Improvements to bus services which serve the sites in coordination with transport providers, including routes and frequency.

## Appendix A: Site Visit Notes

**Royal Shrewsbury Hospital**

Car Park	Demand for parking (Low to High)	Number of free spaces	Unallocated parking	Parking prices	Cycle parking available?	Further Notes	
1 – Mytton Oak Centre	High	3	On verges, footways and yellow lines	Blue Badge Holders: Free 0-20 minutes: Free 20 minutes to 2 hours: £3.50 2 hours to 3 hours: £4.50 3 hours to 4 hours: £5.50 4 hours to 5 hours: £6.50 5 hours up to 24 hours: £8.50		Only disabled spaces free	
2 – Outpatient Parking	High	4	None			Disabled parking area only	
3 – Adj. to A&E Department	High	0	On yellow lines				
4 – Ward Block - Visitor	High	0	None				
4 – Ward Block - Staff	High	1	On yellow lines			Only disabled space free	
5 – Northern Car Park – Staff	High	3	On verges			Car park partly closed – only disabled spaces free	
6 – Northern Car Park – Visitors	High	0	On verges				
7 – West Car Park – Staff	High	0	On verges and footways			Y	
8 – South West – Staff Overflow	High	2	On verges				
9 – Daisy Chain Nursery	Low	10	None				Nursery drop-off only
10 – Maternity & Children’s Unit	High	0	On verges and hatched areas				Mainly drop-offs
11 – Lingen Davies Centre	High	0	Hatched areas/yellow lines				
12 – Shropshire Education & Conference Centre	Medium	5	None			Y	Accessed by barrier
13 – Boiler House	High	2	None				

**Princess Royal Hospital**

Car Park	Demand for parking (Low to High)	Number of free spaces	Unallocated parking	Parking prices	Cycle parking available?	Further Notes
1 – Main Entrance	High	0	On verges and yellow lines	Blue Badge Holders: Free  0-20 minutes: Free  20 minutes to 2 hours: £3.50  2 hours to 3 hours: £4.50  3 hours to 4 hours: £5.50  4 hours to 5 hours: £6.50  5 hours up to 24 hours: £8.50	Y	Part of Main Entrance car park closed for redevelopment
2 – A&E Department Entrance	High	1	On verges		Y	
3 – Mallins Health Centre	Medium	5	On verges			
4 – Eye Clinic	High	0	On footways			
5 – Women & Children’s Ward – Visitor Parking	High	1	On footways, hatched areas and outside of marked bays			
5 – Women & Children’s Ward – Staff Parking	High	16	Outside of marked bays		Y	
6 – Northern Car Park – Staff Parking	High	8	Parking outside of marked bays			
7 – Eastern Car Parks – Staff and Visitor Parking	High	0	On verges and footways			
8 – Apley Village Nursery Parking	Low	17	None			Nursery only parking
9 – Resident Accommodation Parking	High	2	On verges			Residents only parking. Only disabled spaces free
10 – Apley Clinic	High	0	On footways			





Appendix B: 2016 Baseline Transport Study



# NHS Shrewsbury and Telford

## BASELINE TRANSPORT SCOPING STUDY

Report

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002	Following Client Comments	AHC	Draft	28/09/2016

# Contents

<b>1</b>	<b>INTRODUCTION</b>	<b>5</b>
	Introduction .....	5
<b>2</b>	<b>CURRENT SITUATION</b>	<b>6</b>
	Princess Royal Hospital .....	6
	Access .....	7
	Local Highway Network .....	7
	Road Safety .....	8
	Car Parking .....	8
	Non-Motorised Users .....	12
	Public Transport.....	13
	Royal Shrewsbury hospital .....	13
	Access .....	14
	Local Highway Network .....	14
	Road Safety .....	14
	Car Parking .....	15
	Non-motorised Users .....	17
	Public Transport.....	18
<b>3</b>	<b>TRAVEL PLAN REVIEW</b>	<b>20</b>
<b>4</b>	<b>FUTURE SCENARIOS &amp; RECOMMENDATIONS</b>	<b>22</b>
	Introduction .....	22
	Site Options .....	22
	Car Parking .....	22
	Cycle Network Connections.....	26
	On Site Road Assessment.....	27
	Blue Light Only ROUTE (BLOR) – RSH .....	27
	Travel Plan Review Reccomendations .....	28
	Summary of Reccomendations.....	30

**5 SUMMARY**

**33**

**Tables and Figures**

Figure 2-1 Site Location - PRH .....6  
 Figure 2-2 Queueing Outside Main Entrance - PRH.....7  
 Figure 2-3 Collision Data - PRH.....8  
 Figure 2-4 Overflow Parking Women & Children’s Ward Car Park - PRH .....9  
 Table 2-1 Current Staff Parking Charges.....11  
 Figure 2-6 Accessibility Map - RSH .....12  
 Table 2-2 Bus Service Summary - PRH .....13  
 Table 2-3 Telford Train Service Summary - PRH .....13  
 Figure 2-7 Site Location - RSH .....14  
 Figure 2-8 Collision Data - RSH.....15  
 Figure 2-9 Parking Signage - RSH .....15  
 Figure 2-10 Staff Parking North - RSH .....16  
 Figure 2-11 Accessibility Map - RSH .....17  
 Table 2-4 Bus Service Summary - RSH .....18  
 Table 2-5 Train Service Summary – RSH.....19  
 Table 4-1 FTE Staff Members.....23  
 Table 4-2 Parking Space Provision.....23  
 Table 4-3 PRH Car Parking Options Summary .....25  
 Table 4-4 SRH Car Parking Options Summary .....26  
 Table 4-5 Summary of Recommendations.....31

**Appendices**

- Appendix A Car Park Locations
- Appendix B Swept-Path Analysis (Including BLOR Routes)

**1 Introduction**

**INTRODUCTION**

- 1.1 JMP Consultants Ltd has been commissioned by AHR Architects, on behalf of the Shrewsbury and Telford Hospital NHS Trust (SaTH) to provide a review of baseline conditions and future recommendations for the Royal Shrewsbury Hospital (RSH) and the Princess Royal Hospital (PRH) sites.
- 1.2 The SaTH is reorganising the way the trust will function in the future across the two sites. How the reorganisation is to be implemented across both sites is still to be determined but it will see the concentration of Emergency facilities at one location and at the other, the current Emergency facility will be replaced with a Planned Care Site (PCS).
- 1.3 This document provides Travel and Transport Planning advice to support the project team with the preparation of the Outline Business Case (OBC) for submission in October 2016.

## 2 Current Situation

2.1 This chapter examines the baseline conditions at each site, which have been highlighted both through desk-based analysis, and observations undertaken during site visits to each respective site as set out below:

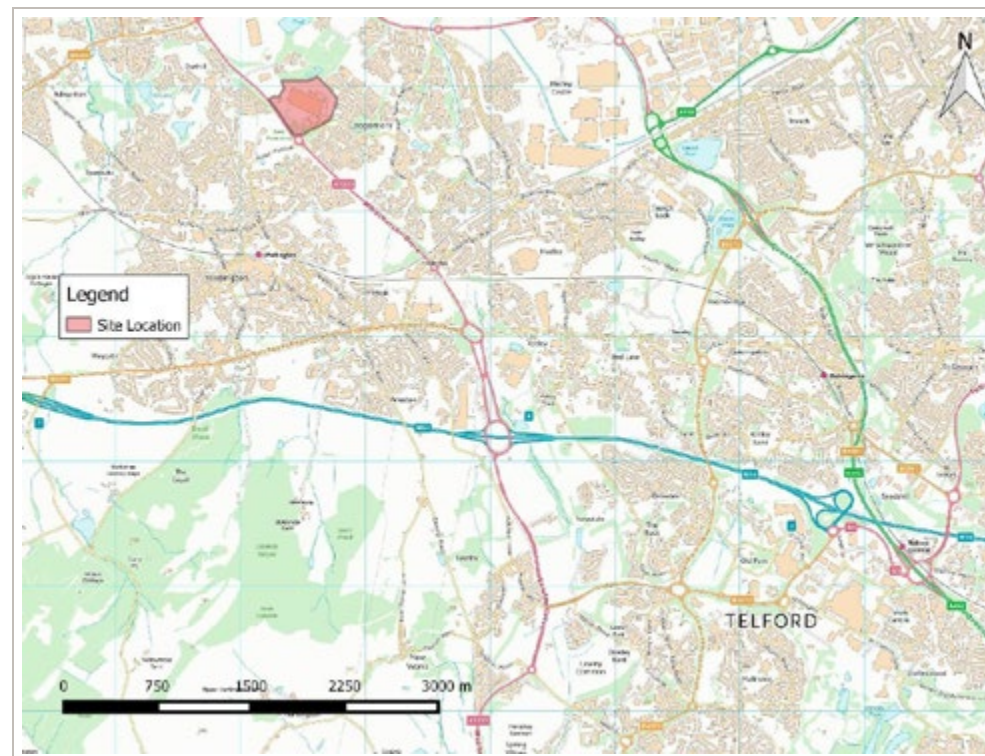
- PRH – Wednesday 24<sup>th</sup> August, 1:00pm
- RSH – Wednesday 24<sup>th</sup> August, 2:30pm
- PRH – Thursday 8<sup>th</sup> September, 3:00pm
- RSH – Thursday 8<sup>th</sup> September, 1:30pm

2.2 During the site visit the travel distance between PRH and SRH was recorded as 25 minutes.

### PRINCESS ROYAL HOSPITAL

2.3 The PRH is located in Apley, approximately 5.5km northwest of Telford Town Centre. It forms the Telford site of the SaTH, providing a range of acute hospital services, mainly for people from Telford, Shropshire, and mid Wales. Apley is a suburban residential area, on the edge of Telford’s rural-urban fringe. Figure 2-1 provides an overview of the site location.

Figure 2-1 Site Location - PRH



GIS

### ACCESS

2.4 Access to the site can be achieved via the priority junction with Grainger Drive and the northern arm of the Apley Roundabout which serves Whitchurch Drive, Apley Avenue and Grainger Drive. Upon visiting the site free-flowing traffic conditions were observed at each of the access points to the site.

2.5 The site is served internally by an unnamed access road, which encircles the main buildings of the hospital and is accompanied by a substantial provision of allocated parking spaces around the perimeter of the buildings. There is no drop-off zone for taxis onsite, instead taxis were seen queueing outside the main entrance as shown in Figure 2-2.

Figure 2-2 Queueing Outside Main Entrance - PRH



### LOCAL HIGHWAY NETWORK

#### Grainger Drive

2.6 Grainger Drive is a speed-camera safety zone, subject to a 30mph speed limit. The road provides a link through the residential areas of Apley and Leegomery towards Leegate Avenue.

2.7 In the vicinity of the hospital site, footway provision is continuous along each side of the road, and is lit throughout.

#### Whitchurch Drive (A5223)

2.8 Whitchurch Drive provides connections south from the site towards M54 Junction 6 towards Telford Town Centre via Lawley Drive, B5072 and West Centre Way. North of the site the road connects with the A442 which provides connections to Sleaford, Crudginton and areas further afield.

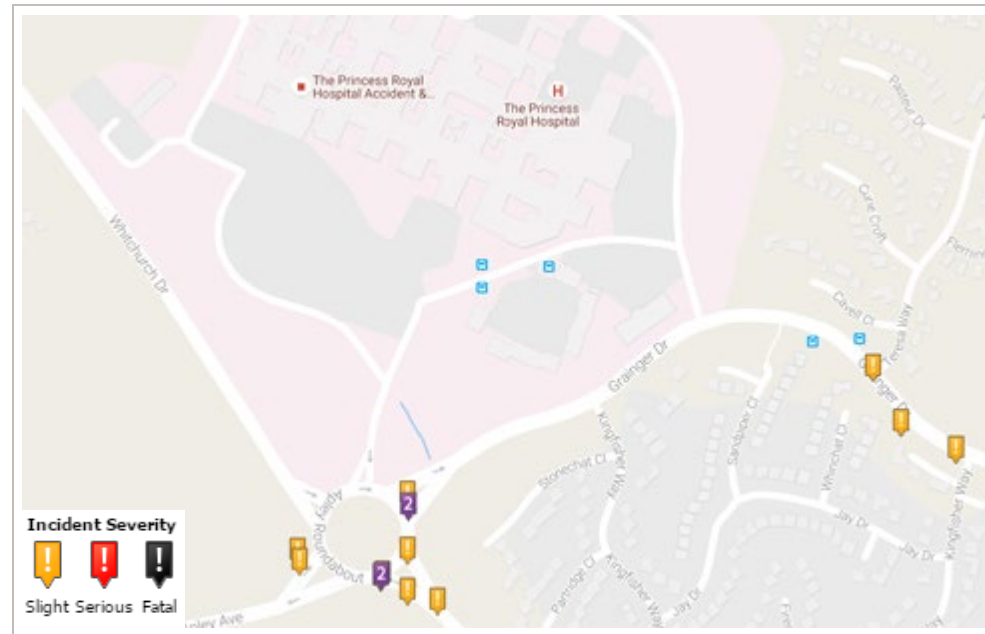
2.9 The section of the road in the vicinity of the site is predominantly rural in nature and subject to a 40 mph speed limit. Footway provision is continuous along one side of the road and is lit throughout.



**ROAD SAFETY**

- 2.10 Collision data has been sourced for the local highway network to determine if there are any clusters or trends which could potentially be exacerbated by any increases in traffic at the site. Crashmap has been used, as the system provides the most recently published Department for Transport (DfT) collision data, from 2011 to 2015.
- 2.11 Figure 2-3 shows that there were no collisions recorded at the site access points off Grainger Drive and Apley Roundabout respectively.
- 2.12 Three 'slight' collisions were recorded on Apley roundabout itself, with a further three recorded on the approach from Grainger Drive and two on each of the approaches from Apley Avenue and Whitchurch Drive. Nonetheless, this is a busy roundabout and the cluster of 'slight' collisions recorded is to be anticipated given the large number of vehicle movements at this location.

Figure 2-3 Collision Data - PRH



Crashmap

- 2.13 After reviewing relevant collision data, no abnormal trends or clusters have been identified on the respective routes and these are unlikely to be exacerbated by potential increases in trips generated by the site.

**CAR PARKING**

**Main Entrance – Visitor Parking**

- 2.14 The majority of visitor parking on site is located immediately south of the main entrance to the hospital. The car park can accommodate a total of 356 vehicles, with an additional 6 disabled spaces, however after liaising with the on-site attendant for the car park, it is understood that approximately 140 spaces to the western side of the car park have now been allocated for staff.

- 2.15 Visitor parking at the site typically peaks between 2-4pm and 7-9pm, which coincides with peak visiting times at the hospital. As part of the second site visit, undertaken on 8<sup>th</sup> September, parking surveys were conducted between 1:45 and 2:30pm. At this time no free spaces were observed within the car park and 10 incidences of unallocated parking were recorded.

- 2.16 During the first visit to the site, the parking attendant indicated that during peak times drivers often park on the grass verges, as there are not enough spaces to accommodate the level of demand at the car park. At the time of the second site visit, all ten incidences of unallocated parking were recorded on the grass verges of the visitor car park.

**Main Entrance – Staff Parking**

- 2.17 As stated above, a provision of spaces to the western side of the main entrance car park have now been allocated for staff. Similar to the visitor section of the car park, no free spaces were observed, and 6 incidences of unallocated parking were recorded, all of which were on the grass verges within the car park.

- 2.18 A further 13 incidences of unallocated parking were recorded along the grass embankments of the unnamed internal access road, which runs adjacent to this car park.

**Emergency Entrance – Staff Parking**

- 2.19 To the west of the visitor car park, adjacent to the hospital's emergency entrance, a further 48 spaces are allocated for staff parking. A total of 7 free spaces were recorded at this location.

**Women & Children's Ward – Visitor Parking**

- 2.20 A second major area of visitor parking is located to the west of the site, adjacent to the Women and Children's Ward (WCW), which comprises a total of 121 spaces. During peak visiting hours, 2 free spaces were recorded at this location, along with 10 incidences of unallocated parking, predominantly along the access road for the car park, as depicted by Figure 2-4.

Figure 2-4 Overflow Parking Women & Children's Ward Car Park - PRH



**Women & Children’s Ward (WCW) – Staff Parking**

2.21 To the west of the WCW Visitors Car Park, there is a second major area of staff parking, which comprises approximately 249 spaces. Upon visiting the site, approximately 85 free spaces were observed at this location, with no recorded incidences of unallocated parking.

**Northern Car Park – Staff Parking**

2.22 The main element of staff parking is situated to the north of the site, with a total of 320 spaces. At the time of the site visit, approximately 42 free spaces and 37 incidences of overflow parking were recorded in the vicinity of this car park; the latter were primarily along the grass verges to the east and the access road to the west, adjacent to the WCW.

Figure 2-5 Overflow Staff Parking – Eastern Site Perimeter - PRH



**Eastern Car Parks – Visitor Parking**

2.23 To the east of the site, adjacent to Ward 16, there is a visitor’s car park, comprised of approximately 20 spaces, all of which were in use at the time of the site visit. At this location 15 incidences of unallocated parking were also recorded.

**Eastern Car Parks – Staff Parking**

2.24 Adjacent to the above referenced visitor car park, there are two staff car parks, outside the Endoscopy and Wrekin Midwifery Units. In total these car parks provide a total of 39 spaces, all of which were in use at the time of the site visit. Furthermore, a total of 41 incidences of unallocated parking were recorded along the grass verges surrounding these car parks.

**Apley Clinic – Staff & Visitor Parking**

2.25 In contrast to the major parking issues observed across the majority of the hospital site, parking appeared to be relatively well managed outside the Apley Clinic, to the southeast of the site. This car park provided 20 spaces for staff and 19 for visitors, all of which were in use at the time of the site visit. Nonetheless, no incidences of unallocated parking were recorded at this location.

**Accommodation Parking – Staff Parking**

2.26 Similar to the above, Accommodation Parking, to the southeast of the site, appeared to be relatively well managed. All of the 51 spaces were in use at the time of the site visit, however no incidences of unallocated parking were recorded at this location.

**Additional Comments**

2.27 In addition to observations made at the main parking areas on site, major issues with regard to unallocated parking were noted on the grass verges immediately east of the site entrance from Grainger Drive. At the time of the site visit a total of 23 vehicles were parked along the grass verges at this location, which has caused major damage to the ground.

**Charging**

2.28 There is a tiered charging system for visitors on site offering a ranges of rates according to the length of stay:

- 0-30 minutes : Free
- 30 minutes to 2 hours : £2.50
- 2 hours to 5 hours: £3
- 5 hours up to 24 hours: £3.50

2.29 Members of staff are able to purchase a staff parking permit through payroll. Table 2-1 below demonstrates the staff parking charges dependent on their employment type.

Table 2-1 Current Staff Parking Charges

Level of Employment	£ Per Annum(month)
Full Time (greater than 22.5 hours per week) Band 1-7 and F1, F2 (Foundation Years 1 & 2)	90 (7.50)
Part Time (fewer than 22.5 hours per week) Band 1-7 and F1, F2	45 (3.75)
Full Time (greater than 22.5 hours per week) Bands 8 and above and medical and dental staff (excluding F1,F2)	120 (10)
Full Time (fewer than 22.5 hours per week) Bands 8 and above and medical and dental staff (excluding F1,F2)	60 (5)

2.30 One way to improve usage of the staff car park would be through greater parking enforcement. As part of the site visit, parking notices were observed on cars without staff permits. In reference to the SaTH website the following rules apply:

- All vehicles must be parked within the marked bays only.
- No parking on double yellow lines or yellow cross-hatched boxes.
- No parking on the grass.
- Only holders of a blue registered disabled badge are allowed to park in the designated disabled parking spaces. They must display their blue badge and are still required to pay on exit.
- Any vehicle parked on the Trust's sites that causes an obstruction for emergency vehicles risks being damaged and will be issued with a Parking Charge Notice.

- The owner of any vehicle that causes damage to Trust property will be liable for the full cost of repair/reinstatement of the damaged property.
- Anyone who parks in breach of the rules is liable to be issued, without warning, with a Parking Charge Notice by CP Plus on behalf of the Trust.

**NON-MOTORISED USERS**

2.31 The site is relatively poorly connected internally for Non-Motorised Users (NMUs). Whilst the area is generally well lit, footway and cycleway provision is intermittent, making the site feel disjointed. The issue is exacerbated further by the lack of clear onsite signage, which hinders wayfinding for NMUs.

**Pedestrians**

2.32 Tactile paving is present on both sides of Grainger Drive and a signalled crossing point is present close to the hospital's eastern entrance. At the main hospital entrance on the Whitchurch Drive roundabout, only one signalled crossing point exists, situated to the north, as depicted by Figure 2-6.

Figure 2-6 Accessibility Map - RSH



GIS

**Cyclists**

2.33 Local traffic free cycle routes surround the hospital site to the north, east and west. The routes provide good links into the centre of Wellington and also connect to National Cycle Route 81 which offers a connection to Telford.

2.34 There is one bicycle shelter located adjacent to the hospitals main entrance, which can accommodate 27 bikes, however upon visiting the site only two of the spaces were being utilised.

2.35 New cycle shelters are situated adjacent to the Helipad and the WCW, however no bicycles were parked here during the site visit.

**PUBLIC TRANSPORT**

**Bus**

2.36 The hospital has a bus station near to the main entrance, which receives a number of services from Telford Town Centre, Wellington and Leegomer, which are detailed below.

Table 2-2 Bus Service Summary - PRH

Route Number	Daytime Frequency	Afternoon Frequency	Evening Frequency
4 – Leegomer – Madeley	5 p/h	5 p/h	4 p/h
15 – Telford – Arleston	1 p/h	1 p/h	1 p/h
16 – Telford – High Ercall	1 service	3 services	No evening service
860 – Lydbury North – Telford	Very infrequent, one service per day		

2.37 Buses from Shrewsbury Bus Station to Telford Town Centre Bus Station take approximately 50 minutes.

**Train**

2.38 The closest train station to the site is Wellington which is approximately a 24 minute walk. Telford Train Station is situated approximately 5.8km southeast of the site. Both stations are located on the Wolverhampton to Shrewsbury line. A summary of services from Wellington Station is outlined below:

Table 2-3 Telford Train Service Summary - PRH

Route	Daytime Frequency	Afternoon Frequency	Evening Frequency
Wellington – B'ham New Street	2 p/h	2 p/h	2 p/h
Wellington – Shrewsbury	2 p/h	2 p/h	2 p/h
Wellington – Holyhead	2 p/h	1 p/h	1 p/h

**ROYAL SHREWSBURY HOSPITAL**

2.39 The RSH is located approximately 2.5km west of Shrewsbury Town Centre, and forms the Shrewsbury Site of the SaTH. The site is situated within the residential area of Bowbrook, toward the west of Shrewsbury's urban-rural fringe.



Figure 2-7 Site Location - RSH



GIS

**ACCESS**

- 2.40 Access to the site can be achieved via the northern arm of the Mytton Oak Road (B4386) / Seacole Way roundabout and the priority junction of Evolution Road / Mytton Road, both of which are located along the site's southern perimeter.
- 2.41 The site is served internally by Evolution Road and Edgecombe Way to the southwest, and an unnamed access road, which encircles the main buildings of the hospital and is accompanied by a substantial provision of allocated parking spaces around the sites perimeter.

**LOCAL HIGHWAY NETWORK**

**Mytton Oak Road (B4386)**

- 2.42 Mytton Oak Road (B4386) provides connections from the site west towards the A5, which in turns provides linkages north towards Oswestry and east towards Telford. West of the site Mytton Oak Road becomes Copthorne Road which provides a route towards the centre of Shrewsbury. In the vicinity of the hospital site the road is subject to a 30mph speed limit. Footway provision is continuous along each side of the road, and is lit throughout.

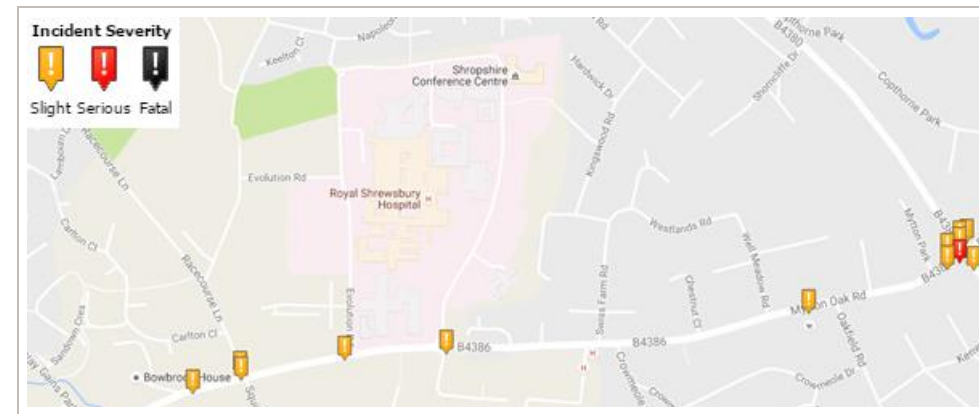
**ROAD SAFETY**

- 2.43 Collision data for the local highway network has once again been sourced from Crashmap for the period between 2011 and 2015, to determine if there are any clusters or trends which could potentially be exacerbated by increases in traffic at the site.

- 2.44 One 'slight' collision was recorded in the vicinity of the site access point off Evolution Road and another 'slight' collision was recorded at the Mytton Road (B4386) / Seacole Way, the northern arm of which provides the primary point of access to the site.

- 2.45 A cluster of collisions has been identified approximately 0.6miles east of the site, at the B4380 / B4386 roundabout. Six 'slight' collisions were recorded at this location, along with one 'serious' collision. This is a busy roundabout and the cluster of collisions recorded is anticipated to an extent on account of the large number of vehicle movements at this location. Nonetheless, as this cluster is not located in close proximity to RSH it is not anticipated that any developments to the site will have an effect upon these statistics.

Figure 2-8 Collision Data - RSH



Crashmap

**CAR PARKING**

- 2.46 At RSH car parking appears to be better managed than at PRH. Double yellow lines along internal access roads were coned to limit overflow parking and grass verges were typically surrounded by fences or high kerbs. Clear signage was also available to discourage parking on grass verges.

Figure 2-9 Parking Signage - RSH





**Mytton Oak Centre –Visitor Parking**

2.47 The majority of parking for visitors is located to the east of the site, in three separate car parks. The most southern car park, for the Mytton Oak Centre, comprises a total of 101 spaces, 25 of which were free at the time of the site visit.

**Outpatients – Visitor Parking**

2.48 The second of the three visitor car parks, for outpatients, comprises a total of 190 spaces. At the time of the site visit a total of 21 free spaces were observed in this car park.

**Ward Block – Visitor Parking**

2.49 The third car park, Ward Block comprises a total of 195 spaces, three of which were free at the time of the site visit.

**Ward Block – Staff Parking**

2.50 The northern section of the Ward Block Car Park includes a provision for 61 staff vehicles. No free spaces were observed at the time of the site visit.

**Northern Car Parks – Staff Parking**

2.51 Approximately 356 spaces are provided for staff to north of the main hospital site, formed of the Treatment Centre (218) and Learning Centre Car Parks (138). 3 free spaces were recorded at the former, along with 9 incidences of unallocated parking, predominantly on grass verges as depicted by Figure 2-10.

Figure 2-10 Staff Parking North - RSH



**Northern Car Parks – Visitor Parking**

2.52 Approximately 40 spaces for visitors are provided to the north of the site, in two small car parks adjacent to the Endoscopy Unit and Treatment Centre. At the time of the site visit 1 free space was recorded at this location, along with 2 incidences of unallocated parking.

**Staff Parking – West**

2.53 The main staff car park is situated to the west of the site, off Evolution Road, and is comprised of 530 spaces. At the time of the site visit 27 free spaces were observed, along with 24 incidences of unallocated parking.

2.54 This car park also contains 22 car sharing spaces, which are favourably located closest to the main hospital buildings. 11 of the 22 spaces were in use at the time of the site visit.

**Additional Parking**

2.55 Additional car parks situated across the remainder of the site were busy, yet typically well managed. However, 15 incidences of unallocated parking were recorded along Evolution Road, in the vicinity of the Estates Centre.

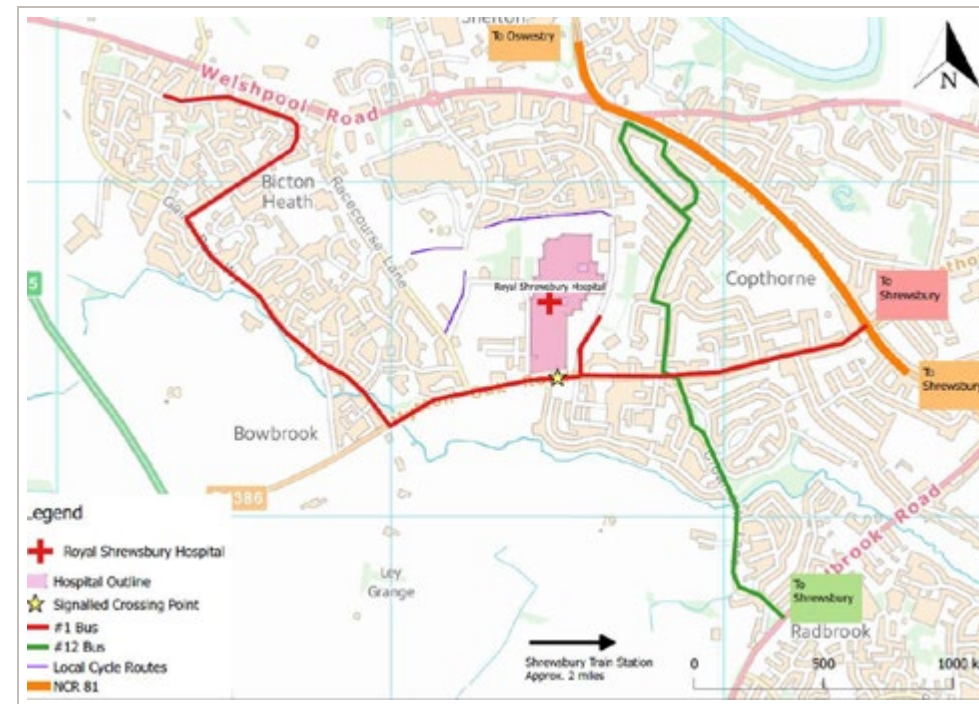
**NON-MOTORISED USERS**

2.56 The site is reasonably well connected internally for NMUs and is generally well lit. Onsite signage is relatively well placed, providing more convenient access for NMUs than observed at the PRH site.

**Pedestrians**

2.57 Tactile paving is present on both sides of Mytton Oak Road which runs directly to the south of the site. Pedestrian refuge crossing zones exist along Mytton Oak Road along with a signalled pedestrian crossing point situated to the west of the main entrance of the site as depicted by Figure 2-11 . Pavements and crossing points exist throughout the hospital grounds, providing good access for pedestrians.

Figure 2-11 Accessibility Map - RSH



**Cyclists**

- 2.58 Local traffic free cycle routes exist to the north and west of the site. National Cycle Route 81 also runs along the north-east of the site as a traffic free route (a small section of on road cycling also exists). The cycle routes provide strong connections to the centre of Shrewsbury.
- 2.59 Cycle shelters were also available on site, all of which accommodated at least one bicycle at the time of the site visit. The largest and most widely used cycle shelter is situated adjacent to the main staff car park. This contains 'Sheffield Stands' with the ability to accommodate 24 bicycles. At the time of the site visit, 7 bicycles were parked in this shelter.

Figure 2-12 Cycle Shelters - RSH



**PUBLIC TRANSPORT**

**Bus**

- 2.60 There are six bus services within close proximity of the RSH as detailed in the table below. Only one bus service (no. 1) goes directly into the site.

Table 2-4 Bus Service Summary - RSH

Route Number	Daytime Frequency	Afternoon Frequency	Evening Frequency
1 – Gains Park – Telford Estate	4 p/h	4 p/h	2 p/h
12 – Shrewsbury – Kingswood Estate	1 p/h	1 p/h	No evening service
74 – Shrewsbury – Llantyllin	1 service	1 service	No evening service
X75 Shrewsbury – Rhayadar	2 services	2 services	No evening service
553 – Shrewsbury – Bishop’s Castle	2 services	2 services	No evening service
558 Shrewsbury – Montgomery	2 services	1 service	1 service

**Train**

- 2.61 Shrewsbury Train Station is the closest to the RSH, approximately 10 minutes by car and 40 minutes via walking. Table 2-5 provides a summary of rail services from Shrewsbury Train Station.

Table 2-5 Train Service Summary – RSH

Route	Daytime Frequency	Afternoon Frequency	Evening Frequency
Shrewsbury – B’ham New Street	2 p/h	2 p/h	2 p/h
Shrewsbury – Manchester	2 p/h	1 p/h	1 p/h
Shrewsbury – Swansea	1-2 p/h	1-2 p/h	2 p/h
Shrewsbury – Cardiff	2 p/h	1 p/h	2 p/h
Shrewsbury - Holyhead	1-2 p/h	1 p/h	1 p/h

### 3 Travel Plan Review

#### Green Travel Plan

3.1 The SaTH produced a Green Transport Plan (GTP) in order to help minimise the impact of staff, patients and visitors on the local highway network. It recognised the issues surrounding car parking at both the PRH in Telford and the RSH at Shrewsbury. It also acknowledges the fact that both sites were constrained by the lack of public transport services for the site users.

3.2 The document outlines:

- What a GTP is;
- The need for a GTP for the Trust;
- Key objectives;
- Measures to be implemented;
- A brief summary of travel to the site;
- Modal shift targets; and
- Implementation and monitoring.

3.3 This GTP does not appear to have a date of issue that we can find however, throughout the document objectives are mentioned for 2008/2009 and so this implies the date being early 2008. It therefore is recommended that the GTP is in need of updating to include measures implemented since the date of issue as well as producing further objectives and targets that may now be more suitable for the sites.

#### Transport Review and Recommendations

3.4 There is also a Transport Review and Recommendations Report dated July 2011.

3.5 The general findings confirmed a shortfall in parking provision at peak times and at PRH this is likely to increase post-reconfiguration.

3.6 A number of high level measures were identified as being in the following categories:

- Proposals for Change: Strategic Issues such as the development of a 'Parking and Transport Strategy' and establishing and agreeing Parking and Transport Mode Principles; and
- Proposals for Change: Tactical Issues such as increasing staff parking charges and revising Grey Fleet rates to HMRC rates.

#### Travel and Transport Plan (TTP)

3.7 A TTP has also been produced for SaTH in 2014. The document was written due to the relocation of staff from the Women's and Children's Centre to the RSH site where car parking was already exceeding capacity. The document sets out plans to be implemented in the long term to reduce single occupancy car journeys by 5% to alleviate the parking issues. Measures on how to do this are outlined in the plan along with the predicted amount of car parking spaces which would be released if the measures are successful. This plan and the targets were written to adhere to planning conditions attached to the planning approval for the new Women and Children's units.

3.8 The current failings of the car park management at the sites are acknowledged within the plan as listed below:

- The financial incentives are not large enough to discourage staff from driving to work;

- The pay banding for parking costs means little difference between lower banded staff and senior staff; and
- The penalty system not being adequately enforced to prevent illegal and inappropriate parking.

#### Staff Travel and Transport Updates

3.9 Two updates have been produced in relation to travel planning which are dated January 2016 and March 2016. These updates have been produced for the Executive Directors and the Trust Board to ensure that the Travel Plans are being monitored and implemented. There is no survey information or target information in these updates, and it is therefore difficult to evaluate current modal shift and whether the targets set have been met.

3.10 The documents provide an update on the various measures and actions mentioned in the Green Travel Plan, The Travel and Transport Plan and the Transport Review and Recommendations. These measures include:

- Employing a Travel Plan Coordinator (TPC);
- Improvements to cycling facilities such as cycle parking, showers and lockers;
- Working with the Trust and Local Authority on improvements to surrounding pedestrian and cycle routes;
- Discounted public transport tickets;
- Promotion and incentivising car sharing;
- Reviewing the car parking permit system;
- Improving the video conferencing facilities;
- Introducing an inter-site shuttle bus service; and
- Reforming the pool car fleet to ensure maximum usage.

## 4 Future Scenarios & Recommendations

### INTRODUCTION

4.1 This chapter provides a series of future scenarios and recommendations which have been formulated in line with observations made as part of the baseline audit of each site. An initial examination of the following key issues is provided:

- Both Sites
  - Rationale for calculating required additional car park and cycle space provision including multi storey provision
  - Assessment of scope of work to connect to surrounding cycle networks
  - Review of the existing on site roads and radius for proposed vehicle types
  - Travel plan review recommendations
- RSH Site Only
  - Viability of providing a 'Blue-Light Only Route' (BLOR)

### SITE OPTIONS

4.2 The SaTH is reorganising the way the trust will function in the future across the two sites. How the reorganisation is to be implemented across both sites is still to be determined but it will see the establishment of an Emergency Site at one location and at the other, the current Emergency facilities will be replaced with a PCS.

4.3 Through discussion of the recommendations outline, reference is made the following options for the two trust:

- Option B – New Emergency Site at PRH
- Option C1 – New Emergency Site at RSH
- Option C2 – New Emergency Site at RSH and W&Cs at PRH

### CAR PARKING

4.4 As highlighted in the baseline review there are major car parking issues across both sites. There have been some steps made by SaTH to address these issues, most notably at the RSH through better enforcement, however further steps are required to improve the overall car park management. The car parks are managed on behalf of the SaTH by CP Plus, Each site's parking provision and associated issues are discussed below.

4.5 In order to provide an indication of traffic associated with the proposed options for each site, the TRICS database (v7.3.2) has been interrogated, using sites from the 'Hospital With Casualty' and 'Hospital Without Casualty' categories. Site surveys have been used to determine, on average, the provision of vehicles travelling to the site as a proportion of total trips. For sites in the 'Hospital With Casualty' category, vehicles accounted for 67% of total trips, where as in the 'Hospital Without Casualty' category, vehicles accounted for 70% of total trips.

4.6 As set out in Table 4-1, the proposed options for PRH and RSH will result in a transition in the number of Full-Time Equivalent (FTE) staff members employed at each site.

Table 4-1 FTE Staff Members

Staff	PRH (% Of Current)	RSH (% Of Current)
Current	2075	2432
Option B	2564 (124%)	1943 (80%)
Option C1	1181 (57%)	3393 (140%)
Option C2	1653 (80%)	3022 (124%)

AHR Architects

4.7 In accordance with traffic profiles obtained from the TRICS database, variations in staff numbers are envisaged to result in equivalent increase in the number of trips associated with each site. From the TRICS data the provision of vehicle trips as a percentage of total trips to the site has been calculated. This has then been applied to the percentage increase in staff for each site option, outlined in Table 4-1. The resulting figure has been applied to parking demand figures set out in Table 4-2, in order to forecast future demand.

Table 4-2 Parking Space Provision

	Capacity	Free Spaces	Unallocated Parking	Demand
PRH	1336	136	145	1345
SRH	1742	91	50	1701

4.8 For example, currently during peak hours there is a demand for 1345 spaces at PRH, which is 9 more than the 1336 capacity. Option B, which will see a new Emergency Site located at PRH, is predicted to result in 124% of the current FTE staff provision on site. For 'Hospital With Casualty' Sites vehicles are predicted to account for 67% of total trips to the site.

4.9 When taking into account current parking demand, and that 67% of new trips associated with the site are likely to be vehicles, it is envisaged that 225 additional spaces will be required on site to accommodate demand.

Increase in staff * vehicle trips as a proportion of total trips	24*0.67=16.08
Current parking demand * forecast vehicle trips	1345*1.168=1561.276
Forecast parking demand – current capacity	1561.276-1336=225.276
Number of additional spaces required to accommodate demand	225

4.10 This method has been employed in order to provide an estimate of required parking demand for each of the Options proposed at PRH and SRH.

### Princess Royal Hospital

4.11 As outlined within the baseline audit of the PRH, there appears to be a major issue with regard to unallocated, overflow car parking, particularly along the grass verges of the sites internal access roads.

4.12 Upon visiting the site it would appear that staff vehicles (identified through the display of a staff permit in the vehicle) account for a large proportion of this overflow parking, predominantly along the verges of the access road to the east of the site. As part of the baseline site audit, a total of 97 incidences of unallocated



staff parking were recorded on site. At the same time, there were 134 available parking spaces for staff, 85 of which were recorded within the ramped staff car park, to the west of the WCW. Through discussions with the car parking attendant on site, it becomes apparent that this car park has been utilised far less since the allocation of approximately 140 spaces for staff from the main visitor car park on the site. It would appear that staff view the ramped staff park as too remote in relation to their destinations and therefore choose to park inappropriately on grass verges along the internal access road. An element of this may also be down to an unawareness of the availability within the ramped staff car park.

- 4.13 In light of the above, it is recommended that any car park management promotes greater use of the ramped staff car park, as a method of reducing incidences of unallocated staff parking on site. One way to improve usage of the staff car park would be through greater parking enforcement. Upon visiting the site it would appear that enforcement only occurs for vehicles failing to display a staff permit. To ensure that parking at the site is properly managed, it is recommended that enforcement warnings should be served for vehicles parking inappropriately, regardless of whether they belong to staff or visitors. Such efforts should be supported by clear signage and information to direct staff to available spaces at existing spaces.
- 4.14 In addition to the principles outlined above, and to further reduce incidences of unallocated staff parking on site, spaces could be formalised adjacent to the Endoscopy Unit. This would provide formalised parking in a location where numerous incidences of unallocated parking are currently observed and provide additional onsite capacity.
- 4.15 As part of Option B for the PRH site, which involves the construction of a new Emergency Site on the existing Main Visitor Car Park, the possibility of a multi-storey car park has been examined. It is envisaged that this could feasibly be delivered on site, situated on land south of the internal access road. Through preliminary analysis it is suggested that this could provide 150 spaces per storey.
- 4.16 In such a case the topography changes between the existing visitor car park and the adjacent access road will have to be properly considered, in order to provide a pedestrian crossing point between the main hospital buildings and the new multi-storey car park. There is also a potential requirement for the access road to be widened, in order to accommodate increased traffic volumes. This is considered to be feasible given the provision of vacant land adjacent to the road. The potential requirement for a filter lane would also need to be considered, in order to prevent vehicles queueing back along the access road.
- 4.17 For Option B, using the method outlined in Paragraph 4.4 – 4.6, and assuming that no efforts to promote alternative modes of travel are successful, parking demand on site is rise from 1345 to 1557 spaces. At the time of the site visit, demand was observed at 1345 space, 9 more than the total on site capacity of 1336. Current demand rather than capacity has been used as a base figure for these calculations in order to highlight future demand for parking.
- 4.18 In this case any new car park would need to account for 221 new spaces, plus the 216 spaces displaced from the visitor centre car park (356 – 140 staff spaces), amounting to a total of 437 spaces. From preliminary analysis of the land to the south of the access road, it would appear that a multi storey car park of 150 spaces per storey could be established, thus suggesting the requirement for a 3 storey car park. Utilising knowledge drawn from previous experience of working on similar schemes, a multi-storey car park of this size would involve a cost of approximately £12,000 per space, thus equating to a total cost of £5.244 million.
- 4.19 For Option C1 and C2, which involve the situation of a new Emergency Site away from PRH, required parking demand is envisaged to reduce significantly. It is envisaged that Option C1 would result in demand for 397 fewer spaces on site, with Option C2 reducing demand by 182 spaces. In the event of either of these options occurring, it is likely that the requirement for additional parking spaces on site would be eliminated.

- 4.20 Table 4-3 provides a summary of car parking for each of the proposed options in relation to current capacity and demand at PRH.

**Table 4-3 PRH Car Parking Options Summary**

	Current Capacity	Current Demand	Future Demand	Net Change
Option B	1336	1345	1557	+221
Option C1	1336	1345	939	-397
Option C2	1336	1345	1154	-182

### Royal Shrewsbury Hospital

- 4.21 Car parking at RSH appears to better managed, however there are still a number of issues which require addressing. Numerous incidences of unallocated parking by staff were observed, which could be addressed through an expansion of staff parking areas in order to meet current demand. This could occur through extension of the main staff car park to the west, or the construction of a multi-storey at this location, as outlined in the proposed options for the site. It is likely that a multi-storey would be the most viable option, given the limitations with regard to available land on site. In this case, further work would be required to determine whether Evolution Road, and in particular the T-Junction with Mytton Oak Road would require upgrading in order to accommodate increased traffic levels
- 4.22 In reference to the plans for the proposed site options, the construction of a new Emergency Site will result in the displacement of 96 spaces from the main staff car park, which must be factored into consideration when calculating the number of additional spaces required on site. In the case of a multi-storey being constructed, the plans indicate that this will provide a total of 155 spaces per storey, however it must be considered that the ground floor of the proposed location of the multi-storey is currently occupied by surface car parking. Any additional parking will therefore need to be provided on the first floor and above (if necessary).
- 4.23 As part of Options C1 and C2, the new Emergency Site would be located at RSH, resulting in an increase in trips to the site. For Option C1, assuming that no efforts to promote alternative modes of travel are successful, parking demand on site is predicted to rise from 1701 to 2151 spaces. In this case any new car park would need to account for 409 new spaces, in addition to 96 displaced by the construction of a new Emergency Site and the 155 which currently occupy the land where the new multi-storey is to be situated. In light of this, the multi-storey would need to provide 660 spaces, at a rate of 155 per storey, which would suggest at a minimum a four storey car park would be necessary. As set out above, utilising knowledge from working on similar schemes, a multi-storey car park of this size would involve a cost of approximately £12,000 per space, equating to an approximate cost of £7.5 million.
- 4.24 With regard to Option C2, again assuming that no efforts to promote alternative modes of travel are successful, parking demand on site is predicted to rise from 1701 to 1977 spaces. In this case any new car park would need to account for 235 new spaces, which again would be in addition to the 96 displaced by the construction of a new Emergency Site and the 155 which currently occupy the proposed location of the new multi-storey. In light of this, the multi-storey would need to provide 486 spaces, at a rate of 155 per storey, which would suggest that a three storey car park would necessary. The 465 spaces required would suggest an approximate total cost of £5.6million.
- 4.25 For Option B, which involves the situation of a new Emergency Site away from RSH, required parking demand is envisaged to reduce significantly. It is envisaged that Option B would result in demand for 280 fewer spaces on site. In the event of this option occurring, it is likely that the requirement for additional parking spaces on site would be eliminated.

4.26 Table 4-4 provides a summary of car parking for each of the proposed options in relation to current capacity and demand at PRH.

**Table 4-4 SRH Car Parking Options Summary**

	Current Capacity	Current Demand	Future Demand	Net Change
Option B	1742	1701	1462	-280
Option C1	1742	1701	2151	+409
Option C2	1742	1701	1977	+235

**CYCLE NETWORK CONNECTIONS**

4.27 As outlined above, one of the key recommendations for any Travel Plan Review centres on improving access for cyclists, which in turn could potentially encourage staff to arrive at either site by modes other than the car. As part of this, it is necessary to examine the potential scope of works to connect to surrounding cycle networks at each site.

**Princess Royal Hospital**

4.28 At PRH, there are several local cycle networks surrounding the site, which permeate through the residential areas of Apley and Leegomery, before connecting with National Cycle Route (NCR) 81, which links with Wellington Train Station and Telford. In spite of this, it appears that cycle parking at the site is largely unused. A number of measures could be considered to encourage increased cycle usage for journeys to work.

4.29 In spite of the widespread provision of cycle routes around the site, cycle infrastructure within the site is inadequate. There are no cycle lanes, with cyclists instead using the busy internal access roads, and signage is relatively sparse. Whilst not wishing to overlook the limitations with regard to available space at the site, there is potential space along the grass banks adjacent to the internal access road where a cycle path could be established. These could interlink with external cycle routes to the south of the site, along Whitchurch Drive and Grainger Drive, which benefit from dedicated cycle lanes and signalised crossings.

4.30 Any cycle lanes provided within the site could also interlink with the existing route along the northern site boundary, which provides connections from Apley Castle towards residential areas to the west. This would also provide an alternative route for those wishing to avoid the busy main roads of Whitchurch Drive and Grainger Drive.

4.31 Any new routes within the site should be accompanied by the provision of frequent, clear signage, as wayfinding was identified as a key impediment to NMU access at PRH.

4.32 There are two cycle shelters, located adjacent to the main entrance and the WCW, however at the time of the site visit only two bicycles were parked in these shelters. It is envisaged that use of the shelters could be significantly improved through the measures outlined above.

**Royal Shrewsbury Hospital**

4.33 At RSH, cycle route provision around the site is relatively sparse. The closest route (NCR 81) is approximately 0.7miles from the site, which provides connections to Shrewsbury Town Centre. In spite of this, cycle use appears to be considerably greater at the site, when compared with PRH. It is envisaged that this may partly be down to the draw from the quiet residential roads surrounding the site.

4.34 Similar to the PRH site, it would again be beneficial to investigate the potential for establishing cycle lanes within the site. Preliminary analysis suggests that there would be a lack of available land given the

concentration of development on the site. Nonetheless, there are several potential options which could be explored in order to enhance access for cyclists. For example, there are existing pedestrian routes which connect residential areas to the hospital which could potentially provide a shared space for pedestrians and cyclists thus enhancing permeability for cyclists.

4.35 Access into the north of the site from Starcross Close could be enhanced, perhaps through widening the current access point and providing a separate lane for cyclists. This would provide an established access point to the large residential areas to the north of the site. Alternatively the path to the north which links the hospital to Everly Close, Napoleon Drive and Painters Place could also be adapted to make it both more pedestrian, cyclist and disability friendly by widening the path and removing the steps.

4.36 Improvements could also be made to the route through to Westhope Avenue, from the east of the site adjacent to the Shropshire Conference Centre. This is currently narrow and overgrown, with little natural surveillance. Enhancing this route would provide greater access to the large residential area to the east of the site, in addition to a shorter linkage with NCR 81.

4.37 As with the PRH, a greater provision of clear signage could be help enhance access for NMUs, as wayfinding was valued as a key limitation to NMU access as part of the baseline site audit.

**ON SITE ROAD ASSESSMENT**

4.38 To ensure that ambulances will be able to approach and enter from the new Emergency Site entrance at each location swept path analyses have been undertaken. These are included in Appendix B.

4.39 The scale and layout of the proposed new Emergency Site entrance at PRH is such that ambulances can use the existing access road and follow the circulatory of the new drop off point.

4.40 At RSH two potential 'Blue-Light Only Routes' (BLORs) have been examined through swept-path analysis, which confirms that an ambulance would be able to negotiate these routes, and perform a U-turn in front of the Emergency Site entrance.

**BLUE LIGHT ONLY ROUTE (BLOR) – RSH**

**New Road Across Land Adjacent to Somerby Drive**

4.41 Taking into account observations made during the two visits to RSH and preliminary desk-based analysis, the potential establishment of a new blue-light route has been examined. It is envisaged that this will be located to the northwest of the site, crossing a section of green space before joining with Somerby Drive, adjacent to the Redwood Centre, as shown in Appendix A. At this stage is it assumed that this land would be made available.

4.42 Currently Somerby Drive is subject to a 20mph speed limit and acts as a major link for residents to the north and west of the site. The road is of sufficient width to facilitate a route for emergency vehicles, however the potential impact on local residents should be considered and it is likely that there would be opposition to a new route for emergency vehicles adjacent to their properties.

4.43 The BLOR could be provided toward the southern side of the green space, with an element of screening provided in the form of fencing or a continuous tree line to mitigate the impact of noise pollution and visual intrusion on surrounding properties.

4.44 Consideration will need to be made of the future of the play area currently situated within the green space, as this may have to be relocated. The topography of the land will also need to be considered, given that the green space is not at grade with the adjacent internal access road. A cutting into the land will therefore need to be made, in order to maintain a suitable gradient for any adjoining BLOR.

4.45 Within the centre of the green space, there are two large trees it is envisaged, therefore, that the input of an ecologist would be required, in order to determine whether or not these are protected species. However it is believed that the route could be provided without the requirement for either tree to be removed. This will require further investigation.

4.46 Finally it is likely that some of the smaller trees, in addition to existing signage and lighting along the border between the existing green space and the hospital, may need to be removed, to allow the BLOR to integrate with the existing internal access roads. As outlined above, there are considerations to be made in order to provide a new BLOR at this location, nonetheless, it is envisaged that these could be overcome, providing a new access point adjacent to the Treatment Centre Staff Car Park.

### Evolution Road

4.47 A second potential option for the BLOR is along the section of Evolution Road to the west of the site, past the Boiler House and Estate, as set out in Appendix A. Evidently this option would not require the same level of intervention as the above option given that much of the BLOR will be along an existing road. This option would, however, be subject to the use of the section of Evolution Road which connects with Racecourse Lane, as outlined below.

### Additional Considerations – Both Options

4.48 For both options outlined above access via a BLOR could be further enhanced through utilisation of the section of Evolution Road which connects with Racecourse Lane. Should a connection be provided between Somerby Drive and Evolution Road, emergency vehicles will be able to access and enter the site to the north and south.

4.49 Restrictions would also need to be in place to prevent stopping along both potential BLORs. Adequate signage would be required to prevent members of the public accessing the routes and interfering with the flow of emergency vehicles. It is also recommended that a lighting system be put in place which prioritises emergency vehicles at the point of access into the site.

### TRAVEL PLAN REVIEW RECCOMENDATIONS

4.50 Following a review of the documents, and taking into account issues identified as part of the baseline audit of the site, we would advise the following recommendations to be implemented by the Travel and Transport team. The aim would be to provoke a reduction in single occupancy vehicle travel to the site, and to help reduce current car parking issues. Encouraging these changes will have many positive impacts on the sites as they develop, including:

- Improving access for vehicles e.g. deliveries, emergency vehicles,
- Improving access for pedestrians and cyclists
- Improving the car parking and access issues for staff and patients

4.51 With regards to the staff travel and transport updates it is recommended that these are issued quarterly to the Executive Directors and Trust Board to ensure that progress is being made with regards to the actions and measures produced through the Travel Plan documents and the Transport studies. There is no record of a steering group or of who these updates are sent to.

4.52 Although the documents mentioned above are comprehensive and acknowledge many transport issues that have hindered the ability to use sustainable modes of transport to the site, they require updating, especially the GTP and the TTP.

4.53 These should be updated to consider all the measures implemented since 2008 and include monitoring of their success. It is recommended that just one document should be produced to encompass both the

GTP and the TTP to avoid repetition, have joined up measures and consistency, and have clear, realistic and achievable measures and targets. More information on this will be given later in this document.

4.54 To ensure their success GTPs and TTPs require the following::

- Travel Plans should conform to the best practice recommended through the National Planning Policy Framework (NPPF) and National Planning Practice Guidance (PPG), especially with regards to the change of use and relocation of staff.
- Travel Plans should ensure and prove that they are in line with National and Local Policy with specific references to these for a joined up consistent approach.
- An analysis of what is currently available to staff, patients and visitors to help them travel sustainably.
- Travel Plans and actions should be based upon site users travel surveys. These need to be tailored to the specific site user needs, for example staff, patient and visitor needs. In order to have an accurate reflection of what specific barriers there are to sustainable travel, surveys must have a statistically accurate response rate. The travel surveys will be reflected in the actions and measures suggested and add justification to the need and success of actions. Travel Plans should include a full analysis of the surveys.
- Develop a marketing strategy to ensure all site users are aware and continuously reminded of sustainable transport options available.
- Investigate the business travel and grey fleet issues to complement the car park management strategy.
- There is mention of other organisations on the site and in the local vicinity. It would be wise to work alongside these organisations, especially with regards to liaising with local public transport operators to improve their services to the sites.
- It is acknowledged that some staff may be relocating. Relocation offers a great opportunity to influence travel behaviour as habits are yet to be formed. A plan should be put in place to assist any relocating staff on their new journeys to work when the new building usages and staff are confirmed.

### Business Travel and Grey Fleet

4.55 It has been acknowledged in the documents that grey fleet and business travel is not well managed with significant costs to the NHS, estimated across SaTH at £900,000 per year. It is therefore important to investigate opportunities on how this can be reduced. If there is less need to travel during the working day and therefore less need to drive to work.

4.56 Simple measures could be put in place to ensure that staff can avoid driving during the working day. These include:

- Introduce a business travel hierarchy and process to seek to reduce business travel mileage and deliver cost savings. It will look to promote firstly alternatives to travel such as teleconferencing, followed by active transport, public transport, pool car usage and car sharing, with grey fleet being used as a last resort.
- Ensuring that teleconferencing systems are available and used effectively and all staff are trained in how to use them;
- Ensure that if no sustainable transport modes are available for business travel that staff are able to car share where applicable (conferences etc.);
- Adopt an electronic mileage claim form to monitor business and grey fleet travel; and
- Ensure all staff are aware of the newly contracted lift share scheme through running events and the dedicated car sharing bays.

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## SUMMARY OF RECCOMENDATIONS

4.57 Table 4-5 provides a summary of the recommendations set out above.



Table 4-5 Summary of Recommendations

Actions	Delivery	Date to be completed
<b>Car Parking Recommendations</b>		
At PRH promote better utilisation of the Ramped Staff Car Park.	NHS Trust	
At PRH ensure that enforcement warnings are given to cars parked in unallocated spaces.	NHS Trust	
At PRH investigate the use of the land that is currently available to the south of the internal access road and consider its usage as a car park as an alternative to a multi storey.	NHS Trust with the support of JMP Consultants	
At RSH investigate further the need for an extension to the main staff car park to the west of the site or a multi storey.	NHS Trust with the support of JMP Consultants	
At RSH investigate if Evolution Road requires upgrading with emphasis on the junction between Evolution Road and Mytton Oak Road in order to provide capacity for vehicles accessing new multi-storey car park.	NHS Trust with the support of JMP Consultants	
Produce and deliver a Car Park Management Strategy for both sites	JMP Consultants	
<b>Cycle Recommendations</b>		
Conduct site cycle audits to identify key priorities to improve infrastructure and way finding for cyclists on site.	JMP Consultants	
Ensure that existing links to residential areas can be utilised by cyclists to encourage permeability to the sites.	NHS Trust with the support of JMP Consultants	
Work with the local authority and cycling groups (such as Sustrans) to ensure that the local cycle network paths are well maintained, free of vegetation, well-lit and have natural surveillance to ensure that cyclists feel secure throughout the year.	NHS Trust, Local Authorities and Sustrans	

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<b>Blue Light Only Route (BLOR)</b>		
Introduce measures to mitigate the impact of noise and visual pollution on local properties.	NHS Trust	
Investigate the future of vegetation and trees surrounding the potential BLOR as well as the children's play area.	NHS Trust with the support of JMP Consultants	
Investigate the use of Evolution Road as a potential alternative BLOR to cutting through the green space.	NHS Trust with the support of JMP Consultants	
Implement Red Route restrictions	NHS Trust and Local Authority	
Implement appropriate signage.	NHS Trust with the support of JMP Consultants	
<b>Travel Plan Review Recommendations</b>		
Produce a Travel Plan to combine the GTP and TTP to take into consideration both staff and visitor travel to the site.	NHS Trust / JMP Consultants	
Set up a Travel Plan Steering Group	NHS Trust	
Conduct a thorough staff and visitor travel survey to feed into the Travel Plan which must reach a statistically accurate response rate. This should be completed annually for monitoring purposes.	NHS Trust with the support of JMP Consultants	
Investigate ways to save time and costs on Business Travel and Grey Fleet issues.	JMP Consultants	
Produce a Car Park Management Strategy.	JMP Consultants	

## 5 Summary

- 5.1 JMP has provided a series of future recommendations to help inform the reorganisation of the PRH and RSH sites. These centre predominantly on car parking, cycle access, the establishment of a BLOR and a review of travel plan principles.
- 5.2 JMP recommend that a car park management strategy is produced for both sites. At PRH focus should be on better utilisation of the ramped staff car park, combined with suitable enforcement measures for cars parked in unallocated space. At PRH, it is also recommended that for Option B, a new 437 space 3 storey car park is provided on land to the south of the internal access road, costing approximately £5.244 million. At RSH in the case of Option C1 being realised, a new multi-storey is deemed necessary, which will provide 660 spaces over 4 storeys at a total cost of £7.5 million. For Option C2, a multi-storey comprising 486 spaces over 3 storeys is considered appropriate, costing approximately £5.6 million. At RSH, given the proposed location of any multi-storey, further investigation will be required to determine whether Evolution Road requires upgrading in order to provide capacity for additional vehicles accessing this location.
- 5.3 With regard to cycle infrastructure, JMP recommend that cycle audits are undertaken in order to identify key priorities to improve infrastructure and way finding for cyclists at both sites. Existing links to residential areas should also be examined further, in order to determine whether these can be utilised by cyclists, enhancing permeability of the two sites. It is also recommended that SaTH work with the local authority and cycling groups (for example Sustrans) to ensure that the local cycle network paths are adequately maintained, free of vegetation, well-lit and benefit from natural surveillance to ensure cyclists feel secure throughout the year.
- 5.4 In the case of an Emergency Site being located at RSH, a new BLOR is proposed for emergency vehicles. In order to support this, JMP recommend that further investigation is undertaken to examine the future of vegetation and the existing play area which are currently situated on the green space to the northwest corner of the site. The use of the exiting section of Evolution Road to the west of Estates may also be considered as a potential alternative route. In the case of a BLOR being brought forward, JMP recommend that appropriate red routes restrictions and subsequent signage are introduced to prevent conflict with public vehicles. In the case of the BLOR being located on green space to the north of the site, JMP would also recommend appropriate screening is provided to mitigate the potential for noise pollution and visual intrusion on existing properties situated adjacent to the green space.
- 5.5 Finally, a number of recommendations are made surrounding a comprehensive review of the travel plans for the two sites. JMP suggest that a travel plan is produced to combine the GTP and TTP to take into consideration both staff and visitor travel to the site, and that a steering group is set up to support this. A thorough staff and visitor travel survey is also required, to feed into the travel plan. This should be completed annually for monitoring purposes. Further investigation is also recommended surrounding potential ways to save time and costs on Business Travel and Grey Fleet Issues.

## Appendix A

### CAR PARK LOCATIONS

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## Appendix B

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# Fire Strategy



# Royal Shrewsbury Hospital, Outline Fire Strategy

Revision: R00  
Date: 10/02/23  
Project Number: MA23006



# Royal Shrewsbury Hospital, Outline Fire Strategy

Revision: R00  
Date: 10/02/23  
Project Number: MA23006



### Quality Management

Revision	Date	Comment	Author	QA & Technical Review	Approver
R00	10/02/23	Issue for inclusion in Stage 2 information	MH	KSS	RR





Contents

- 1 Introduction .....5
  - 1.1 Appointment.....5
  - 1.2 Applicable Legislation.....5
  - 1.3 Design Basis and Guidance.....5
  - 1.4 Reference Information.....5
  - 1.5 Key Considerations.....5
- 2 Description of the Project.....6
- 3 Fire Safety Systems .....7
  - 3.1 Fire Detection and Alarm System.....7
  - 3.2 Hold Open Devices.....7
  - 3.3 Emergency Lighting.....7
  - 3.4 Emergency Exit Signage .....7
  - 3.5 Escape Lifts.....7
  - 3.6 Dry Risers.....7
  - 3.7 Smoke Ventilation.....7
  - 3.8 Emergency Power .....7
- 4 Means of Escape .....8
  - 4.1 Evacuation Strategy – Patient Areas .....8
  - 4.2 Horizontal Means of Escape.....9
    - 4.2.1 Provision of Compartments.....9
    - 4.2.2 Dimensions of Escape Routes .....9
    - 4.2.3 Travel Distances.....9
  - 4.3 Vertical Escape .....10
    - 4.3.1 Staircases .....10
    - 4.3.2 Escape Lifts.....11
  - 4.4 Plant/ Roof Escape .....11
  - 4.5 Basement .....11
- 5 Internal Fire Spread.....12
  - 5.1 Internal Linings.....12

- 5.2 Load Bearing Elements of Structure .....12
- 5.3 Compartmentation & Fire Resisting Construction.....12
  - 5.3.1 Hazard Rooms.....12
  - 5.3.2 Hazard Departments .....13
  - 5.3.3 Openings & Concealed Spaces.....13
- 5.4 Very High Dependency Patients.....13
- 6 External Fire Spread .....13
- 7 Fire Service Access.....13
  - 7.1 Firefighting Shafts.....13
  - 7.2 Vehicle Access.....13
  - 7.3 Water Supplies.....14
  - 7.4 Existing Emergency Department .....15
- 8 Conclusion .....16
- 9 References .....17
- Appendix A – Fire Strategy Plans.....18
  - Figure 1: Building location ..... 6
  - Figure 2: Fire conditions ..... 8
  - Figure 3: Stages of Progressive Horizontal Evacuation ..... 8
  - Figure 4: Evacuation sequence ..... 8
  - Figure 5: Stair lobby..... 10
  - Figure 6: Escape from central stair ..... 10
  - Figure 7: Hose coverage – current proposal ..... 14
  - Figure 8: Hose coverage – potential relocated stair positions ..... 14
  - Figure 9: Fire service access ..... 15
  - Table 1: Reference drawings.....5
  - Table 2: Key items for consideration.....5
  - Table 3: Travel Distances .....9
  - Table 4: Recommendations for linings .....12
  - Table 5: Fire resisting construction.....12
  - Table 6: Hazard rooms.....12
  - Table 7: Permissible locations of transfer grilles, fire dampers and fire and smoke dampers13



## 1 INTRODUCTION

### 1.1 Appointment

This report describes the Outline Fire Strategy for the construction of a new building at Royal Shrewsbury Hospital as part of the hospital transformation programme.

The purpose of this fire strategy document is to inform the design by outlining the key fire safety provisions necessary within this new building to comply with the Building Regulations 2010 (as amended) [1]. This document is produced for design team information. As the design develops, a detailed strategy will be produced for formal approval.

### 1.2 Applicable Legislation

Building Regulations 2010 (as amended), Part B, Fire Safety applies to building design, whilst for fire safety provisions and management in occupied buildings, compliance with the Regulatory Reform (Fire Safety) Order 2005 (FSO) [2] is needed.

The strategy has been developed and laid out in a manner that is deemed most suitable to achieve its main purposes. In doing so, it is structured to align with the requirements of the Building Regulations, 2010, Part B namely:

- B1 – Means of warning and escape;
- B2 – Internal fire spread (linings);
- B3 – Internal fire spread (structure);
- B4 – External fire spread; and
- B5 – Access and facilities for the fire service.

The fire safety strategy primarily addresses life safety under the Building Regulations and has not been developed to address property protection. However, the features that are included for life safety, as required by the Building Regulations 2010, will contribute in some extent to business and property protection.

### 1.3 Design Basis and Guidance

The fire safety design is based on the guidance given in the Health Technical Memoranda suite of documents, and in particular HTM 05-02 Fire safety in the design of healthcare premises 2015 [3].

HTM 05-02 should allow the current statutory regulations to be applied sensibly within a framework of understanding and if applied correctly, will satisfy all the requirements of Part B of Schedule 1 of the Building Regulations.

Part of this project is a refurbishment project, in which case any existing deviations from guidance may remain provided that they are not made any worse by the refurbishment.

### 1.4 Reference Information

This report is based on the drawings listed in the following table.

Table 1: Reference drawings

Drawing Number	Drawing Title	Revision & Date
RSH-AHR-60-01-DR-A-08201	Level 1 Ground Floor – GA Plan	P02 06/02/23
RSH-AHR-60-02-DR-A-08202	Level 2 First Floor – GA Plan	P03 06/02/23
RSH-AHR-60-03-DR-A-08203	Level 3 Second Floor – GA Plan	P02 06/02/23
RSH-AHR-60-04-DR-A-08204	Level 4 Third Floor – GA Plan	P02 06/02/23
RSH-AHR-60-05-DR-A-08205	Level 5 Roof 1 – GA Plan	P02 06/02/23
RSH-AHR-60-06-DR-A-08206	Level 6 Roof 2 – GA Plan	P02 06/02/23
RSH-AHR-60-XX-DR-A-08301	Sections	P01 10/01/23
RSH-AHR-60-XX-DR-A-08401	Elevations Sheet 1	P01 10/01/23
RSH-AHR-60-XX-DR-A-08402	Elevations Sheet 2	P01 10/01/23
RSH-AHR-60-01-DR-A-01401	Level 01 – Site Plan	P01 01/02/23
RSH-AHR-60-XX-DR-A-08102	Site Location Plan	P01 06/02/23
RSH-FIR-ZZ-XX-DR-L-00001	Preliminary Landscape Master Plan	P01 03/02/23
RSH-AHR-36-01-DR-A-08201	Emergency Department – 36 – Level 1 Proposed GA	P03 03/02/23

### 1.5 Key Considerations

There are areas of the current design which do not align with current guidance, these are noted in the following table. These are to be addressed as the design develops, any alternative proposals to those recommended by HTM will be subject to Building Control approval.

Table 2: Key items for consideration

Item	Proposed Solution	Reference
The maximum compartment sizes recommended by HTM are exceeded meaning some areas will have extended travel distances to reach a neighbouring compartment.	An equivalent solution by increasing fire resistance to sub-compartment walls and additional sub-compartmentation may be considered acceptable. This is to be reviewed as the design progresses and compartment sizes reduced where practicable.	4.2.1
The central stair does not discharge to outside.	The stair locations are to be revised, they currently do not provide adequate fire service access.	4.3.1
A minimum of two escape lifts are recommended. These should be in separate fire compartments. Currently only one bank of lifts is shown on the plans.	Additional escape lifts to be provided associated with a different stair core.	4.3.2
Provision of firefighting shafts does not meet minimum recommended by HTM (a minimum of 5).	At least one more firefighting shaft (two if practicable) should be provided such that hose coverage is achieved throughout the building.	7.1

## 2 DESCRIPTION OF THE PROJECT

The project is a combination of new build and refurbishment of an existing building. The refurbishment part of the project will cover the existing A&E department. This is a single storey part of the hospital which has existing links to neighbouring buildings and will link to the proposed new building. The height to the top occupied floor (Level 4) is approximately 14 m above access level (Level 1).

The new building will have 4 floors of clinical spaces with roof top plant. There is an existing basement area (Level 0) which will be below the new building.

The following departments are provided by the new building:

- Level 1 (Ground): Emergency Department, Acute Medical Unit, Gynae and Short stay ward
- Level 2: Delivery, Neonatal and General Ward
- Level 3: Paediatrics and Maternity
- Level 4: Oncology and Critical Care

The patient dependency will be a mix of normal dependency and very high dependency. The majority of patients in the building are expected to require assistance in the event of an evacuation and movement of some patients would be life threatening and require multiple staff members to assist.

There are 3 staircases proposed for the new building with a fourth being accessible via link to existing building.



Figure 1: Building location



### 3 FIRE SAFETY SYSTEMS

#### 3.1 Fire Detection and Alarm System

A fully addressable analogue type L1 category system meeting the recommendations of HTM 05-03 Part B [4], BS 5839 – 1 [5] and the relevant parts of BS EN 54 [6] will be provided throughout the building and will be installed to facilitate the progressive horizontal evacuation strategy. Fire alarm panels should be provided at locations accessible by the fire service. It is noted that fire alarm panels in hospitals are often also provided at nurse stations to allow staff to manage the evacuation based on the location in which the fire detection system was activated.

The means of warning should be discussed with hospital personnel, a conventional alarm system may not be appropriate depending on the patient characteristics.

Break-glass call points should be provided where there is not a high risk of malicious activation by patients. Options for call point types are to be considered with regard to security and risk of inappropriate usage. The final location and type of call points is subject to agreement with the Client and Approval Authorities.

#### 3.2 Hold Open Devices

Where fire doors in the closed position are considered a hindrance to day to day operation of the building, hold open devices should be installed such that upon activation of the detection system they will release and close. HTM recommends that these are not installed on staircase doors. Where installed, such devices should be in accordance with BS 7273-4 [7].

#### 3.3 Emergency Lighting

Emergency lighting will be provided in accordance with the recommendations of BS 5266: Parts 1-7 [8] and HTM 06-01 [9]. Emergency lighting will illuminate all occupied areas, common evacuation routes (internal and external as necessary) and essential areas including plant areas. It will also illuminate a safe exit route including fire exits, fire alarm call points, changes in level or direction, external assembly points and firefighting equipment.

#### 3.4 Emergency Exit Signage

All escape routes within staff areas are to be distinctively and conspicuously marked by emergency exit signs following the recommendations of BS ISO 3864 Part 1 [10] and BS 5499 Part 4 [11]. Escape route signage should be provided to include directions outside the building to the nominated assembly point.

#### 3.5 Escape Lifts

As there are patients classed as being very high dependency located at upper levels in the new building then a minimum of two escape lifts are to be provided. These should be located in separate compartments such that one will always be available. Escape lifts should be provided in accordance with HTM 05-03 Part E. Note that HTM 05-03 Part E [12] states that if an escape lift shares a protected shaft with other lifts, then they should also be designed as escape lifts. Escape lifts should be within 120 minute fire resisting enclosure and should be protected by ventilated lobbies.

#### 3.6 Dry Risers

Dry risers are required in each firefighting shaft, these should be in accordance with BS 9990 [13].

#### 3.7 Smoke Ventilation

Automatic opening vents (AOVs) are to be provided in each staircase (head of stair or at each landing level) and in all stair lobbied and escape lift lobbies. Size recommendations:

- 1 m<sup>2</sup> geometric free area AOV at each stair landing level or 0.7 m<sup>2</sup> aerodynamic free area at head of stair
- Ventilated lobbies 1.5 m<sup>2</sup> geometric free area AOV

#### 3.8 Emergency Power

Emergency power will be provided to all essential life safety equipment as part of the full hospital back up system. Emergency power should be provided to the following systems:

- Fire detection and alarm system
- Emergency lighting system
- Escape lifts
- AOVs





## 4 MEANS OF ESCAPE

### 4.1 Evacuation Strategy – Patient Areas

The fire safety guidance in HTM states that evacuation of an entire hospital may not be practical and would likely pose a risk to patients due to trauma or their medical condition, there are three fire conditions identified which could lead to evacuation. These are shown in Figure 2.

This strategy assumes that staffing levels will be maintained in accordance with HTM to ensure that the emergency plan can be implemented at any time. The required staffing levels should be included in a fire safety management strategy to be produced by the building operators.

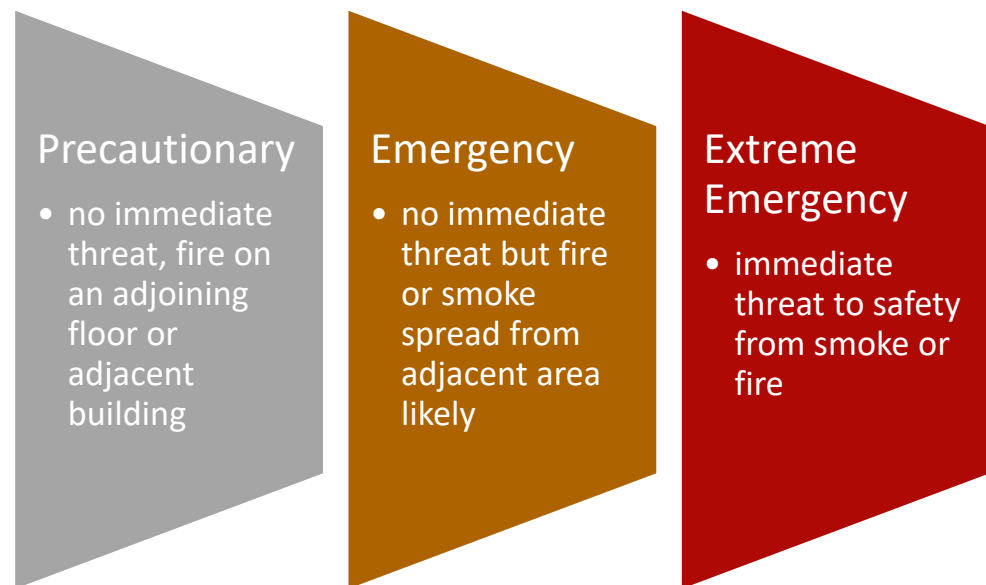


Figure 2: Fire conditions

In buildings where the occupants are unable to evacuate without assistance, a Progressive Horizontal Evacuation (PHE) strategy is used. The principle of PHE is to move occupants from any area affected by fire to an adjacent area on the same level separated by a fire and smoke resisting barrier designed to protect occupants from fire and smoke. Occupants may remain in the adjacent compartment until the fire is dealt with or await further assistance for onward evacuation if required. Each level will be divided into fire compartments.

This procedure is heavily reliant on ensuring there is sufficient numbers of trained staff available to assist in moving the occupants as discussed earlier. The FSO requires the responsible person to produce an evacuation procedure, have sufficient staff to implement it and ensure that members of staff are adequately trained. The PHE stages are shown in Figure 3.

In the event of an extreme emergency the sequence of evacuation is expected to be as shown in Figure 4.

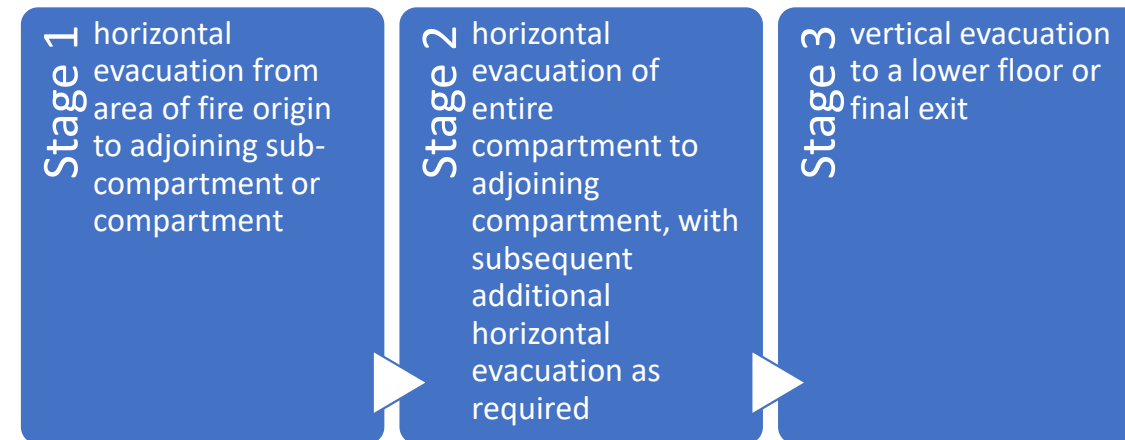


Figure 3: Stages of Progressive Horizontal Evacuation

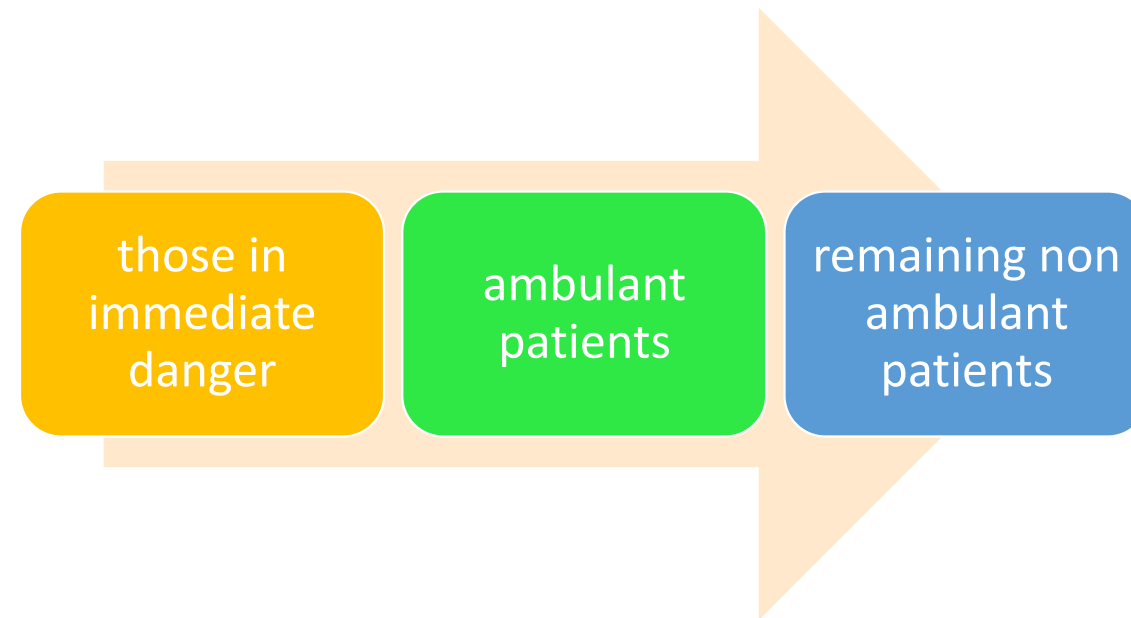


Figure 4: Evacuation sequence



## 4.2 Horizontal Means of Escape

### 4.2.1 Provision of Compartments

To implement a PHE strategy the building will be divided into fire compartments and sub-compartments, each compartment should be capable of accommodating the designed occupancy of the most highly occupied adjoining compartment as well as its own normal occupancy including space for medical equipment for continuity of care and space for beds.

Levels up to 12 m above ground level greater than 1000 m<sup>2</sup> in area containing patient access should be divided into a minimum of three compartments, levels above 12 m above ground level should be divided into a minimum of four compartments, each compartment should:

- Align with departmental boundaries to aid in operational procedures and continuity of care
- Not exceed 2000m<sup>2</sup> in area
- Have at least three exits that provide escape to adjoining but separate compartments (one of which should provide access to a stair/ final exit)
- Be divided into sub-compartments (where there is patient access) if:
  - it has a floor area greater than 750 m<sup>2</sup>
  - contains departments to which more than 30 patients will have access at the same time
  - contains sleeping accommodation for more than 30 patients (reduced to 10 bedrooms in mental health wards)

Note that due to the reliance on staff to evacuate patients in the event of a fire, the above patient numbers are only acceptable if the Trust confirm their management procedures allow for sufficient staff to be present to evacuate these patient numbers. This is to be confirmed at the next stage.

Levels 1 to 3 of the new building will be divided into a minimum of 3 compartments, the top storey (Level 4) will be divided into 4 compartments. The patient numbers and exit requirements will align with the above, however, in order to align with departmental boundaries, the maximum compartment area specified by HTM 05-02 is likely to be exceeded. The provision of additional sub-compartmentation is expected to be sufficient to ensure the functional requirements of the Building Regulations are met. This would be subject to Building Control approval.

The single storey Emergency Department should be divided into a minimum of 3 compartments in accordance with the above. Where compartments/ sub-compartments provide means of escape in both directions, the doors should swing in both directions.

There are external play areas at second floor (Level 3), these are provided with alternative means of escape, these areas should be provided with a means of warning so that occupants will be alerted in the event of a fire.

The fire strategy drawings in Appendix A show preliminary indicative compartment locations.

### 4.2.2 Dimensions of Escape Routes

Within departments where beds and patient trolleys are being moved the width of these spaces in accordance with the relevant HBNS, is generally adequate for means of escape but as a minimum the following widths should be provided:

- 1200 mm for up to 200 people
- An additional 275 mm for every additional 50 people where there are more than 200 people.
- HTM 05-02 specifies the minimum width where bed evacuation is required, should be 1550 mm.

### 4.2.3 Travel Distances

Travel distances to adjacent compartments, sub-compartments, stairs and final exits should be limited in accordance with HTM as per Table 2. There are some compartments which currently exceed recommended limits meaning that some travel distances are likely to be extended beyond the recommended 60 m maximum, this will be reviewed as the design develops.

Table 3: Travel Distances

		Travel in one direction	Travel in more than one direction
Within an in-patient sub-compartment to an adjoining compartment, sub-compartment or stairway/ final exit		15 m	30 m
Within an in-patient compartment to an adjoining compartment or stairway/ final exit		15 m	60 m
Elsewhere		18 m	30 m
Plant Room	Within the room	12 m	25 m
	Low risk plant (AHUs etc)	25 m	35 m



4.3 Vertical Escape

4.3.1 Staircases

The new building is planned to have 3 staircases with a fourth available via link to existing building. In accordance with HTM 05-02, a building with three staircases should have no more than 200 patient beds on any one upper storey. The number of beds shown does not exceed 200 per upper storey.

All staircases should be designed to accommodate mattress evacuation. All staircases (and lifts) should be provided with protected lobbies. These lobbies should be located so that they do not form part of a circulation route. The current design shows lobbies on circulation spaces, this is to be reviewed as the design develops.

Staircases should discharge direct to outside or by way of a protected routes maintaining the level of protection afforded to the stair itself.

All staircases discharge direct to outside with the exception of the central stair which discharges to a corridor, provides a link to the main entrance area with café and an alternative towards the EPAS department entrance, see Figure 6. The location of this stair is an issue for fire service access, refer to Section 7.

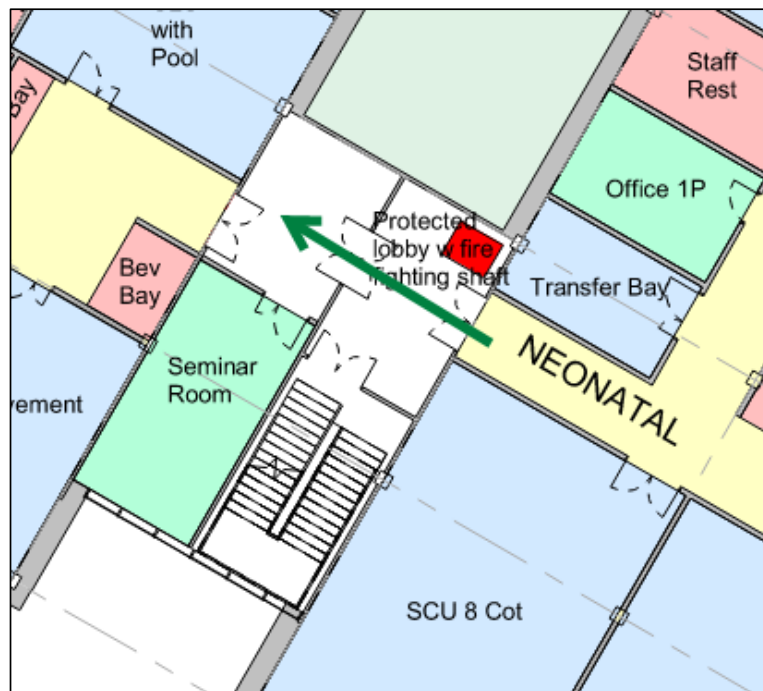


Figure 5: Stair lobby



Figure 6: Escape from central stair



#### 4.3.2 Escape Lifts

Due to the dependency of patients at upper levels, a minimum of two escape lifts is recommended. These should be located in separate compartments such that both cannot be compromised simultaneously. Escape lifts to be in accordance with HTM 05-03 Part E.

Escape lifts should be enclosed in 120 minutes fire resisting construction. The lift lobbies should be provided with ventilation via 1.5m<sup>2</sup> automatic opening vent.

The current design shows lifts in the central core only, it is recommended that an escape lift is added to one of the other stair cores to align with the guidance in HTM 05-02.

#### 4.4 Plant/ Roof Escape

There are two roof top plant levels. Level 5 has a reduced footprint which houses internal plant, the remaining roof area (and Level 6 roof) is expected to have PV panels installed.

Plant space travel distances are noted in Section 4.2.3 above. Any escape route which is in open air should not be more than 60m in a single direction and 100m in a single direction.

It is understood that the central stair will continue to serve Level 5 and escape hatches will be provided in some or all of the other staircases as an alternative means of escape.

Access to Level 6 is to be confirmed, it is expected that access will be limited to maintenance of PV panels.

#### 4.5 Basement

Access to the existing basement is via the existing outpatients department (Block 31). The proximity of the new building may impact on an existing escape route, this is to be reviewed as the project progresses.





## 5 INTERNAL FIRE SPREAD

### 5.1 Internal Linings

Surfaces applied to walls and ceilings can contribute to the spread of fire, in order to limit the potential for fire spread across the walls and ceilings, HTM states the minimum recommendations as shown in Table 4. European class is recommended in accordance with BS EN 13501-1 [14].

Table 4: Recommendations for linings

Location	National classification	European class
Small rooms (less than 4 m <sup>2</sup> )	1	C-s3, d2
Circulation spaces	0	B-s3, d2
Other rooms	0	B-s3, d2

It is noted that these do not apply where other functional criteria for medical purposes are required where rooms provide specialist functions.

### 5.2 Load Bearing Elements of Structure

The height to the top occupied storey is approximately 14 m above Level 1 (ground level) therefore all loadbearing elements of structure should be provided with a minimum of 90 minutes structural fire protection in accordance with BS EN 13501-2 [15].

As a single storey healthcare building, the Emergency Department should be provided with 30 minutes, as this is a refurbishment, any new elements of structure are to be provided with 30 minutes protection. Any existing damaged fire protection being retained should be repaired to maintain 30 minutes structural fire resistance.

### 5.3 Compartmentation & Fire Resisting Construction

As discussed earlier, the building is to be divided into compartments and sub-compartments in support of the progressive horizontal evacuation strategy. Additional fire resisting construction is noted in Table 5.

Protected shafts containing staircases should be provided with opening windows (or similar) providing a clear opening of 1 m<sup>2</sup>.

Where compartment and sub-compartment walls have a junction with an external wall a 1 m strip of fire resisting construction should be provided to the external wall.

Dead ends should be avoided where practicable, if there are dead-ends more than 4.5 m in length then they should be enclosed in fire resisting construction.

Table 5: Fire resisting construction

Location	Fire Resistance (minutes)
Compartment floors <sup>1</sup>	REI 90
Protected shafts (risers) <sup>1</sup>	REI 90
Firefighting shafts	REI 120
Escape Lifts	REI 120
Compartment wall <sup>1</sup>	REI 60
Sub-compartment wall	REI 30
Junctions of compartment and sub-compartment walls with external wall should have a storey-height 1 m wide strip of fire resisting construction <sup>1</sup>	REI 60
Junctions of external wall with a low-level roof – the portion of roof within 3 m of the external wall along the whole length of the junction should be fire rated	REI 30
Dead end corridors greater than 4.5 m in length	REI 30
Cavity barriers	30E 15I
Fire Hazard rooms	REI 30
Life Safety Plant	REI 120

<sup>1</sup> For the Emergency department these are REI 30 as it is a single storey healthcare building

#### 5.3.1 Hazard Rooms

Fire hazard rooms (as defined in Table 5) should be separated with a minimum of 30 minutes fire resistance.

Table 6: Hazard rooms

Fire Hazard Rooms	
Chemical stores	Store rooms
Clothes storage	Relatives' overnight stay room
Disposal rooms	Ward kitchens
Cleaners' room	Communal bathrooms in mental health premises
Hub rooms	Linen stores
Lift motor rooms	Staff on-call rooms
Main staff changing and locker rooms	Patient bedrooms provided specifically for: <ul style="list-style-type: none"> <li>▪ People with mental health needs</li> <li>▪ People with learning disabilities</li> </ul>



### 5.3.2 Hazard Departments

HTM 05-02 classes non-patient areas as normal or hazard departments. Those classed as hazard departments are not permitted to be adjacent to some patient areas without additional provisions. Some hazard departments are not permitted to be adjacent to a compartment which is accessible to very highly dependent patients.

There are very high dependency patients expected to occupy this building therefore location of such departments will be considered in relation to the patient dependency.

### 5.3.3 Openings & Concealed Spaces

All openings in floors and compartment (or sub-compartment) walls should be protected to provide a minimum of the same period of fire resistance as the compartment structure. Where a compartment wall has a junction with a roof, the wall should be taken up to the underside of the roof covering and fire stopped. HTM specifies a zone 1.5 m on either side of the wall should have a roof covering of designation AA, AB or AC on a substrate or deck of limited combustibility.

Cavity barriers should be provided in buildings to prevent the spread of fire through concealed spaces, cavity barriers should be provided throughout the building in accordance with HTM 05-02.

Cavity barriers will be provided to ensure that the maximum length of a void is no more than 20 m, each barrier should achieve a minimum of 30 minutes fire resistance.

Ventilation ducts should maintain the period of fire resistance of the construction through which they pass. The requirements vary based on the duct location i.e. depending on the purpose of the fire resisting element they penetrate. Table 7 provides suitable options based on the location of the ventilation penetration. Fire dampers shall be provided in accordance with BS EN 13501-3 [16].

Table 7: Permissible locations of transfer grilles, fire dampers and fire and smoke dampers

Location	Damper Type	Activation
Compartment floor, wall, sub-compartment and protected shaft	Fire and smoke damper	Activated by automatic fire detection
Cavity barrier	Fire damper or fire and smoke damper	Can be thermal activation or activated by automatic fire detection
Fire hazard room	Fire damper, fire and smoke damper or air transfer grille	Dampers can be thermal activation or activated by automatic fire detection, air transfer grille automatic fire detection activation only

## 5.4 Very High Dependency Patients

Department/ compartment entrance to areas containing very high dependency patients should be provided with protected lobbies to reduce the potential for smoke spread into such departments. It is also recommended that in intensive care/ critical units that rooms within patient access sub-compartments are limited to those which are required in the vicinity of patient beds, other rooms such as bulk stores and offices should be within a separate sub-compartment.

## 6 EXTERNAL FIRE SPREAD

Buildings should be constructed such that the risk of fire spread to neighbouring buildings is low. BR 187 [17] presents a method for determining the minimum separation distance required to the relevant boundary. A detailed analysis will be provided as the design develops, this will likely result in some fire rated construction required to the external walls if in close proximity to adjacent buildings, surrounding roads or the site boundary. It is also proposed to consider external fire spread across the two lightwell spaces given that occupants will remain in the building in the event of a fire.

It is understood that the external wall construction provided will be of A2-s1, d0 reaction to fire classification, this exceeds current HTM 05-02 recommendations but may become a recommendation for healthcare buildings in the future.

## 7 FIRE SERVICE ACCESS

### 7.1 Firefighting Shafts

The building is approximately 14 m to the top storey (excluding plant level) and the largest floor is approximately 5,500 m<sup>2</sup> (excluding staircases and lightwells) In accordance with HTM a building of this height should be provided with 3 firefighting shafts plus an additional fire fighting shaft for every additional 900 m<sup>2</sup> above 3300 m<sup>2</sup>. Therefore, to meet the guidance 5 firefighting shafts are recommended.

These firefighting shafts should have:

- 120 minute fire resisting enclosure
- Dry risers providing hose coverage within 45m of the entire floor plate measured along a route suitable for laying a hose
- Vehicle access to within 18 m of the dry riser inlet
- Ventilated staircase (1 m<sup>2</sup> geometric free area AOV at each level or 0.7 m<sup>2</sup> aerodynamic free area at head of stair)
- Ventilated lobbies (1.5 m<sup>2</sup> geometric free area AOV)

The building currently is shown to have three firefighting shafts with access to a fourth existing stair in the adjoining building. It is not expected that this stair is an existing firefighting shaft. If it is an existing firefighting shaft, its location does not provide much hose coverage to the new building. With the current provision there is insufficient hose coverage achieved by the stair locations. An alternative solution with a reduced number of firefighting shafts may be possible but this is likely to only be achievable if the firefighting shafts can provide adequate hose coverage. Hose coverage with current stair proposal is shown in the Figure 7, Figure 8 shows potential stair locations which would improve hose coverage and fire service access to the firefighting shafts. An additional firefighting shaft is expected to be necessary to achieve the requisite hose coverage, alternatively, the provision of sprinklers would reduce this recommendation.

### 7.2 Vehicle Access

Access for fire service vehicles should be available within 18 m of a dry riser inlet and without the vehicle having to reverse more than 20 m. Access to the staircases on the perimeter of the building (1 and 3) will be readily available. Access to the central stair (stair 1) in its current location is not accessible for a fire service vehicle within 18 m, it is recommended that the position is revised so that it can be accessed from outside, Figure 9 shows vehicle access in the vicinity of the new and refurbished building.



### 7.3 Water Supplies

Where a new building with a compartment more than 280 m<sup>2</sup> in area is constructed more than 100 m from an existing hydrant, additional hydrants are to be provided within 90 m of an entry point to the building and not more than 90 m from an adjacent hydrant. The location of existing hydrants is to be confirmed.



Figure 7: Hose coverage – current proposal



Figure 8: Hose coverage - potential relocated stair positions





### 7.4 Existing Emergency Department

The fire service access to the area undergoing refurbishment is unlikely to be altered by the refurbishment works. The existing fire strategy for the building should be reviewed to ensure it is not compromised by the refurbishment. There is understood to be an existing road designated for fire service use which is being retained.



Figure 9: Fire service access





## 8 CONCLUSION

This document assesses the proposed layout of the new and refurbished buildings at Royal Shrewsbury Hospital. The layout has been assessed against the recommendations of HTM 05-02] and is generally in accordance with the guidance however, where the building design appears to derogate from this guidance improvements or alternative solutions have been recommended.

The fire strategy will be reviewed as the design develops, current key areas for review are:

- Fire service vehicle access and existing fire hydrant availability.
- Number/ position of firefighting shafts, the current stair provision does not provide adequate access for the fire service.
- Impact on the existing adjoining building.
- Review of compartment sizes.

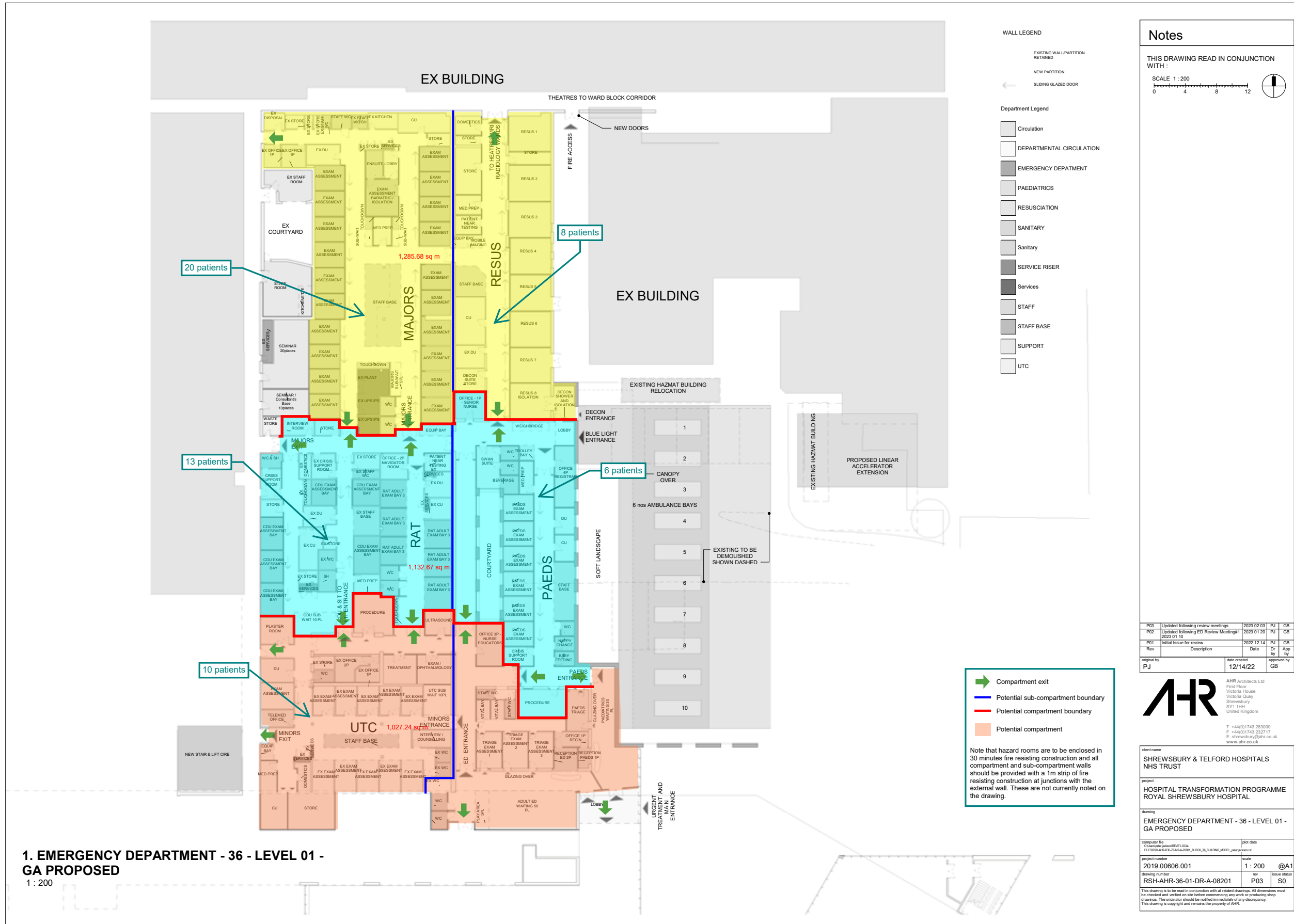


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APPENDIX A – FIRE STRATEGY PLANS



- WALL LEGEND**
- EXISTING WALL/PARTITION RETAINED
  - NEW PARTITION
  - SLIDING GLAZED DOOR
- Department Legend**
- Circulation
  - DEPARTMENTAL CIRCULATION
  - EMERGENCY DEPARTMENT
  - PAEDIATRICS
  - RESUSCITATION
  - SANITARY
  - Sanitary
  - SERVICE RISER
  - Services
  - STAFF
  - STAFF BASE
  - SUPPORT
  - UTC

- Compartment exit
  - Potential sub-compartment boundary
  - Potential compartment boundary
  - Potential compartment
- Note that hazard rooms are to be enclosed in 30 minutes fire resisting construction and all compartment and sub-compartment walls should be provided with a 1m strip of fire resisting construction at junctions with the external wall. These are not currently noted on the drawing.

**Notes**

THIS DRAWING READ IN CONJUNCTION WITH :

SCALE 1 : 200

Rev	Description	Date	Dr	App
P03	Updated following review meetings	2023 02 03	PJ	GB
P02	Updated following ED Review Meeting 1	2023 01 20	PJ	GB
P01	Initial Issue for review	2022 12 14	PJ	GB

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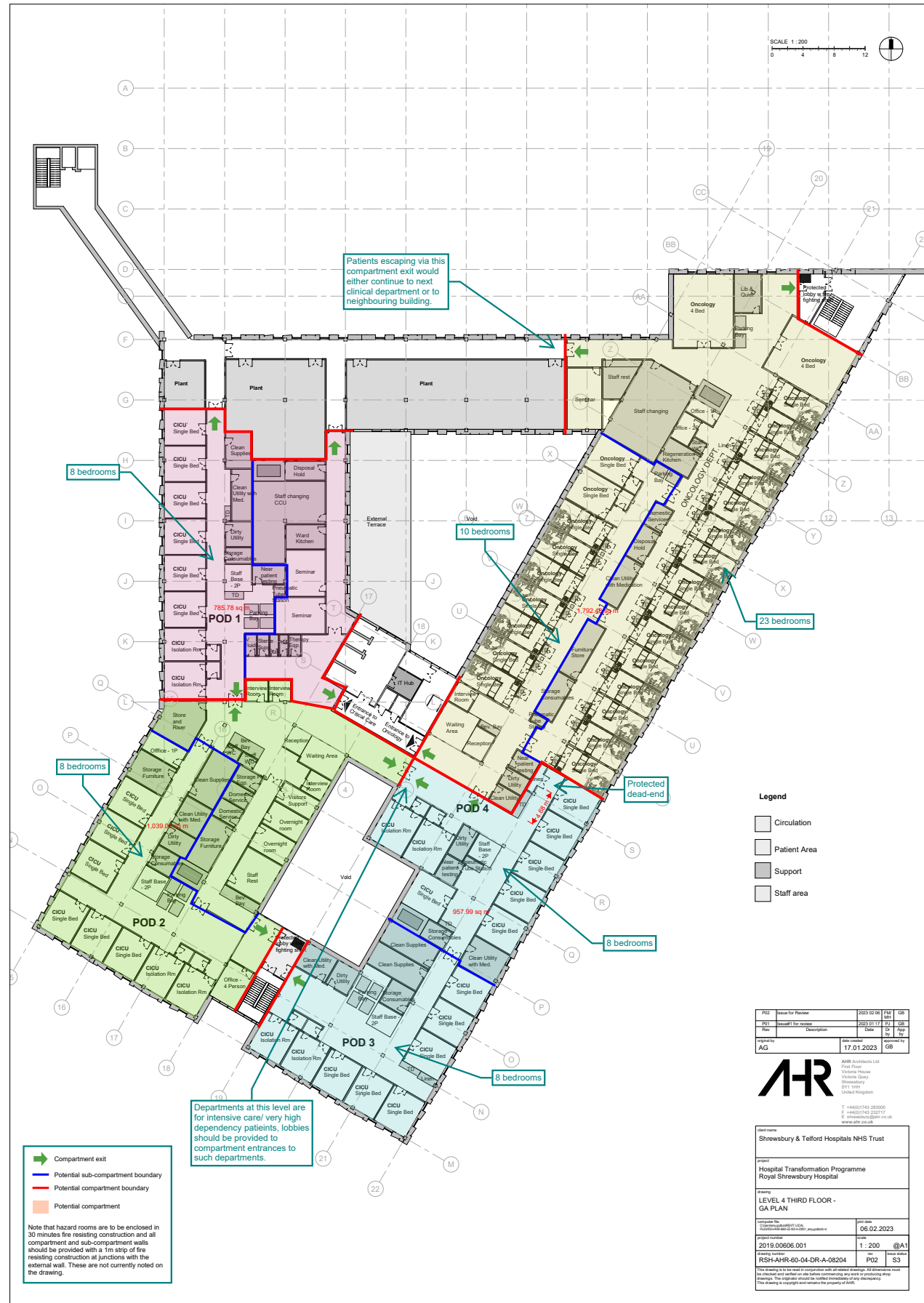
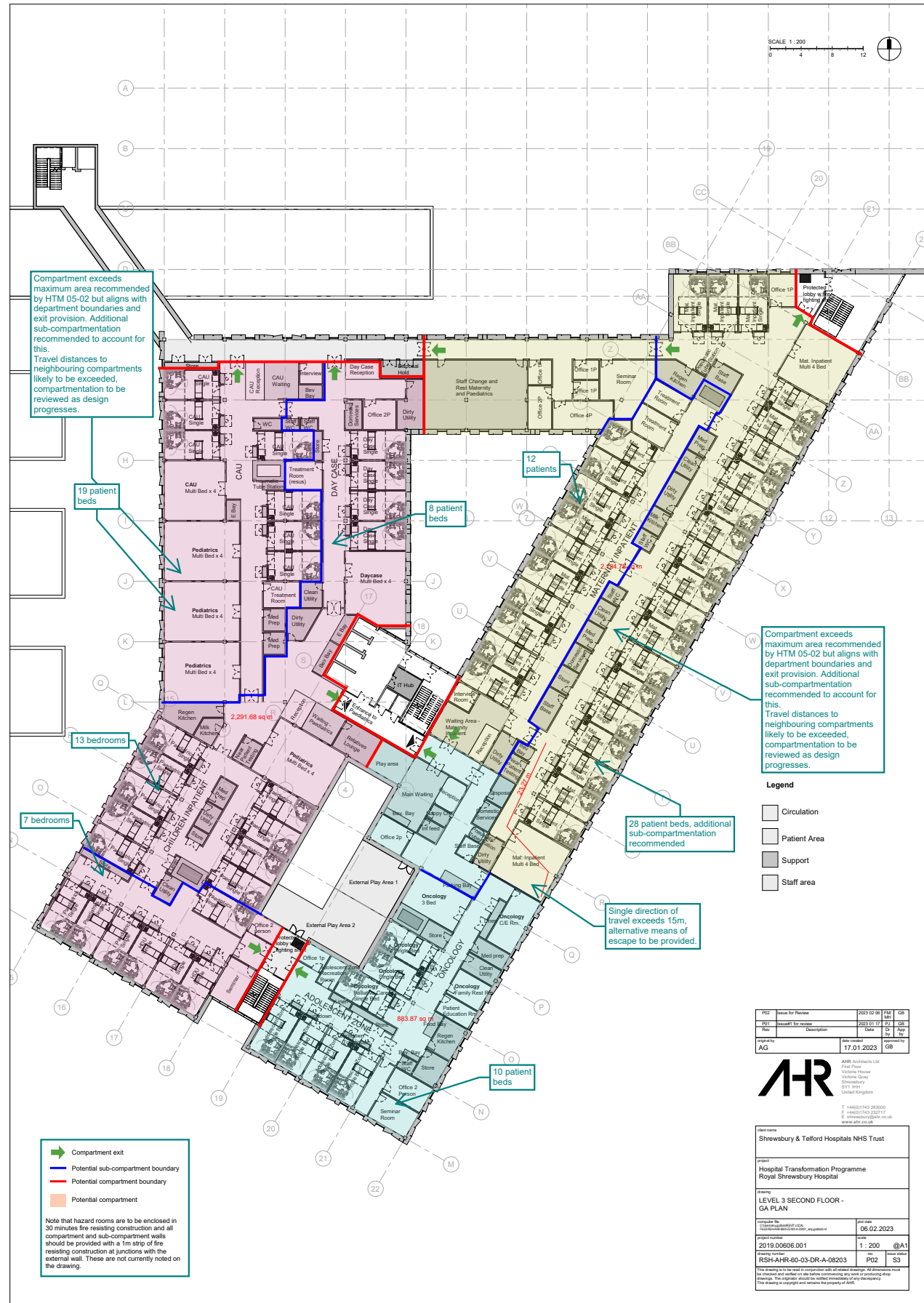
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drawing number	RSH-AHR-36-01-DR-A-08201
rev	P03
issue status	SO

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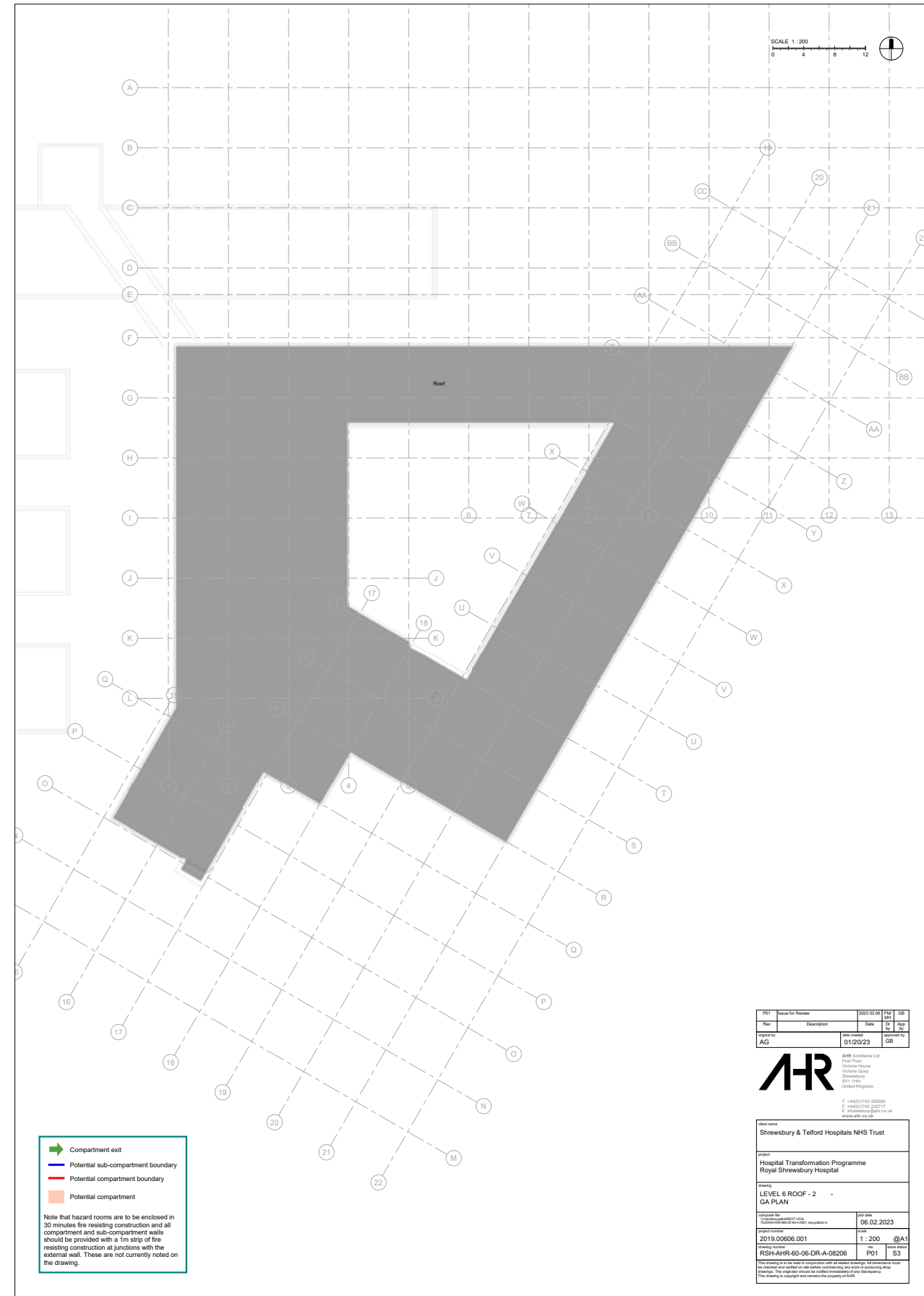
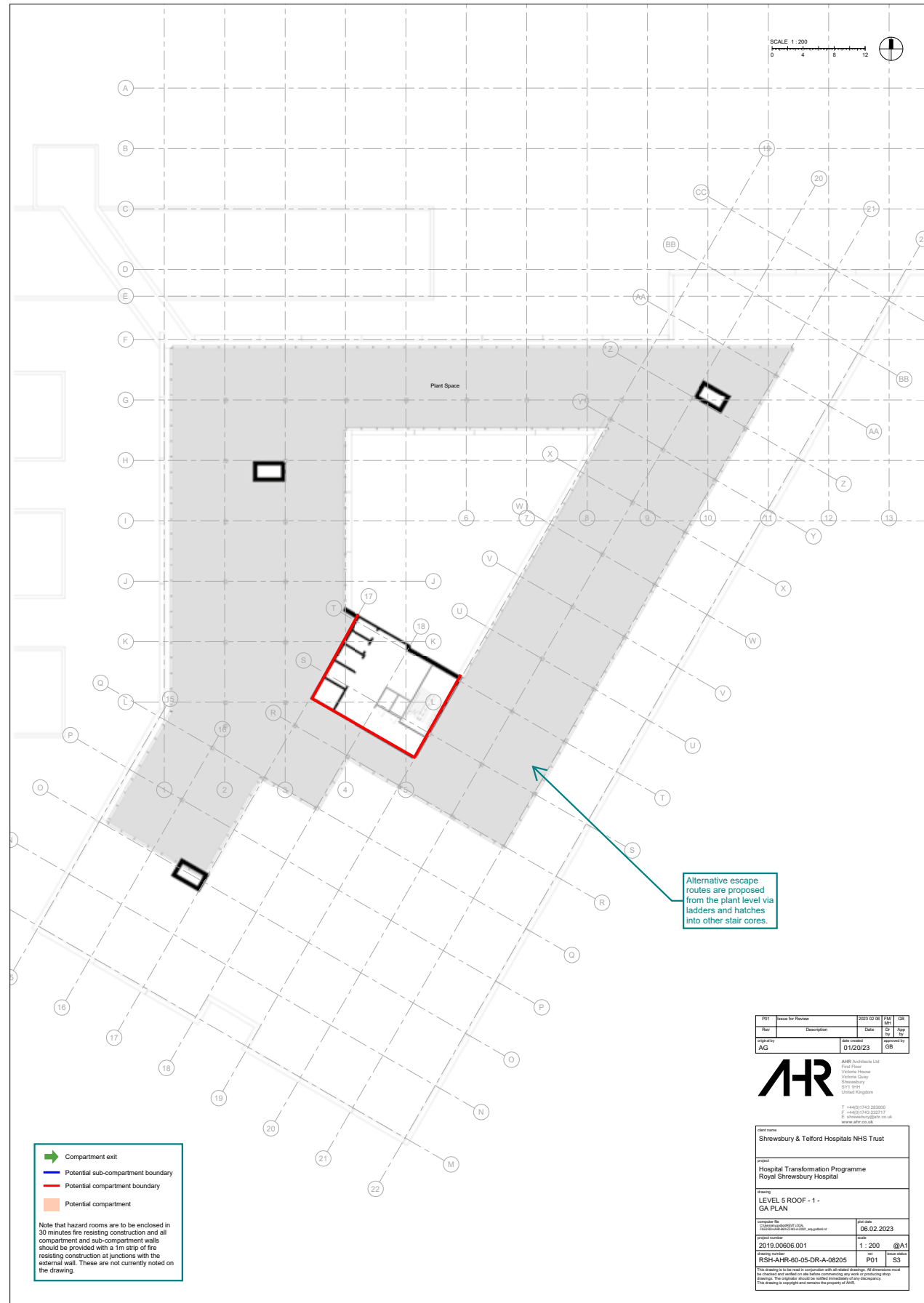
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# Access, Servicing and Maintenance Strategy



# Access, Servicing and maintenance strategy

## External Public Access

The overall design of the site has been considered from first point of contact when entering the site. The orientation of the new building ties into the existing at a critical access point for A&E, future inpatient and outpatient services. A clear entry point will be visible from the road, car parks and bus route which will form of an integral critical corner of the new building. The design will be developed to promote free movement around the site for all members of the public including the elderly, frail or disabled.

Using the landscaping design to support this, all pedestrian routes will be well illuminated and easy to read. The external pathway materials selected for public areas will be firm, durable and slip resistant under foot. Consideration has been made at this early design stage regarding the blue light route with new accessible parking spaces being designated close to the building to avoid cross over. A drop off one way loop will also be located here and a repurposed drop off space further up the road on the same side will form a new bus stop. The existing public car parking opposite the building will be reconfigured to potentially house the relocated helicopter landing station and consideration is currently being made over future care parking capacity with raised decks, the public care parking strategy will mean that clear pedestrian crossing will be maintained as per the existing strategy with new areas developed to support the new developments.

A new feature canopy will provide shelter from the elements as pedestrians approach via the drop off or on foot. The new main entrance will consist of clear wayfinding to define the separate A&E entrance from the main entrance on approach under the new canopy. Barrier matting will be installed in the new entrance lobby to reduce the risk of slipping on tile and vinyl flooring within the main hospital or emergency department.

## Internal design and access considerations

The 2010 Equality Act has been considered throughout the design of the building, providing a fully inclusive environment that allows access to everyone regardless of disability. Floor finishes will be provided that will both provide anti slip qualities appropriate to the room use such as corridors or ensuite accommodation but will not impede the use of wheelchairs. The choice of interior finishes will have a huge impact on service users, the design will support dementia friendly considerations and visually impaired service users by providing a high contrasting environment for washrooms and accessible areas. Reducing aggression in emergency environments such as A&E is important from both a staff and patient safety perspective, space to allow for clear wayfinding and important information will be incorporated into the design.

Example taken above from the Felix Platter Hospital Switzerland of clear high contrast signage at lower eye level, high contrast floor finish that is anti-glare and even with coved skirting up to 100mm above finish floor level. The flooring is pattern free with low contrast thresholds and minimal joints.

## Ease of cleaning and maintenance

As part of our evidence-based approach to design of buildings and systems, we have undertaken extensive research and building visits prior to developing our own design solution as some of these are quite specialist healthcare Environments. In relation to build quality, we were particularly considering the following:

- Finishes
- Cleaning and Maintenance strategies
- Plant provision
- Ease of operation
- Safety of systems
- Energy saving design and systems

The buildings studied and visited are best practice examples of Healthcare Environments from both UK and Europe such as Chase Farm, Chesterfield Royal Hospital New Ward Block and the Felix Platter Hospital in Switzerland. These visits established expectations for the use a space may expect during the course of a typical day and regimes in place to ensure cleanliness and that each area was adequately maintained.

Although expectations and regimes do change between hospital Trusts, a number of common themes do emerge which we have incorporated into our approach for SaTH.

- Keep it simple – whilst many of the buildings had sophisticated BMS systems in place which have helped reduce energy use and improve monitoring, manual overrides are crucial in the first few years of operation to ensure building users still feel in control of the system
- Make the building users feel in control – the provision of manually opening vents and operated lighting will alter people's perception of thermal comfort, particularly in a naturally ventilated space
- Develop a cleaning regime that works for a healthcare setting
- Insist on durable finishes throughout – healthcare buildings require very robust finishes which are able to withstand heavy duty use. Ensure every surface is durable and can be replaced if required. This is not mis-use of the building but the nature of the activity occurring in specific healthcare environments
- Ensure any sustainability measures will actually work with the proposed usage of the building – if measures are being proposed, ensure they do not have a negative impact on the functionality of the building
- Ensure the building FM team are integrated into the RDD process – this will help to reduce energy use in the finished building as they will more likely embrace new BMS systems and other energy saving proposals if they can take ownership as early as possible for a system

Further feedback specifically from SaTH will be taken into consideration during the development of our design.

## Maintenance

The building envelope forms of fairly deep plan and central courtyard spaces which has a very efficient wall to floor ratio as far as possible in consideration of giving every patient bedroom a window, which in turn reduces the amount of façade to maintain. The geometry of this façade is very simple with repeat detailing with complicated junctions designed out meaning these will not have to be maintained and the choice of cladding as our primary material is a tried and tested material which requires minimal cleaning and maintenance over the life of the building.

Image above of Chesterfield Royal Hospital rainscreen cladding system with regularised panelling for ease of maintenance.

The roof finish of reinforced bitumen warm roof system has been selected as this is a robust and extremely tough system, offering a service life in excess of 35 years when installed by an approved contractor. The system has been specified in conjunction with a proprietary with PIR insulation, offering a Reaction to Fire Classification of BROOF(t4) and a compressive strength of 120 kN/m<sup>2</sup>. The system offers predominantly torch-free detail design - to deliver safe application techniques in the vicinity of combustible construction materials located on, or connected to, the roof such as timber substrates or upstands and abutments to cladding. The application methods meet NFRC Guidance Document 'Safe2Torch' Roof parapets will be provided in order to provide a safe environment for maintaining the roof finish and any photovoltaics that will be present. The majority of the plant will be housed internally to provide a sheltered environment for maintenance staff. Our lift design strategy which ensures the goods lift and another smaller lift can access the very top level of the building will reduce the cost of repairing and replacing parts of plant as less equipment will be required during installation with the need for mechanical lifting equipment kept to only the occasional item.

Areas of green roof are being suggested to be of low maintenance sedum combined with photovoltaics as a biosolar approach. Solar/Photovoltaic panels can work more efficiently on a roof when installed over a green roof system due to the micro-climate around the panels which effectively reduce the effects of extreme temperatures. Sedum roofs are low maintenance in nature as slow growing and store water in succulent leaves allowing them to survive drought conditions.

C cleaning of windows and glazing a pole fed system will be able to access all elevations containing glazing will the glazing not reaching over 18meters in height. A level access path for maintenance will be installed around the building to support this.

All interior products that have been selected will meet the HTM guidance on infection control standards and will provide a durable and robust finish to support the Trusts cleaning regimes using their preferred cleaning methods and products, further consultation with infection control will take place during the next design stage to support this.

Maintenance consideration have been made for the walls to the most vulnerable spaces such as bed spaces, corridors, and utility rooms. These are areas will be clad in a tough wall protection up to an appropriate height for the activity taking place in those areas reducing the need for repairs throughout the life span of the building.

The proposed finishes will ensure that the desired outcomes for build quality are met in the following ways:-

- Quick and easy cleaning – none of the proposed materials require a maintenance or cleaning regime which is not familiar to the building FM team. A daily cleaning regime will be utilised for the building
- Accessibility to plant – Where possible, plant has been located on ground floor to ensure it can be accessed from outside the building without the need to disturb building users. Roof top plant is accessed by a large goods lift ensuring the best possible access
- Designed out complexity – We have been meticulous in ensuring details and physical components are simple, serviceable and less likely to fail.
- Standardised equipment across sites – Common components and materials between both blocks ensure there are increased familiarity and the ability to stock spare parts which can be used on both buildings.
- Plant access – At high level, plant can all be safely accessed and is always a minimum of 4m from the building edge to reduce the risk of falls from height.
- Appearance of building – Using standardized cladding as the primary material will ensure the performance of the façade will be maintained for the life of the building with very little cleaning or maintenance.
- Zoning of plant – A zoned service strategy will minimise the amount of energy used by the building
- Water conservation – A grey water recycling system has been suggested as connected to our roof drainage section and is located beneath the ground on the south of our site

### Lifecycle

All of the materials on the façade have been designed to last for the life of the building and should not require replacement. The primary material of EQUITONE cladding will not need to be replacement during the concession period. With an expected lifetime of 50 years or more, EQUITONE panels often outlast the building lifetime. They are designed for disassembly with reversible fixation systems, allowing reuse in facade cladding or other applications. The product is cradle to cradle certified. All EQUITONE waste generated in the production phase is recycled in material loops, such as transportation to the cement kiln, where it is reactivated.

Our proposal to use reinforced bitumen warm room system has a life span in excess of 35 years.

High quality finishes have been selected in public spaces to ensure they will have minimal lifecycle requirements. The vinyl floor finish can have a lifespan for up to 25 years and has the ability to be patch repaired if damaged.

Continuation of healthcare and critical care has been considered during this early design stage to ensure that the design responds to the need to allow the majority of maintenance and replacement to take place without disrupting services with the performance of the building sustained throughout.



# Cost Plan

Refer to  
separate  
document

# To Be Endorsed



### Report Endorsement

The stage 2 report forms part of a sequential design development process and is intended to summarise Design development at this point in time. As part of this process there are two forms of information contained within the report; information which will be developed further; and design decisions that require endorsement in order to allow the design development to take place

#### Design elements to be developed in greater detail:

- 1:200 layouts – to coordinate fully with SOA
- Detailed Mechanical and electrical coordination to fully reflect MEP spatial requirements and strategies
- Landscaping and entrance areas – in response to building envelope development and security strategy
- Structural grid – as a consequence of potential value engineering
- Detailed Elevational treatment
- Parking – in response to developed transport strategy
- Temporary works and phasing
- PRH works
- Typical rooms

#### Design decisions requiring endorsement

Clinical stacking and overall adjacencies - Need agreement in principle on locations of departments overall and communication spaces in between

- Endorse overall MEP strategy which is centralised / decentralised arrangements
- General site strategy
- Bedroom sizes and configuration
- Clinical narrative
- Reduction in floor plate as part of VE process – see appendix A

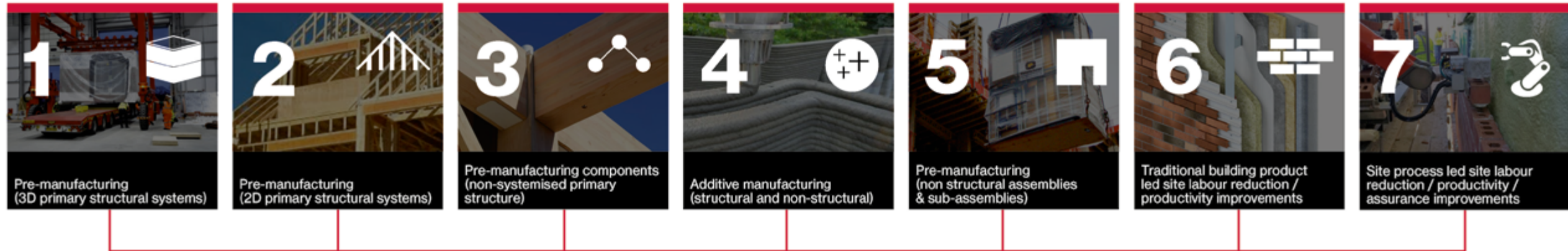


**MMC DEFINITION SUMMARY**

This document is intended to support bidders to the Affordable Housing Programme (AHP) by providing a plain English guide to the concept and definition of Modern Methods of Construction (MMC). Bidders to the AHP will be required to note the types of MMC that are being deployed within their delivery programmes. To support bidders in that exercise, this note explains the MMC definition framework, and the types of construction that are currently encompassed within the seven categories of MMC. It should be noted that MMC is a rapidly evolving approach, and that the forms of construction in each of the categories may change over the course of the AHP. The GLA will notify investment partners if the definition of MMC changes from what is set out in this document.

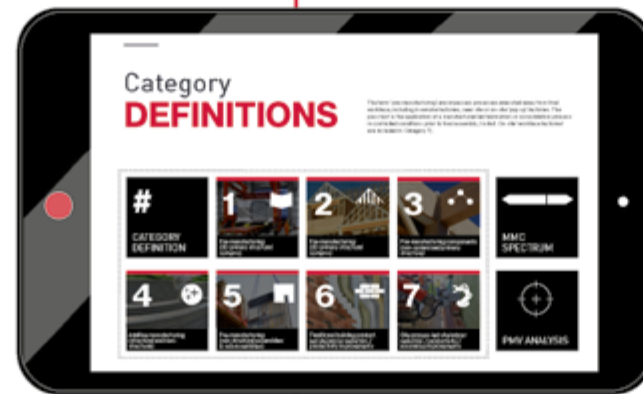
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**Modern Methods of Construction (MMC)**



**WHAT IS THE MMC FRAMEWORK?**

The MMC definition framework is a seven category definition framework that enables a full and future-proofed range of 'Modern Methods of Construction' used in homebuilding to be better understood with regularised terminology. The GLA requires bidders to the AHP to include information on the forms of MMC they are using, and the MMC definition framework enables this information to be collated in a structured manner. All categories outlined in this document form part of the Government's definition of MMC, as adopted in London's AHP.



The definition framework spans all types of pre-manufacturing, site-based materials and process innovation. This definition framework is an output of the MHCLG Joint Industry Working Group on MMC which is tasked with improving stakeholder education and understanding of MMC with particular reference to enabling better access to mortgage finance, insurance and assurance. The term 'pre-manufacturing' encompasses processes executed away from final workforce,

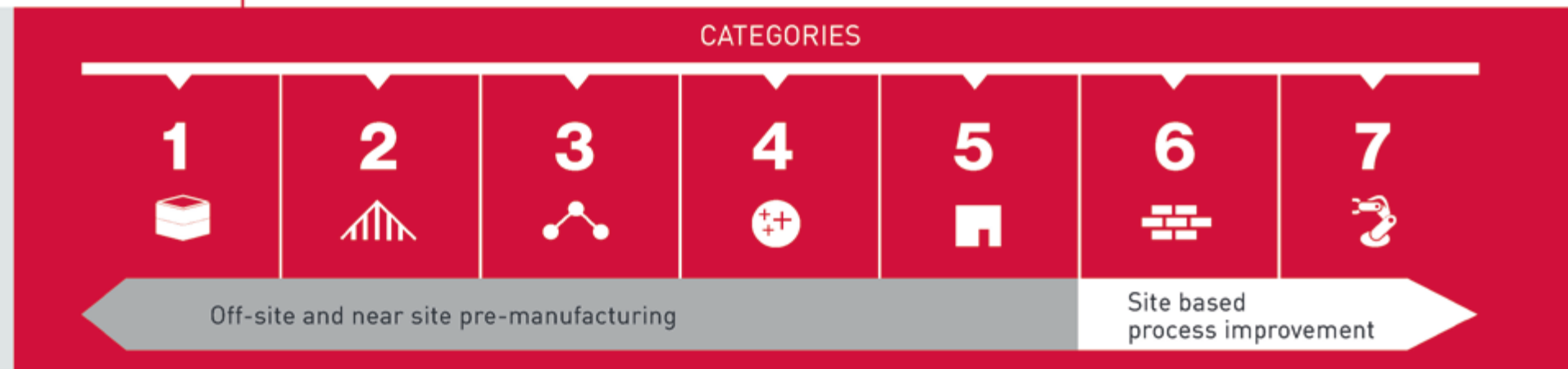
including in remote factories, near site or on-site 'pop up' factories. The pass test is the application of a manufactured led fabrication or consolidation process in controlled conditions prior to final assembly / install. On-site 'workforce factories' are included in Category 7).

The pages that follow explain each of the categories in more detail, incorporating the sub-categories that bidders will be required to report against.

**1** Category 4, additive manufacturing, relates to the 3D printing of components or whole elements of buildings. While this form of MMC is not available for use in construction projects currently, it is expected to be used in the future and so it has been included to ensure the definition framework is future-proofed. Given this, we exclude category 4 from the more detailed explanation of the categories on the pages that follow.

**WHAT IS MMC?**

A range of approaches which spans off-site, near site and on-site pre-manufacturing, process improvements and technology applications.





1 

2 

3 

STRUCTURAL CATEGORIES

5 

6 

7 



Category 1. MMC – Vision Modular Systems for Pocket Living at Mapleton Crescent

Category 1

PRE-MANUFACTURING (3D PRIMARY STRUCTURAL SYSTEMS)

The creation of 3D volumes – boxes effectively – away from site which are then combined on site to create a building. The extent of work that is carried out to the “box” can vary, as set out below. This is the form of MMC that incorporates the highest level of pre-manufacture, and utilises a range of core materials, also set out below.

Four sub-types based on the amount of factory-based finishing:

- 1a. Module only, fitted out on site;
- 1b. Module plus internal fit out only;
- 1c. Module plus internal fit out plus cladding and roof;
- 1d. Module plus pods to fit out rooms

TYPICAL SYSTEMS

- Timber
- Steel
- CLT

NOTES

1 Although this category has the highest level of pre-manufacture it can still be combined with other categories such as foundation systems (category 3), pods (5) and material and process improvements (6 & 7)



Category 2b. MMC – Cygnum for Norwich City Council, Goldsmith Street

Category 2

PRE-MANUFACTURING (2D PRIMARY STRUCTURAL SYSTEMS)

The creation of 2D panelised and framing systems away from site that are assembled on site to create the structure of a building. There is a wide range in the extent of pre-manufacture between the three sub-categories with the systems utilised in category 2c incorporating significantly more consolidation of materials than 2a. Typically utilises timber and steel as the core component, with concrete solutions also available although generally these are used less in residential development.

Three types based on the amount of consolidation in the panel system:

- 2a. Frame only – typically walls, floors, roof and stairs;
- 2b. Frame plus insulation, internal linings;
- 2c. As 2b plus doors, windows, external cladding

TYPICAL SYSTEMS

- Light Gauge Steel
- Timber frame

NOTES

1 The remainder of the construction beyond the frame may subsequently be delivered using traditional methods and/or elements from other categories such as foundation systems (category 3), pods (5) and material and process improvements (6 & 7)



Category 3c. and 3d. MMC – Mace for QDD at East Village

Category 3

PRE-MANUFACTURING COMPONENTS (NON-SYSTEMISED PRIMARY STRUCTURE)

The use of pre-manufactured components to form part of the structure of a building. Can incorporate foundation solutions as well as solutions for the main structure. Typical materials include timber and concrete.

Seven typical types:


- Foundations
- 3a. Driven or screw piles;
- 3b. Pre-fabricated pile caps or ring beams
- 3c. Columns, walls and/or beams;
- 3d. Floors;
- 3e. Integrated columns and walls and beams;
- 3f. Staircases;
- 3g. Roofs

NOTES

1 These solutions can be used in combination with any of the other categories, with the foundations systems able to work with volumetric (category 1) and panelised (2) and all categories able to be combined with non-structural components (5) and material and process improvements (6 & 7)



1 

2 

3 

**NON-STRUCTURAL CATEGORIES**

5 

6 

7 



Category 5a. and 5i. MMC – Mace for QDD at East Village

**Category 5**

**PRE-MANUFACTURING (NON STRUCTURAL ASSEMBLIES AND SUB-ASSEMBLIES)**

The use of pre-assembled components that do not form the structure of the building but which consolidate materials and processes that otherwise would be delivered on site. These solutions can be used in isolation in an otherwise traditionally constructed project, and include reasonably commonly used items such as bathroom pods.

Two overarching types of component:

- 3D – e.g. pods
- 2D – e.g. façades, floors, walls

In total there are 12 types as follows:

3D

5a. Bathroom pods; 5b. Kitchen pods; 5c. Bathroom and kitchen pods combined; 5d. Mechanical and electrical (M&E) pods, e.g. pre-fabricated utility cupboard

2D

5e. Façade assemblies; 5f. Roof assemblies

M&E assemblies

5g. In-unit assemblies; 5h. Vertical risers; 5i. Central plant; 5j. Floor cassettes; 5k. Wall cassettes; 5l. Pre-hung door sets

NOTES

**i** This category of solution can be used in isolation or in combination with any of the other categories



Category 6e. brick slips, Stofix for Urbanest, Vauxhall

**Category 6**

**TRADITIONAL BUILDING PRODUCT LED SITE LABOUR REDUCTION / PRODUCTIVITY IMPROVEMENTS**

The evolution of traditional building materials so that they are quicker, easier and safer to install. This can typically involve either large format versions of traditional materials, or materials that have been developed to be easier to install with less reliance on on-site labour.

In total there are **five types** as follows:

LARGE FORMAT PRODUCTS

- 6a. Internal walls;
- 6b. External walls;
- 6c. Roofing finishes;

OTHER

- 6d. Materials that have been specifically cut to size, e.g. pre-sized plasterboard;
- 6e. Materials that have been adjusted to be easier to install, e.g. brick slips

NOTES

**i** This category of solution can be used in isolation or in combination with any of the other categories



Category 7d. visual aid – mixed reality goggles being trialled by Trimble

**Category 7**

**SITE PROCESS LED SITE LABOUR REDUCTION / PRODUCTIVITY / ASSURANCE IMPROVEMENTS**

The use of systems and processes on-site to drive productivity by removing unnecessary workstages, enabling better and faster installation and improving health and safety.

This is the category with the largest breadth of options and the list is likely to grow. There are **nine types** as follows:

SITE CONDITIONS PROTECTION/IMPROVEMENT

7a. Measures to protect, or encapsulate, the site to secure weather-proof conditions; 7b. Standardised temporary work (e.g. a modular scaffold)

DIGITAL PROCESS IMPROVEMENT

7c. Use of BIM connected to on-site workflows

SITE WORKER AUGMENTATION

7d. Visual aids (e.g. AR/VR); 7e. Physical aids (e.g. exoskeletons); 7f. Productivity tools (e.g. GPS)

SITE MANAGEMENT TOOLS

7g. Robotics (e.g. brick laying); 7h. Autonomous plant (e.g. driverless cranes); 7i. Digital verification (e.g. digital scanning)

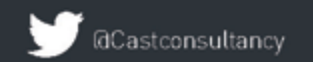
NOTES

**i** This category of solution can be used in isolation or in combination with any of the other categories



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(draft v7.2)



**Think Globally, Act Locally**  
*Healthcare with a kind touch and a small footprint*

**NHS**  
The Shrewsbury and  
Telford Hospital  
NHS Trust



**PACT** Partnering · Ambitious  
Caring · Trusted

**Our Vision:** To provide excellent care for the communities we serve



# Foreword

The responsibility that the health care service has towards our patients, visitors, staff, volunteers and society as a whole, has helped shaped the ambitions of this Trust. It is also one of the 10 Pledges that the Shropshire, Telford & Wrekin Integrated Care System (STW ICS) has committed to and is an NHS priority with targets. In conducting our business, we want to create sustainable value through innovative solutions. This conviction is the foundation on which the strong engagement of our people and the long-term successful development of SaTH is built. Our ambition to operate sustainably throughout the Trust and along our entire value chain will help to improve our efficiency and reduce risks and will positively contribute to the efforts to address climate change that affect us all.

In conjunction with Shropshire, Telford and Wrekin Integrated Care System (STW ICS), we will recognise and respond to the global climate emergency - developing an environmentally friendly health and care system by delivering high quality care and improved public health without exhausting natural resources or causing severe ecological damage. The emphasis during the 2020/ 21 covid pandemic on providing many outpatient appointments remotely, has demonstrated we can deliver effective patient care and can avoid thousands of miles of patient transport.

The international community has made enormous progress toward a common understanding of sustainability priorities. We want to continue to actively contribute to achieving this, through further embedding sustainability in our business. In playing our part, we are engaging with our people, utilising their knowledge and expertise, developing partnerships in all areas of our activities, and finally relying on the strength of our reputation as a sector leader in sustainability matters. This is also part of the strategic vision for partners in our local ICS:- As the world faces up to a climate emergency, we are committed to delivering an internationally recognised system known for its environmentally friendly services that make the best use of our resources.

In recent years, we have continued the excellent progress towards our sustainability goals. Our Sustainable Development Assessment Tool score against the core standards (a national assessment tool developed by the NHS Sustainability Development Unit) increased from 72% to 76%. Our buildings-related carbon emissions continue to fall, we have a successful equipment reuse scheme, our catering department has eliminated plastic cutlery and introduced compostable takeaway containers and we have developed garden areas for staff, patients and wildlife. We have moved to a green electricity tariff, undertaken extensive LED lighting replacement, and are in the process of upgrading the Building Energy Management System at RSH, all of which are reducing our carbon emissions.

The coming year will see us continue this good work, by refreshing our Sustainability targets to reflect NHS and wider national targets. The NHS has recently set itself an ambitious target for its own activities to be carbon net zero by 2040, and those of its suppliers by 2045. As part of our future reconfiguration of clinical services, we will introduce more energy efficient buildings, and the new buildings will follow national requirements to be carbon net zero.

This Green Plan is the successor to the Sustainable Development Action Plan and sets out what the Trust needs to do over the next five years to further enhance our sustainability and continue along the carbon net zero journey.



# Contents

## 1. Introduction

## 2. Drivers for Change

## 3. The Trust's Vision

## 4. Our Governance including Risk Management.

## 5. United Nations – Sustainable Development Goals.

## 6. Tracking Progress and Reporting – The Sustainable Development Assessment Tool (SDAT).

## 7. SaTH SDAT Report 2020.

## 8. Key Areas of Focus:

### 8.1 Corporate Approach.

### 8.2 Asset Management and Facilities.

### 8.3 Travel and Logistics. Asset Management and Utilities.

### 8.4 Adaptation.

### 8.5 Capital Projects.

### 8.6 Green Space and Biodiversity.

### 8.7 Sustainable Care Models.

### 8.8 Our People.

### 8.9 Sustainable Use of Resources.

### 8.10 Carbon and Greenhouse gases (GHGs).

## 9. Finance.

## 10. Risk.

## 11. Contact.

# 1. Introduction

The Shrewsbury and Telford Hospital NHS Trust is the main provider of general hospital services for nearly half a million people in Shropshire, Telford & Wrekin and mid-Wales.

In common with many NHS Trusts, our estate comprises a mixture of building types and ages, consuming considerable quantities of energy to heat, cool and light— costing circa £3.2m and producing around 19,000 tonnes of CO<sub>2</sub> per annum. Our water usage is approximately 189,000 m<sup>3</sup> and costs circa £317k per annum. As our main clinical services are split across two sites, we also incur significant expenditure on travel. Our staff also undertake considerable commute mileage owing to the rural nature of the county and the inconsistency of public transport. The Trust produces in excess of 700,000 inpatient meals, generates almost 3,000,000 pieces of laundry and 1,804 tonnes of waste per year, with all the associated resources.



This Trust has been a “Good Corporate Citizen” for 12 years and has participated annually in the NHS sustainability assessment using the Sustainable Development Assessment Tool. We are immensely proud of our sustainability programme; we aim to create sustainable value with everything we do together with our staff, partners and stakeholders. We are committed to the protection of the environment through reducing our usage of resources including single-use plastic, reducing our emissions, creating habitats and environments such as new garden areas for wildlife which our staff and patients can enjoy, reducing inter-site vehicle movements, and no longer allowing diesel models for replacement pool and lease vehicles.

In October 2020, the NHS set itself an ambitious target for its own activities to be carbon net zero by 2040, and those of its suppliers by 2045. This will greatly impact upon the way the NHS commissions and delivers its services, and the buildings that it uses to do so, undoubtedly resulting in some of the biggest changes that the NHS will have seen since its inception. It will require changes to our estate, transport, catering, aerosol inhalers and anaesthetics, models of care – including remote consultations and care at home, and greater use of technology.

This Green Plan (the successor to the previous *Sustainable Development Management Plan*) will enable us to maintain the current momentum of sustainability improvements and will continue to deliver tangible financial and local environmental benefit.

The Lead Director for Environmental Sustainability at the Trust is Helen Troalen (Director of Finance).

The Trust has an active Good Corporate Citizen group, with representatives from across a broad spectrum of services and departments, reflecting the core standards issued by the NHS Sustainable Development Unit – each of which has a part to play in delivering sustainable services. The targets set in this Green Plan are based upon our most recent (2020) sustainability assessment, using the NHS Sustainable Development Assessment Tool, together with some advance ideas around starting to prepare for decarbonising our estate.



## 2. Drivers for Change to improve Sustainability

There are five categories of Drivers for Change that apply to the NHS:

### 1. Legislative

Civil Contingencies Act.  
Climate Change Act 2008.  
Town and Country Planning Act 1990 and subsequent amendments.  
Local Government and Public Involvement in Health Act 2007.  
Public Services (Social Value) Act 2012.  
Modern Slavery Act 2015.  
COSHH Regulations 2002 Environmental Permitting Regulations (England and Wales) 2016.  
Social Value Act 2012.  
Equality Act 2010.

### 2. International Guidance

International Panel on Climate Change (IPCC) AR 5 2013.  
United Nations (UN) Sustainable Development Goals (SDGs) 2016.  
World Health Organisation (WHO) toward environmentally sustainable health systems in Europe 2016.  
World Health Organisation (WHO) Health 2020; European policy for Health and Wellbeing.

### 3. UK Guidance

National Policy and Planning Framework 2012.  
Department for Environment, Food and Rural Affairs (DEFRA) The Economics of Climate Resilience 2013.  
Department for Environment, Food and Rural Affairs (DEFRA) Government Buying Standards for Sustainable Procurement 2016  
changing climate.

Adaptation to Climate Change – Planning guidance for health and social care organisations (NHS SDU)  
Adaptation Report for the Healthcare System 2015 (NHS SDU).  
Building Research Establishment Environmental Assessment Method (BREEAM)  
Various food standards e.g. Red Tractor, Dolphin Friendly, Sustainable Fish Cities etc.)

### 4. Local

Core Strategy Development Plan Documents.  
Site Allocations and Management of Development (SAMDev) Adopted Plan.  
Shropshire, Telford & Wrekin Sustainability and Transformation Partnership (STP) / Future Fit recommendations.  
One Public Estate (lead organisation: Shropshire Council)  
STW ICS Strategy and 10 Pledges

### 5. Healthcare specific

The Carter Review 2016 (and Model Hospital indicators)  
Sustainability and Transformation Partnership (STP) plans  
NHS Long Term Plan 2019  
NHS Sustainable Development Strategy 2014 – 2020  
NHS Standard Contract 2020 – 2021 (and subsequent versions)  
NHS Operational Planning Guidance 2020 – 2021 (and subsequent versions)  
NHS SDU's Health Outcomes of travel Tool (HOTT)  
Dept. of Health - Health Technical Memoranda (HTMs), Health Building Notes(HBNs)  
Procurement 4 Carbon Reduction Tool (P4CR)  
Delivering a 'Net Zero' National Health Service' October 2020, NHSE&I

# 3. The Trust's Vision

As a Trust, our sustainability goal is to "provide healthcare with a kind touch and a small footprint".

We are fortunate to be located in a beautiful part of the country and we share a responsibility to keep it that way. We have a duty to protect and enhance an environment that is beneficial to the half million people that live here now, and in the future, and also for all the visitors that come to enjoy the assets that Shropshire has to offer.

Through this Green Plan, and in conjunction with other health organisations and public sector bodies, we will work to move towards beneficial influences on the environmental, financial and social issues associated with our activities.

We will do this by undertaking an annual assessment of our impacts and focusing on the areas that give the greatest benefit to the natural and human environment. We will continue to use the Sustainable Development Assessment Tool (or other successor methodology proposed by the Greener NHS Unit, and this will also be used for monitoring and reporting purposes.

We will aim to ensure that our business and activity contributes positively to the following, and also to our four *Values* - which our staff demonstrate in their daily work - and which will help us as a Trust to achieve a positive contribution to these.

1. the environment
2. the community, including our staff
3. the health of our population
4. the future



Our Vision: To provide excellent care for the communities we serve

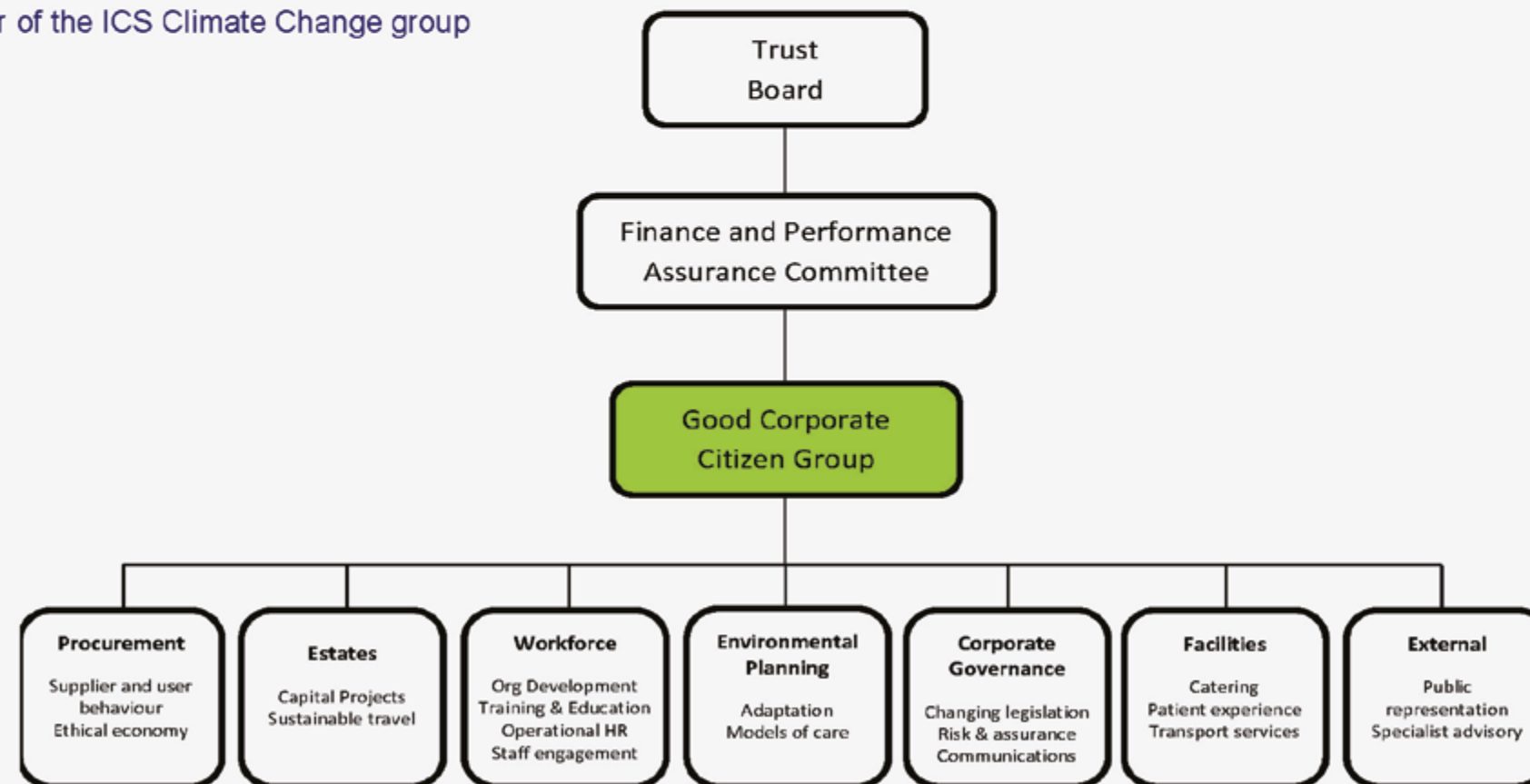


# 4. Governance

SaTH has a Good Corporate Citizen group which meets quarterly. Membership comprises representation from Estates, Facilities, Corporate Governance, Travel, Communications, Clinical and Medical staff, Workforce, Procurement and external partners.

The group provides summary 'AAA' reports through the Finance and Performance Assurance Committee together with a comprehensive annual report, which also goes to the Board of Directors' public meeting, presented by the Director of Finance. These documents are publicly available from the Trust website.

SaTH is also a core member of the ICS Climate Change group



# 5. United Nations Sustainable Development Goals

The 2030 Agenda for Sustainable Development, adopted by all United Nations Member States in 2015, provides a shared blueprint for peace and prosperity for people and the planet, now and into the future.

The 17 Sustainable Development Goals (SDGs) are the world's best plan to build a better world for people and our planet by 2030. The SDGs are a call for action by all countries - poor, rich and middle-income - to promote prosperity while protecting the environment.

They recognise that ending poverty must go hand-in-hand with strategies that build economic growth and address a range of social needs including education, health, equality and job opportunities, while tackling climate change and working to preserve our ocean and forests.

SaTH is positively contributing – at various levels – to all of these goals.

### Contribution to the 17 UN Sustainability Goals at a local level

SaTH is contributing to 14 of the goals:



...and is making progress with the remainder:



Source: <https://sdgs.un.org/goals>



## 6. Tracking Progress and Reporting –

### The Sustainable Development Assessment Tool (SDAT).

To measure SaTH's position and progress with respect to sustainability, we have used the NHS Sustainable Development Unit's annual *Sustainable Development Assessment Tool* (SDAT). It is an online self-assessment system aligned to the UN Sustainable Development Goals (SDGs)

#### MODULES:

The tool uses 296 statements across ten core modules, which are:

1. *Corporate Approach*
2. *Asset Management & Utilities*
3. *Travel and Logistics*
4. *Adaptation*
5. *Capital Projects*
6. *Green Space & Biodiversity*
7. *Sustainable Care Models*
8. *Our People*
9. *Sustainable use of Resources*
10. *Carbon / GHGs*

Each statement is aligned with up to three United Nations Sustainable Development Goals, which are ordered in level of relevance but are scored equally.

#### CROSS-CUTTING THEMES:

There are four cross-cutting themes against which performance is assessed for each module:

1. Governance & Policy (covers policies, reporting and governance undertaken by the Trust)
2. Core responsibilities (covers elements that are directly controlled by the organisation)
3. Procurement and Supply chain (highlights purchasing or commissioning of products and services)
4. Working with Staff, Patients & Communities (highlights how we can influence and promote health)

#### RESPONSES:

Each statement in the SDAT has four potential answers.

**Yes** – where the organisation can demonstrate action, process or outcome(s) that fulfil the statement. Value: 3 points.

**In Progress** – allows the organisation to gain some credit for fulfilling at least 50% of the statement, having a process in development or where a policy draft is awaiting final Board approval. Value: 2 points.

**No** – where no, or less than 50% progress has been made against the statement. Value: 0 points.

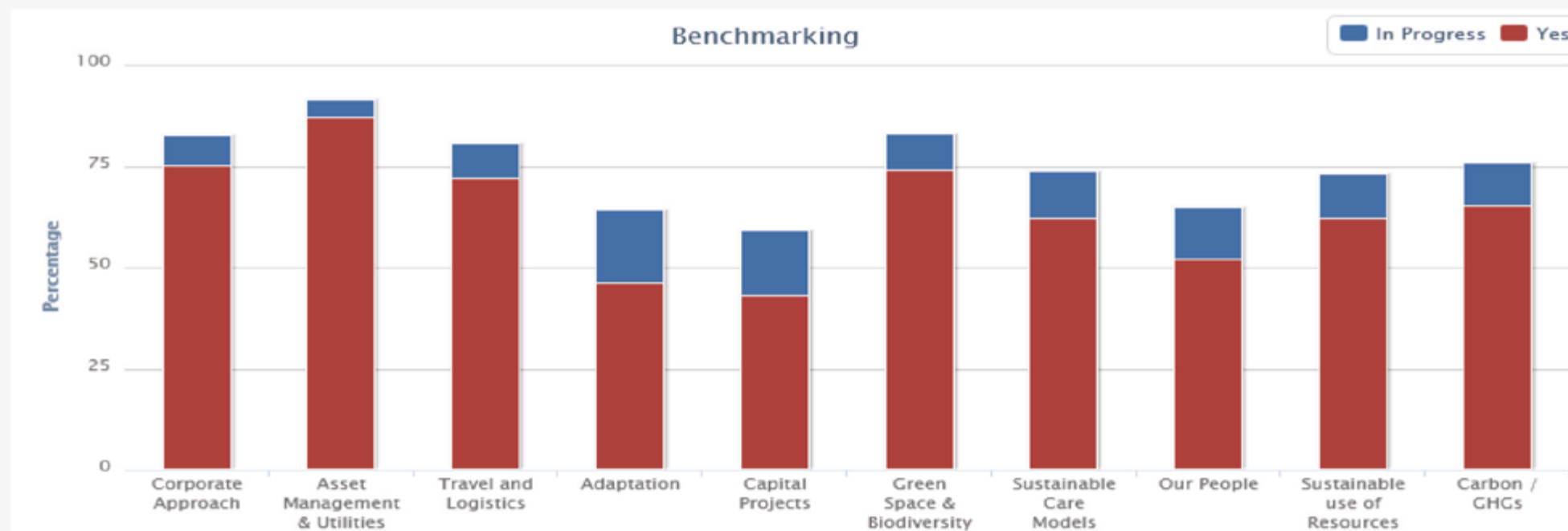
**N/A** – can be used where the statement definitely cannot apply to the organisation. (Removed from final calculation, so as not to affect the percentage score).

# 7. SaTH's Sustainable Development Assessment Tool (SDAT) Report 2020

In 2020, SaTH had improved its overall position from 72% to 76% against the SDAT targets. The scores within each module are shown below. Our score was 58% in 2014 when the current assessment methodology was developed.

Good progress has been made during the 12 months in the areas of Corporate Approach, Asset Management and Utilities, Travel and Logistics, and Sustainable use of Resources. It is encouraging to note that very few areas show no progress and that there are many areas where work is being undertaken to move along the scale to *fully implemented*.

The SDAT output report also enables easy identification of modules where progress is being made and there is potential to move to fully implemented (see below).





## 8. Key Areas of Future Focus

The SDAT tool serves to identify areas that require focused attention. This together with national guidance and commissioning requirements, serve to formulate this five-year plan.

One of the main changes introduced within the past few months has been the NHS commitment to achieve carbon net-zero for its own activities by 2040 and those of its suppliers by 2045. Formal guidance on the route to achieve this is awaited and will as above, necessitate changes to this Green Plan. SaTH is however already considering the implications – particularly for the built environment and the proposals set out in this Green Plan are representative of our current position.

The SDAT assessment for 2020, highlighted five modules that are below the 75% threshold and are therefore lowering the overall score achieved by the Trust. These are:

- 8.1 Travel and Logistics
- 8.2 Adaptation
- 8.3 Capital Projects
- 8.4 Our People
- 8.5 Sustainable Use of Resources

Whilst attention will be focussed on these modules, the other modules also offer potential and will continue to be pursued; Sections 8.6 to 8.10.

The SDAT acts as a pointer to the opportunities that could be considered to realise sustainability improvements. These are listed under the *Opportunities* heading in each section. Not all are realistic or appropriate for SaTH and therefore a selection has been used to propose improvement schemes to be worked on during the period covered by this Green Plan.

These are listed under the *Planned Improvements* heading in each section, with target dates and mechanisms for measurement included in the action plan in the appendix.

# 8. Key Areas of Future Focus

## 8.1 Corporate Approach (Governance, Workforce, Engagement, Procurement)

### 8.1.1 Present Position:

Overall score of 77% with particular strengths around government and Policy, and Procurement and Supply Chain.

### 8.1.2 Opportunities for development during 2021 -2026: Governance and Policy

- Leadership programmes that embed sustainable development, including environmental sustainability in all business cases, engaging with patients and visitors and local stakeholders on Sustainable Development Policy

#### Core Responsibilities

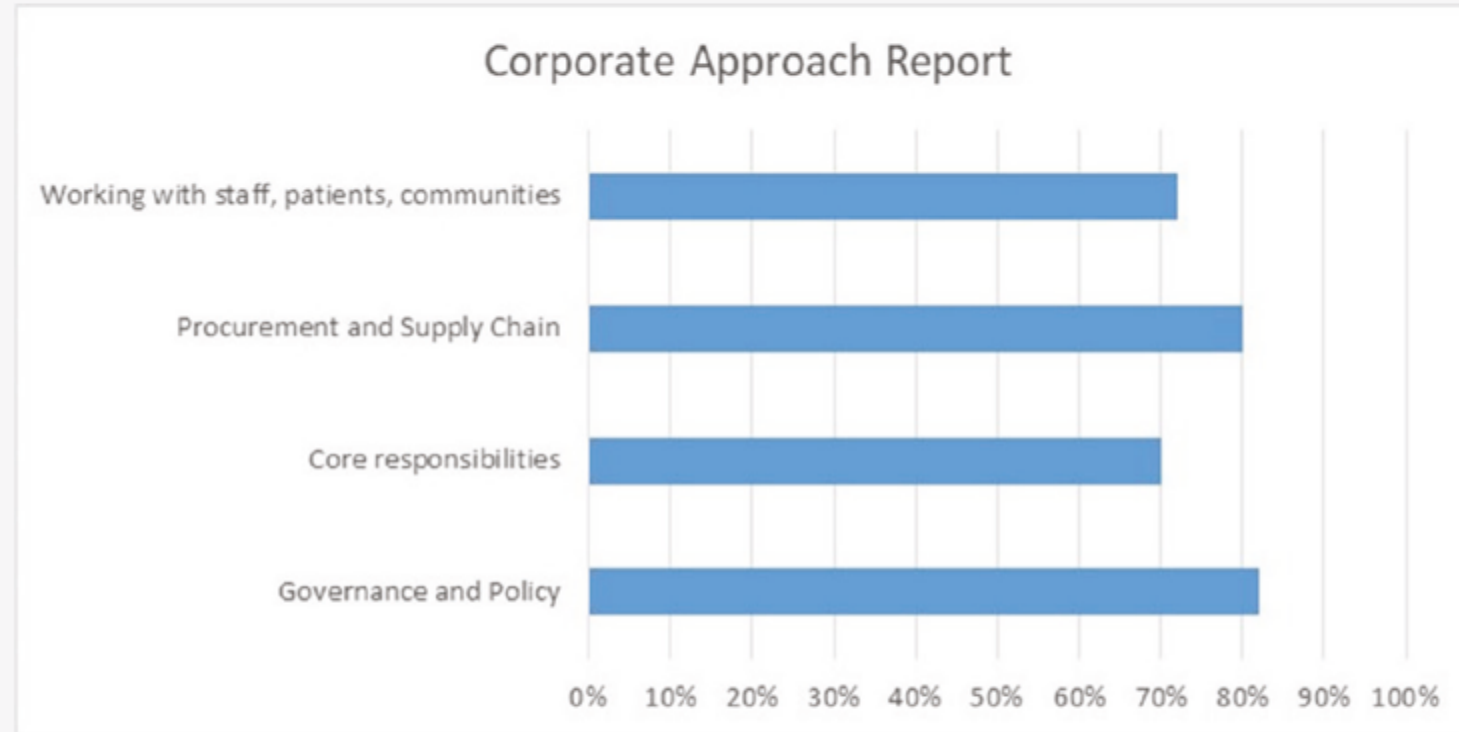
- Training, monitoring and engagement with staff

#### Procurement and Supply Chain

- Inviting and rewarding supplier innovation relating to sustainability and quantifying these

#### Health of staff, patients and communities

- Ongoing engagement



# 8. Key Areas of Future Focus

## 8.2 Asset management and facilities (Estates, HTP and Communication)

### 8.2.1 Present position:

Overall score 77% with particular strengths around Governance and Policy, and Core Responsibilities.

### 8.2.2 Opportunities for development during 2021-2026:

#### Governance and Policy

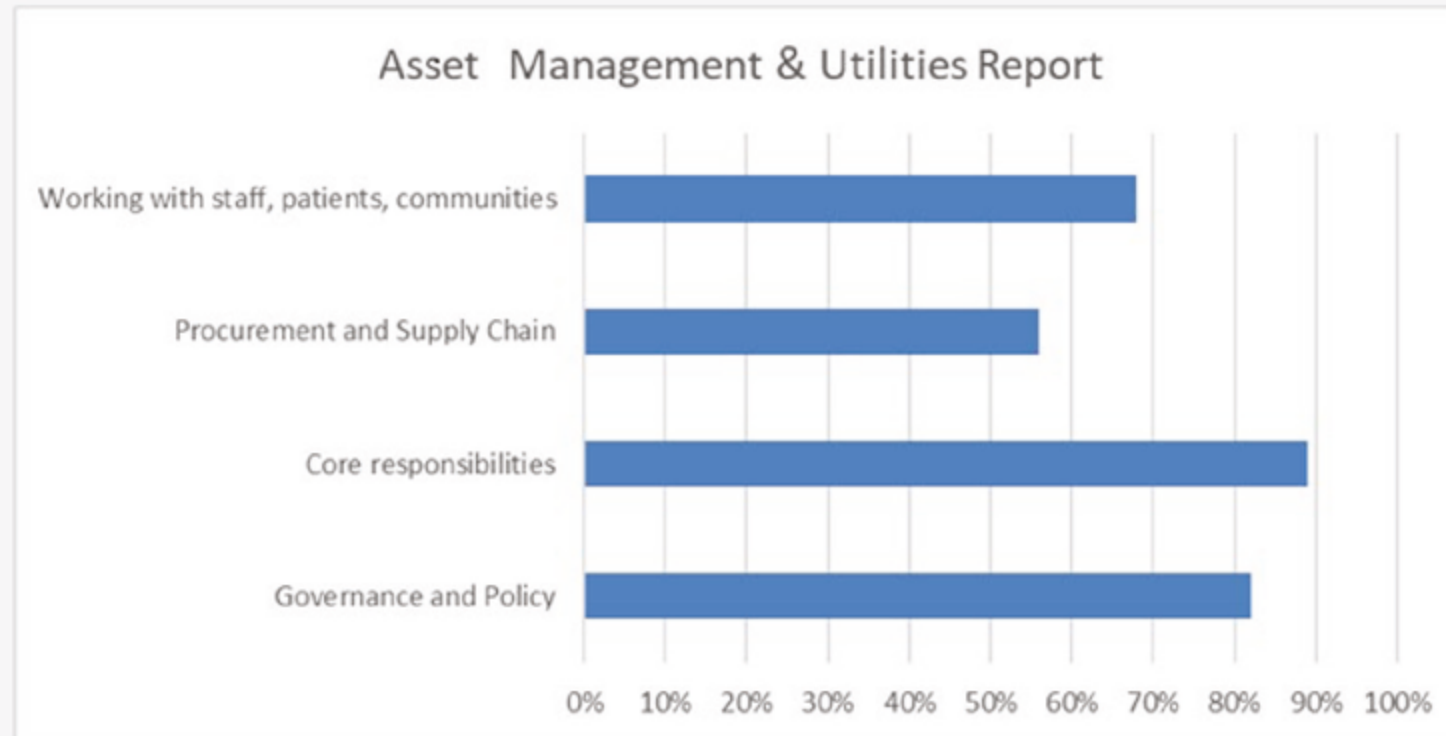
- Reviewing our building stock and developing a sustainable buildings plan.

#### Procurement and Supply Chain

- Energy / water usage by goods as part of lifecycle costs, embracing alternative funding mechanisms for energy / water efficiency.

#### Health of staff, patients and communities

- Offering energy / water efficiency advice to staff.





# 8. Key Areas of Future Focus

## 8.3 Travel and logistics (Estates and Facilities)

### 8.3.1 Present position:

Overall score 71% with particular strengths around Governance and Policy, Core Responsibilities and Health of staff, patients and communities.

### 8.3.2 Opportunities for Development during 2021-2026:

#### Governance and Policy

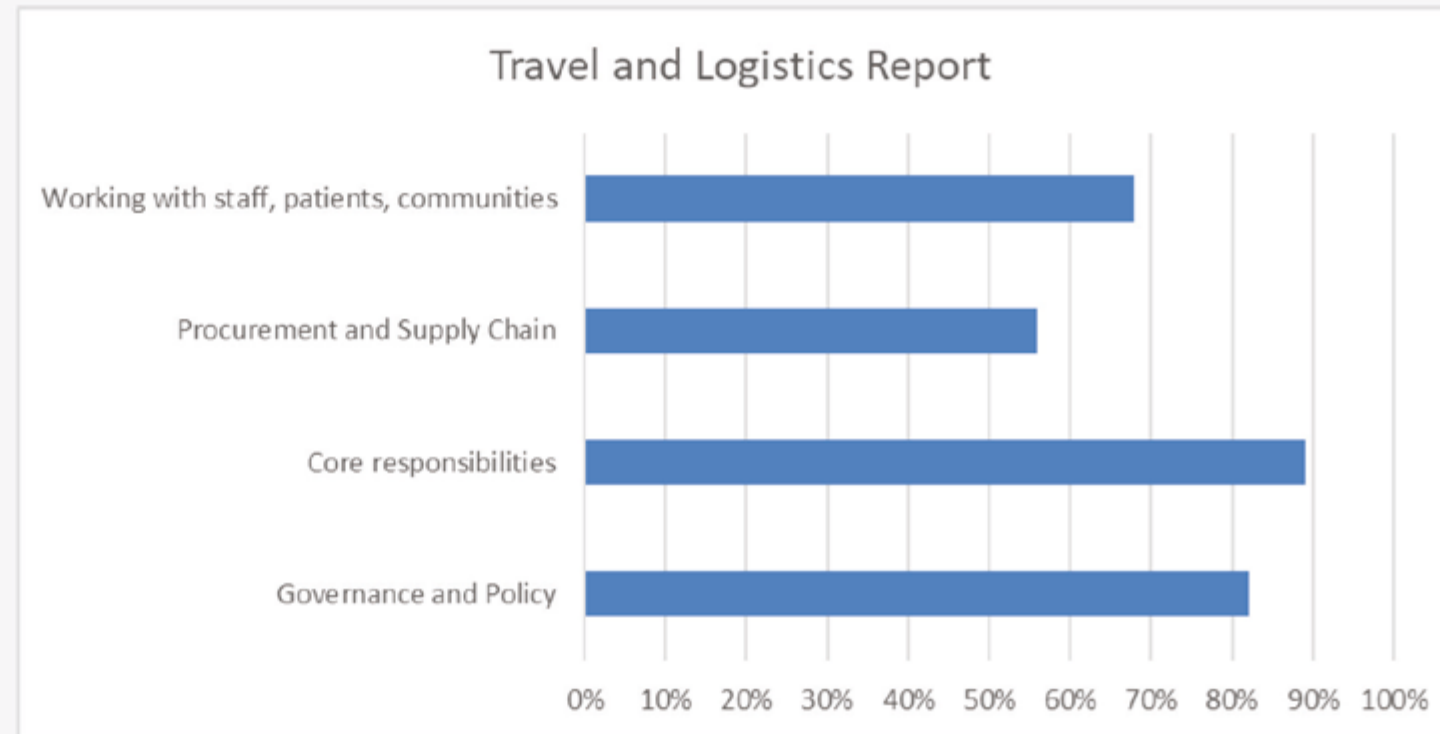
- Measuring business mileage, measuring our carbon emission levels, air quality impacts, and managing all these.

#### Core Responsibilities

- Provision of electric vehicles and electric vehicle charging points, availability of video conferencing.

#### Procurement and Supply Chain

- Setting targets to reduce greenhouse gases (GHG) and air pollution associated with logistics, assessing emissions from our own fleet during procurement of vehicles, and greater use of the SDU's Health Outcomes of Travel Tool (HOTT).





# 8. Key Areas of Future Focus

## 8.4 Adaptation (Emergency Planning)

### 8.4.1 Present Position:

Overall score 64% with particular strength around Core Responsibilities.

### 8.4.2 Opportunities for Development during 2021-2026:

#### Governance and Policy

- Risk assessment and Risk Register entries, assessing local impacts and mitigation measures.

#### Core Responsibilities

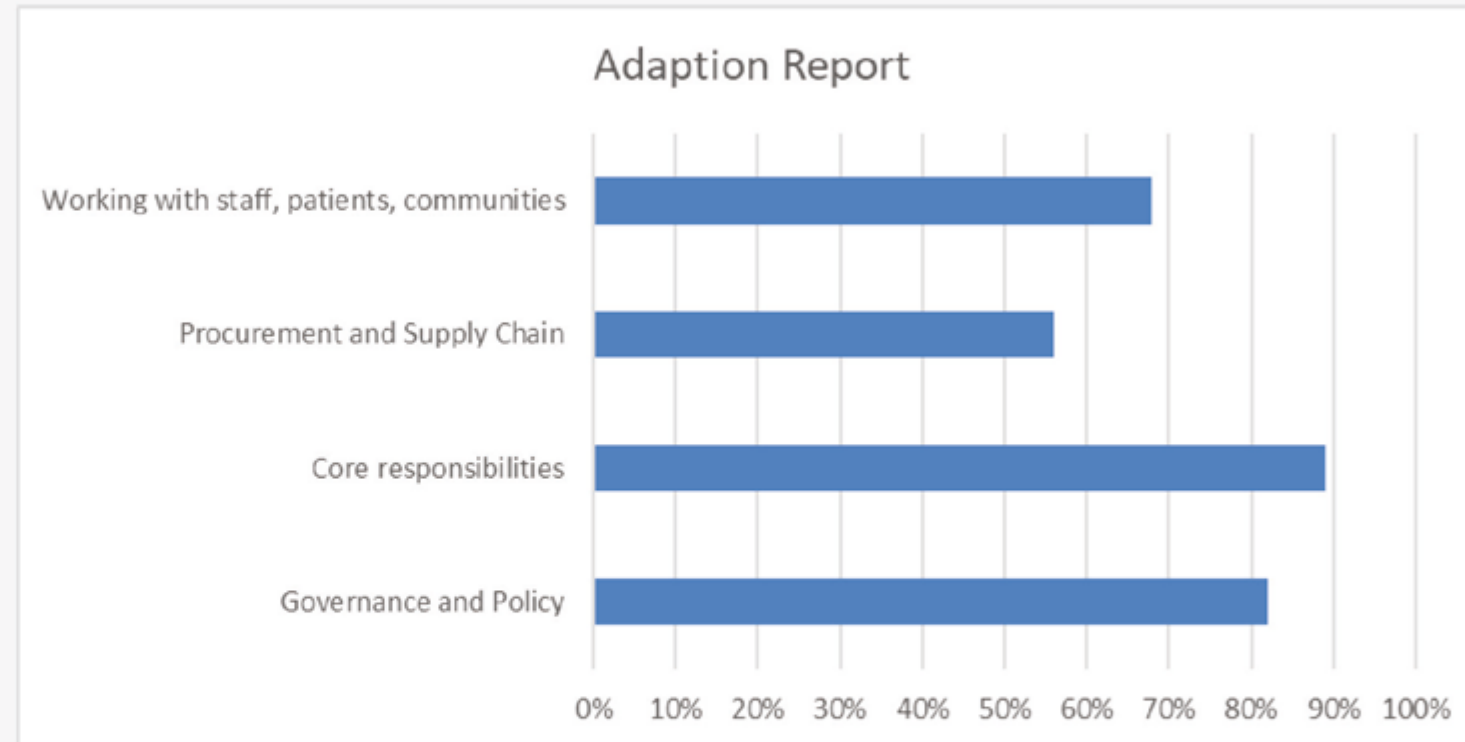
- Assessing and acting upon local climate change impacts and flooding risk, assessing the financial impact and risk to workforce / service continuity, supporting vulnerable communities.

#### Procurement and Supply Chain

- Supplier resilience.

#### Health of staff, patients and communities

- Working with the local Joint Strategic Needs Assessment (JSNA) to support vulnerable communities during extreme weather
- Working with ICS Climate Change group and other partners



# 8. Key Areas of Future Focus

## 8.5 Capital Projects (Estates)

### 8.5.1 Present Position:

Overall score 59% with particular strength around Core Responsibilities.

### 8.5.2 Opportunities for Development during 2021-2026:

#### Governance and Policy

- Sustainability aims for all capital projects.

#### Core Responsibilities

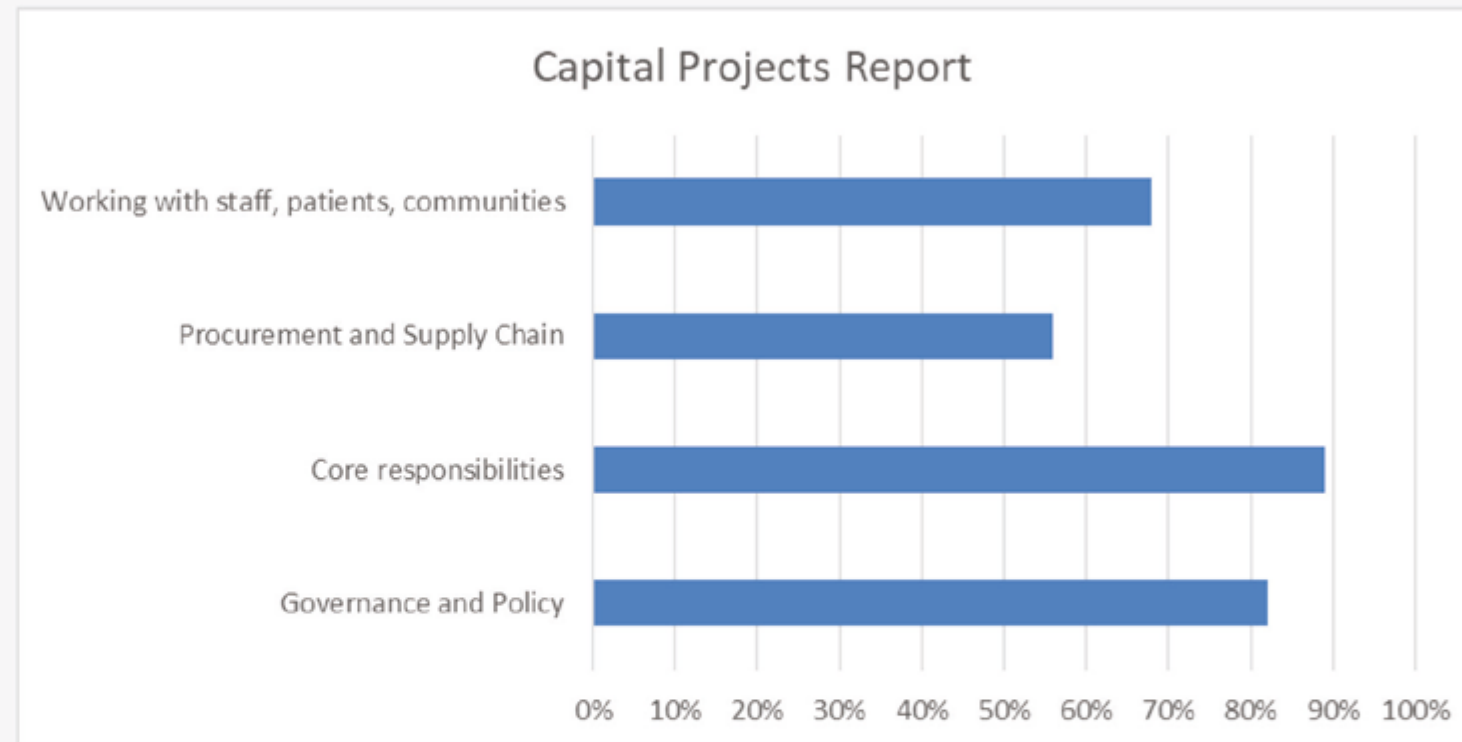
- Making greater use of an accredited certification route e.g. BREEAM, future-proofing buildings, checking that design criteria are performing as expected, and reviewing in-use performance of new areas.

#### Procurement and Supply Chain

- Low impact solutions, embedding social value outcomes (e.g. local labour) and applying whole-life costings.

#### Health of staff, patients and communities

- Sharing best practice.



# 8. Key Areas of Future Focus

## 8.6 Green space and biodiversity (Estates/Workforce)

### 8.6.1 Present Position:

Overall score 83% with particular strength in Procurement and Supply Chain, and good performance elsewhere.

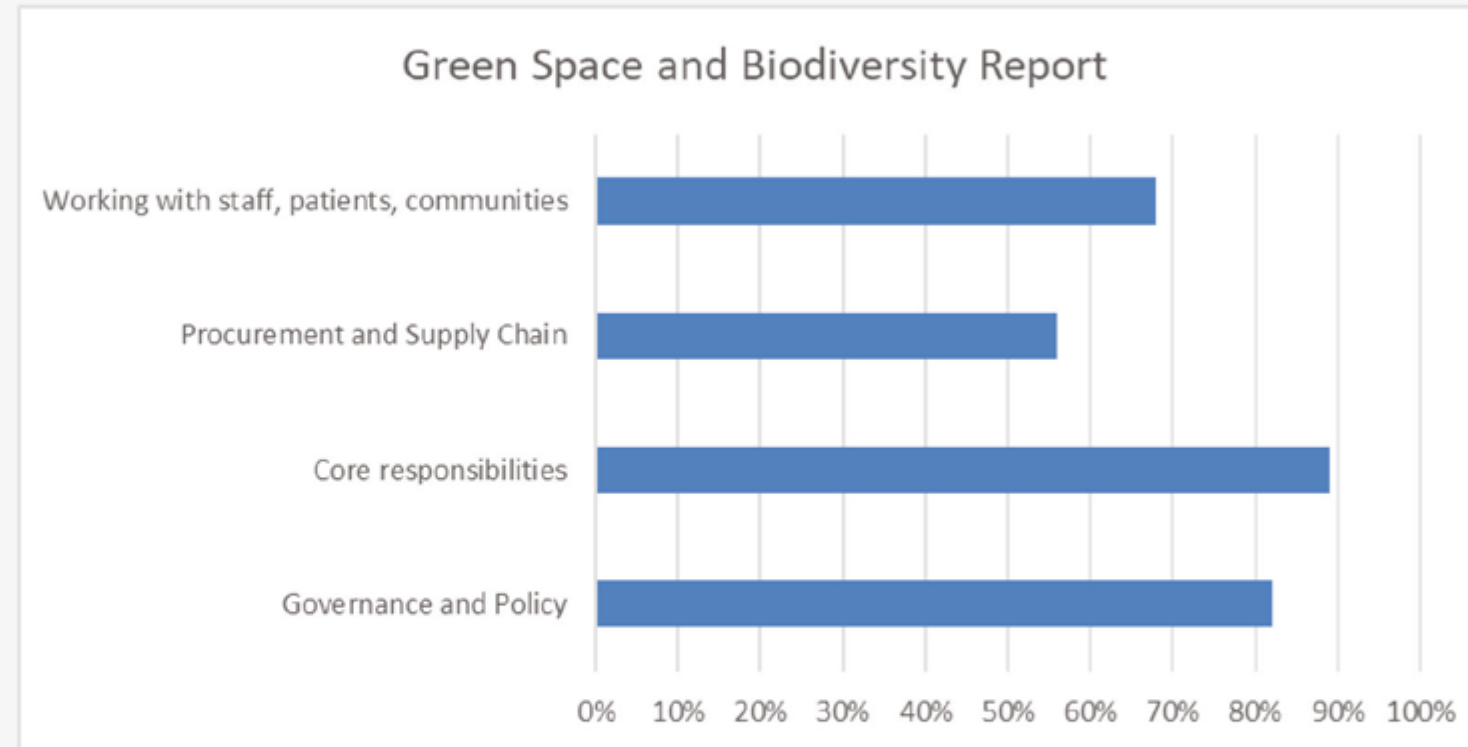
### 8.6.2 Opportunities for Development during 2021-2026:

#### Governance and Policy

- Green space strategy / biodiversity plan.

#### Core Responsibilities

- Measuring staff wellbeing related to green space
- Health of staff, patients and communities
- Growing food on site.



# 8. Key Areas of Future Focus

## 8.7 Sustainable Care

### 8.7.1 Present Position:

Overall score 74% with particular strengths around Core Responsibilities, and Health of staff, patients and communities.

### 8.7.2 Opportunities for Development during 2021-2026:

#### Governance and Policy

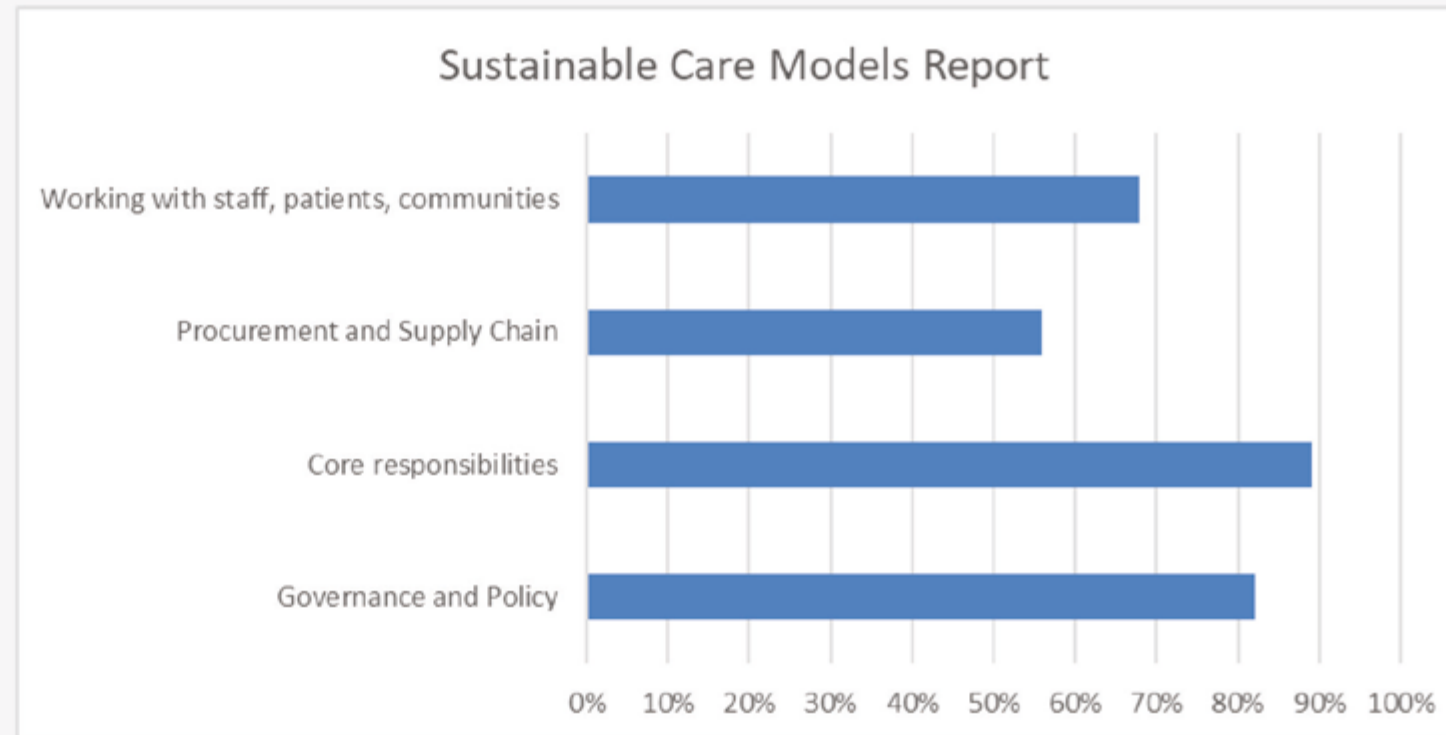
- Ensuring the Board is aware of health benefits of holistic sustainable principles, embedding 'prevention' in all models of care, including sustainability as a quality dimension in care models, delivering sustainable care model training to Board.

#### Core Responsibilities

- Utilising all patient contact opportunities to promote healthy and sustainable lives including diet, using specific mechanisms to test sustainable care models.

#### Procurement and Supply Chain

- Utilising resources sustainably, reducing waste and hazardous substance usage.





# 8. Key Areas of Future Focus

## 8.8 Our People (Workforce)

### 8.8.1 Present Position:

Overall score 67% with particular strengths around Governance and Policy, and working with staff, patients and communities.

### 8.8.2 Opportunities for Development during 2021-2026:

#### Core Responsibilities

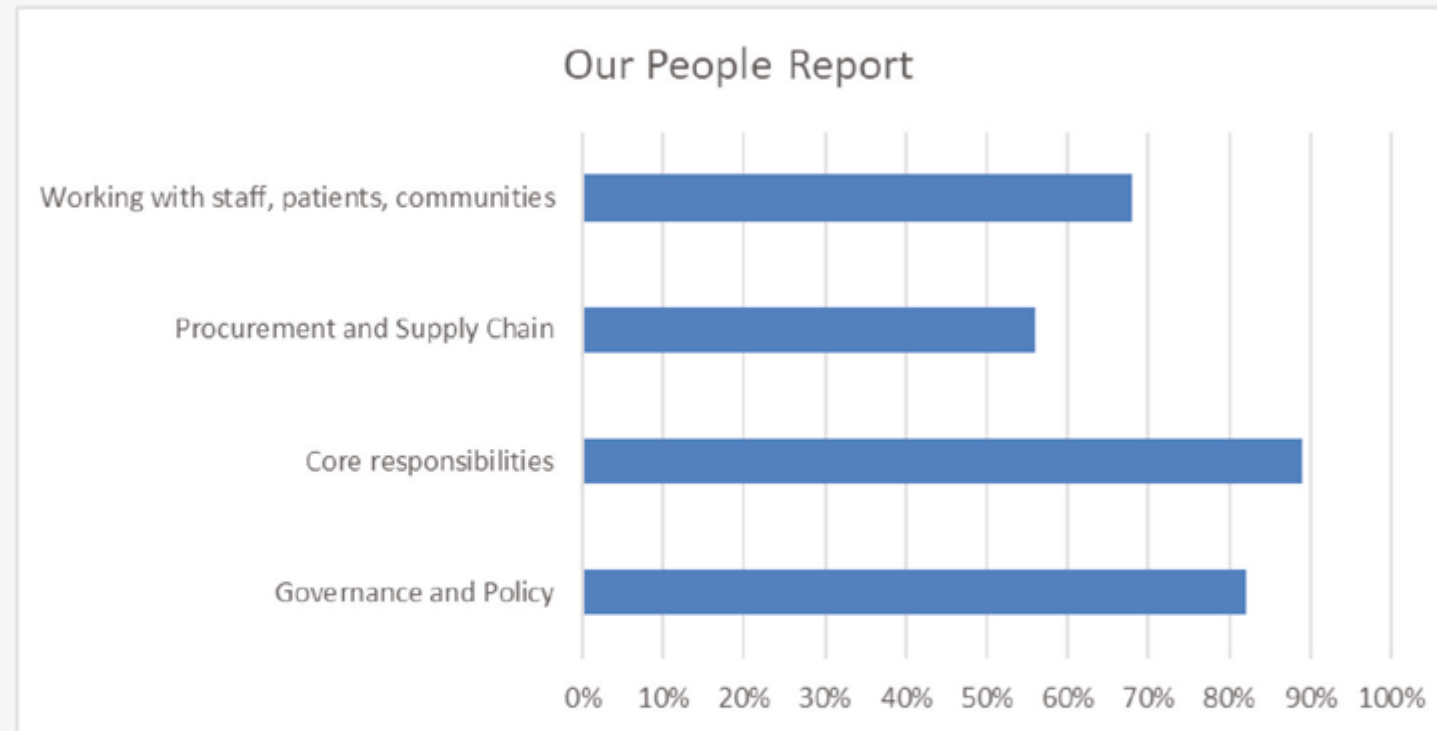
- Training Needs Analysis for up-skilling and succession planning, Planning and supporting health choices for staff, creating a smoke free environment, increasing staff knowledge and encouraging staff to be part of the Trust's sustainability journey including through demonstrating sustainable behaviours, demonstrating that staff retention and health & well-being is improving.

#### Procurement and Supply Chain

- Accessing suppliers' E&D approaches, modern slavery.

#### Health of staff, patients and communities

- Working with other local employers to improve skill bases in our community.



# 8. Key Areas of Future Focus

## 8.9 Sustainable Use of Resources (Workforce and Facilities)

### 8.9.1 Present Position:

Overall score 69% with particular strengths around Governance and Policy, and Core Responsibilities.

### 8.9.2 Opportunities for Development during 2021-2026:

#### Core Responsibilities

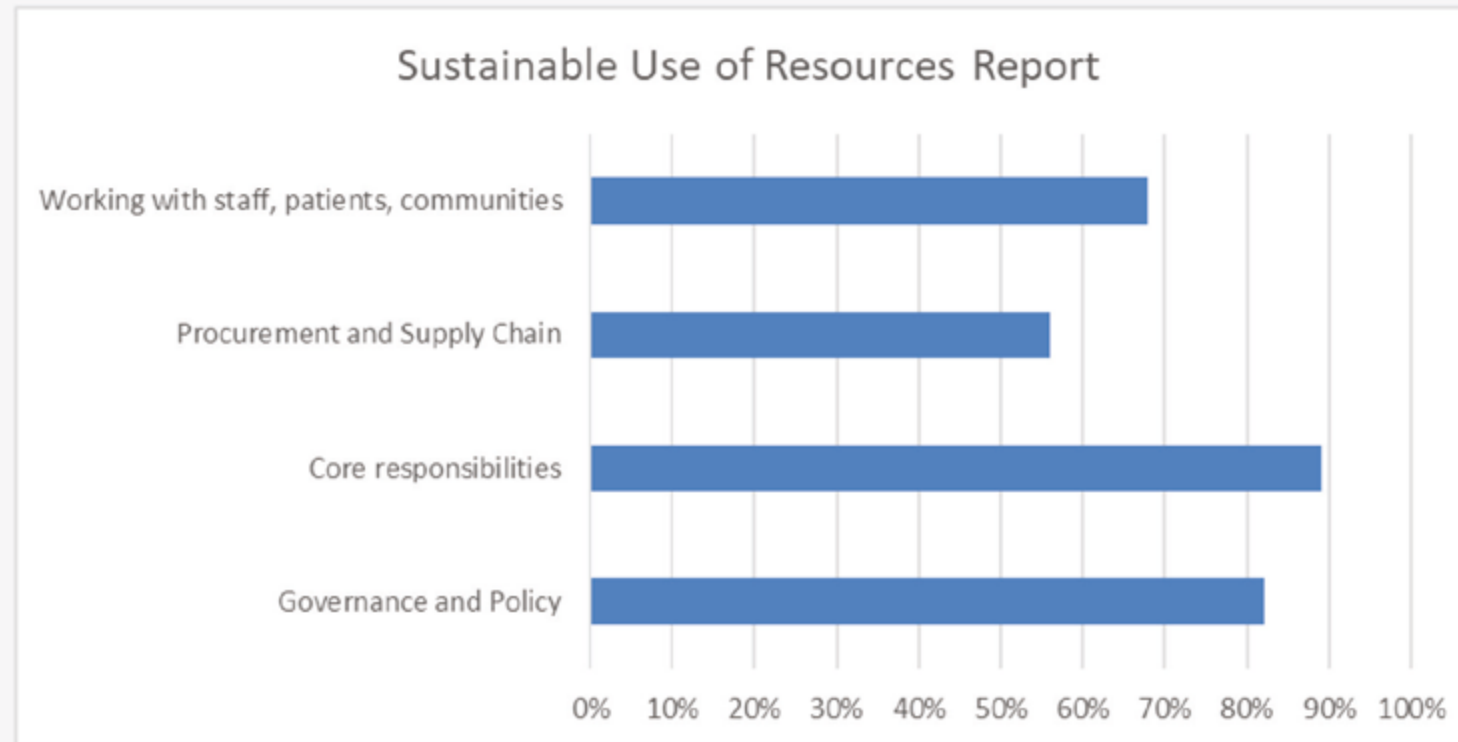
- Staff training in minimising use of chemicals.

#### Procurement and Supply Chain

- Tracking food miles and food environmental impact, maximising fresh food, understanding the hazardous substance content of the products we procure and working with contractors to reduce such products, encouraging and seeking evidence that suppliers are reducing their use of resources, sharing best practice.

#### Health of staff, patients and communities

- Working with external bodies to promote healthy food choices, encouraging staff to minimise waste and expense at home, including around food and commodities.



# 8. Key Areas of Future Focus

## 8.10 Carbon/Greenhouse Gases (Estates, Finance, Procurement, Medical Directorate, Facilities – Car Leasing)

High-level targets have been set for the route to NHS activities carbon net-zero by 2040 and suppliers by 2045.

### 8.10.1 Present Position:

Overall score 77% with particular strengths around Governance and Policy, and Core Responsibilities.

### 8.10.2 Opportunities for Development during 2021-2026:

#### Governance and Policy

- Measuring and reducing travel and associated carbon footprint – business and patient transport, applying sustainability objects to all capital projects.

#### Core Responsibilities

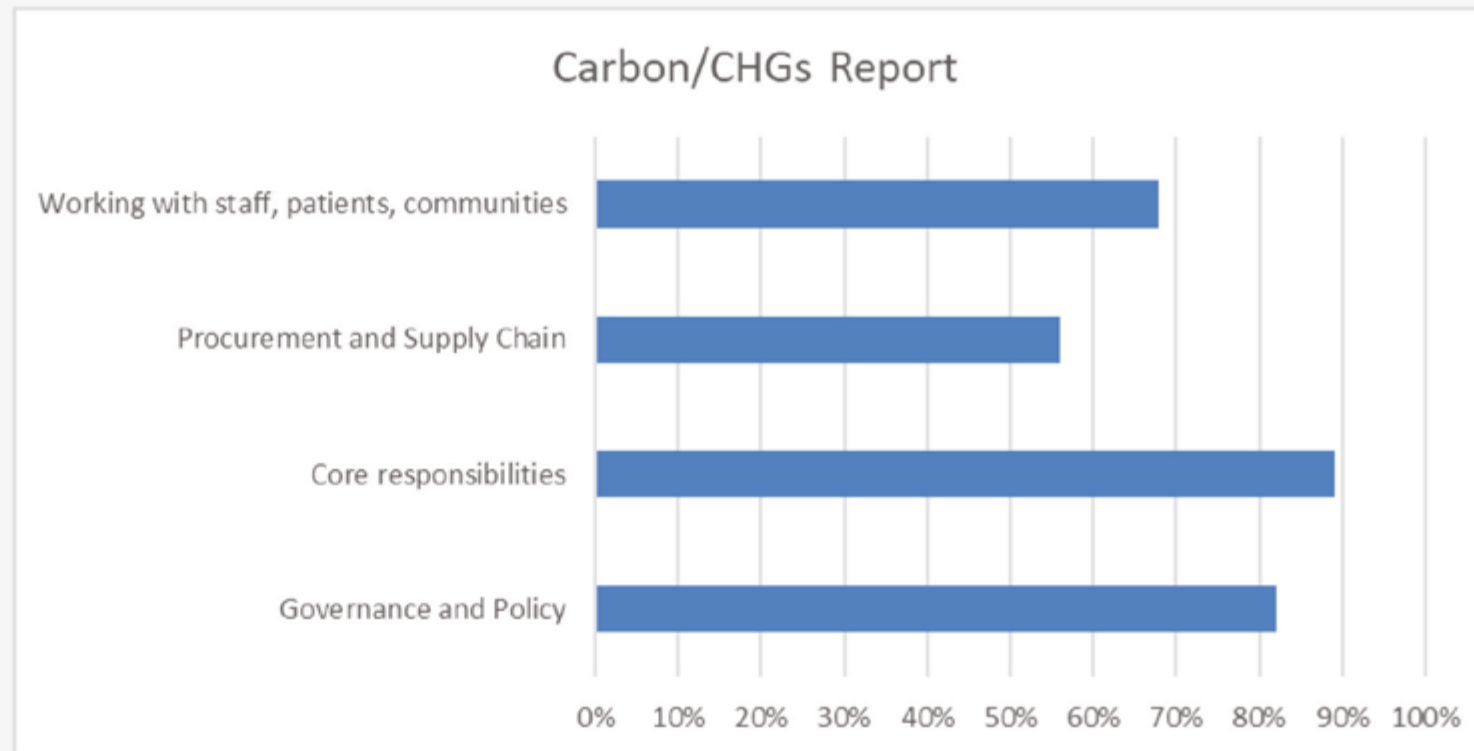
- Maximising carbon reduction opportunities in all estates investments (energy and transport).

#### Procurement and Supply Chain

- Including low carbon & low environmental impact in design briefs, maximising resource efficacy re-use / low carbon etc.) for new builds and refurbishments, contracts to specify and measure reduction targets for air emissions, measure data on suppliers' environmental impacts

#### Health of staff, patients and communities

- Quantifying our citizen carbon footprint i.e. staff and patient carbon emissions – commuting and home energy – and offering advice.





## 9. Finance

All activities incur a cost, whether that is financial and or environmental.

It is often the case that an environmental cost carries with it a financial cost, either as a result of profligate use of natural resources or, through taxes on environmental emissions and costs for treatment.

Reducing our environmental impact is therefore highly likely to reduce the financial impact, albeit that sometimes to achieve this, a capital investment is required.

The Trust will also seek to utilise external funding to reduce our carbon wherever possible.



# 10. Risk

By adopting a proactive and positive approach to Environmental Sustainability, the Trust is mitigating against risks in the following areas:

## 10.1 Finance:

The costs associated with resource usage and waste emissions are ever increasing and place a burden on Trust finances. Careful management of our use of resources, how we dispose of our waste will help to keep these costs under control.

Costs are reported annually in ERIC and also the Trust Annual Report.

## 10.2 Carbon emission targets / climate change:

The Trust is continuing to make reductions in carbon emissions through energy efficiency measures. We aim to meet or exceed national and NHS targets. The latest NHS Operational Planning Guidance states that the NHS will develop a national decarbonisation and climate change plan during 2020, and the Trust welcomes this. It goes on to state that all new buildings and refurbishments should be delivered to net zero carbon standards. SaTH has the ideal opportunity to meet this requirement, through the present reconfiguration of our estates and services, and discussions are on-going with the architects and design engineers. This will be the single biggest opportunity for the Trust to present itself as a leader in this field.

## 10.3 Legislative compliance:

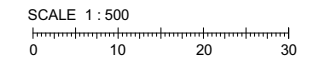
The Trust follows all legislative requirements for management of activities having an environmental impact through emissions and discharges, and is licensed where necessary. We use the NHS Premises Assurance Method to validate our compliance.

## 10.4 Reputation:

Environmental harm is something that makes news – and the public are ever more alert to, and aware of, non-compliance. The Trust makes every effort to ensure that its activities are compliant with legislation and also – given that we are a 24-hour facility - that they create minimal impact on our neighbours and the local environment.

## 10.5 Patient, visitor and staff experience:

No one wants to spend time in hospital but, we aim to ensure that for those that are visiting our sites, and for our staff too, the environment is as pleasant as is possible for a working environment. We have invested time, money and effort into our grounds and the buildings to make them welcoming. We seek patient views through various channels and patient representatives, with the aim of creating a positive experience for all.



**Departments (Lv00)**

- Inpatient Wards
- Main Concourse
- Stores
- Treatment



Rev	Description	Date	Dr by	App by
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original by	date created	11/22/22	approved by	CP
ETU				

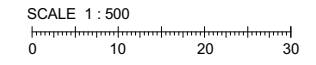
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client name	
Shrewsbury & Telford Hospitals NHS Trust	
project	
Hospital Transformation Programme - Royal Shrewsbury hospital	
drawing	
Level 00 - GA Plan - By Department	
computer file	plot date
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RSH-AHR-B01-00-DR-A-2002 P1	status

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### Departments (Lv02)

- Delivery + MLU
- Gynaecology
- Neonatal Suites
- Inpatient Wards
- Theatres
- Main Concourse



Rev	Initial Issue	Description	Date	Dr by	App by
original by	ETU	date created	11/22/22	approved by	CP

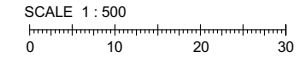
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project	
Hospital Transformation Programme - Royal Shrewsbury hospital	
drawing	
Level 02 - GA Plan - By Department	
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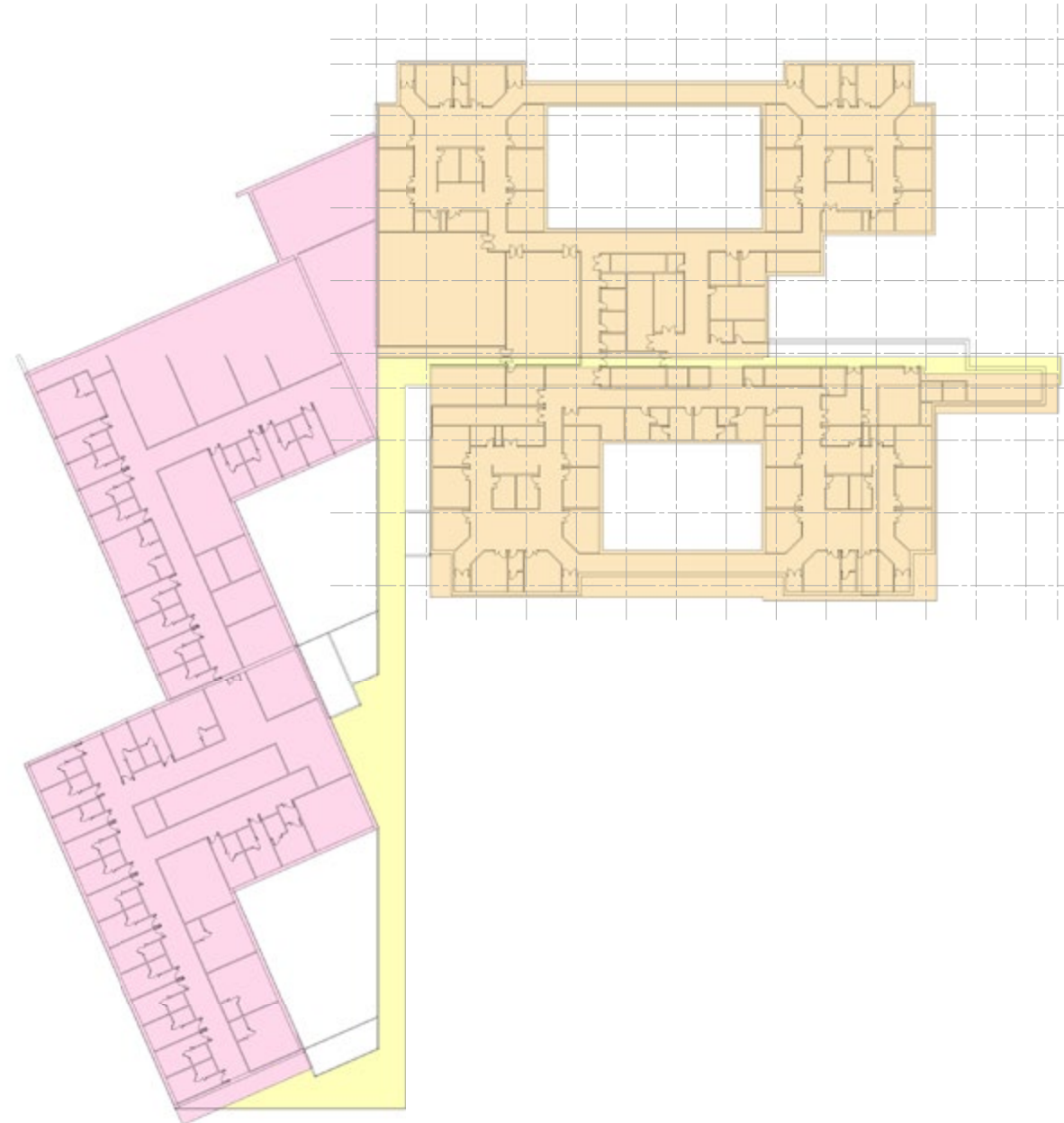
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### Departments (Lv03)

- Key**
- Main Concourse
  - Maternity
  - Maternity Inpatient



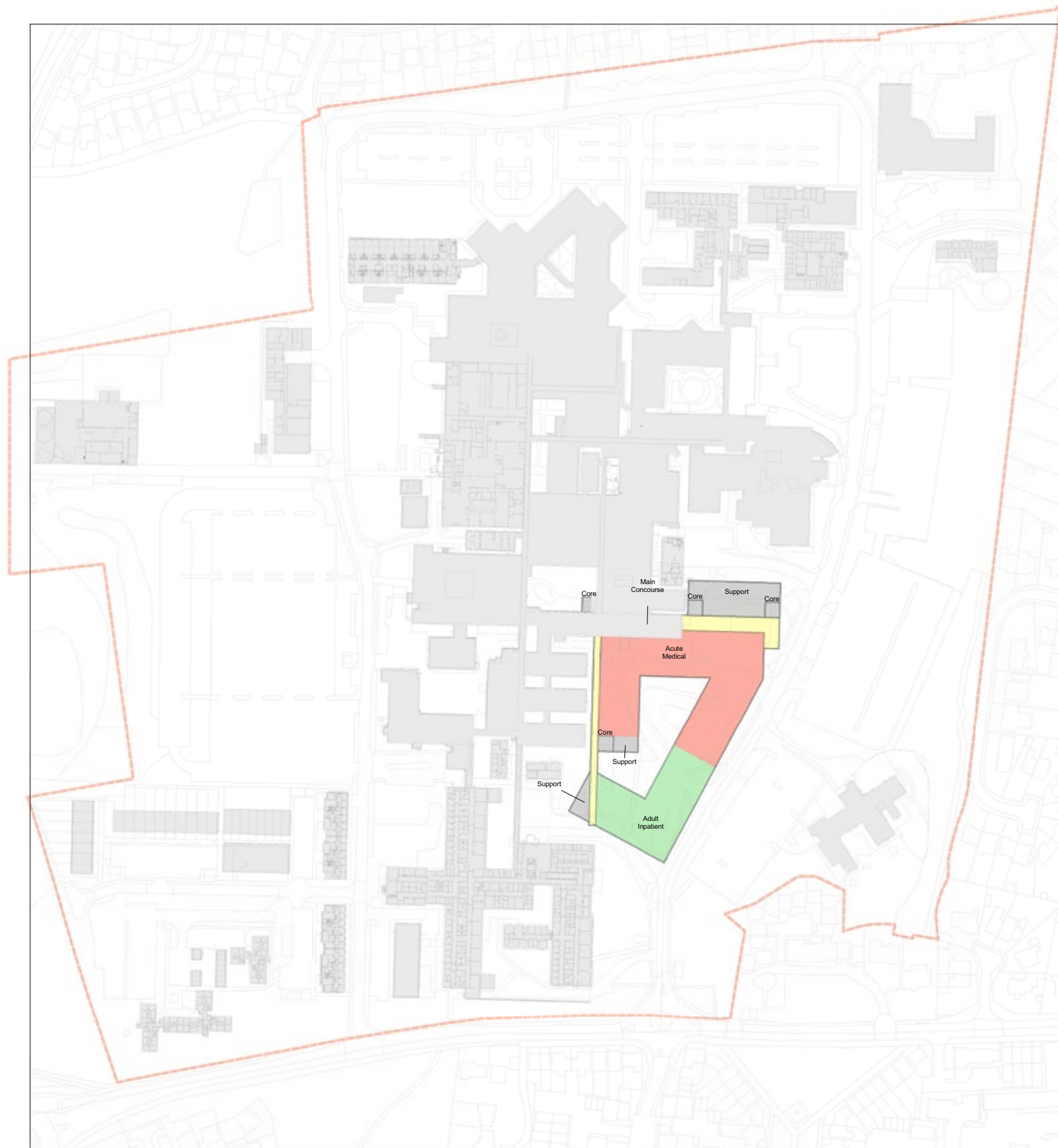
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original by	date created	11/22/22	approved by	CP
ETU				

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client name	Shrewsbury & Telford Hospitals NHS Trust		
project	Hospital Transformation Programme - Royal Shrewsbury hospital		
drawing	Level 03 - GA Plan - By Department		
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**Department**



- Indicates Site Boundary
- Adult Inpatient
- AMU (new build)
- Main Concourse
- Support

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original by	ETU	11/18/22	ETU	CP
date created		11/18/22	approved by	CP



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client name  
Shrewsbury & Telford Hospitals NHS Trust

project  
Hospital Transformation Programme - Royal Shrewsbury hospital

drawing  
Level 01 - Site Wide Plan - Alternative Option

computer file  
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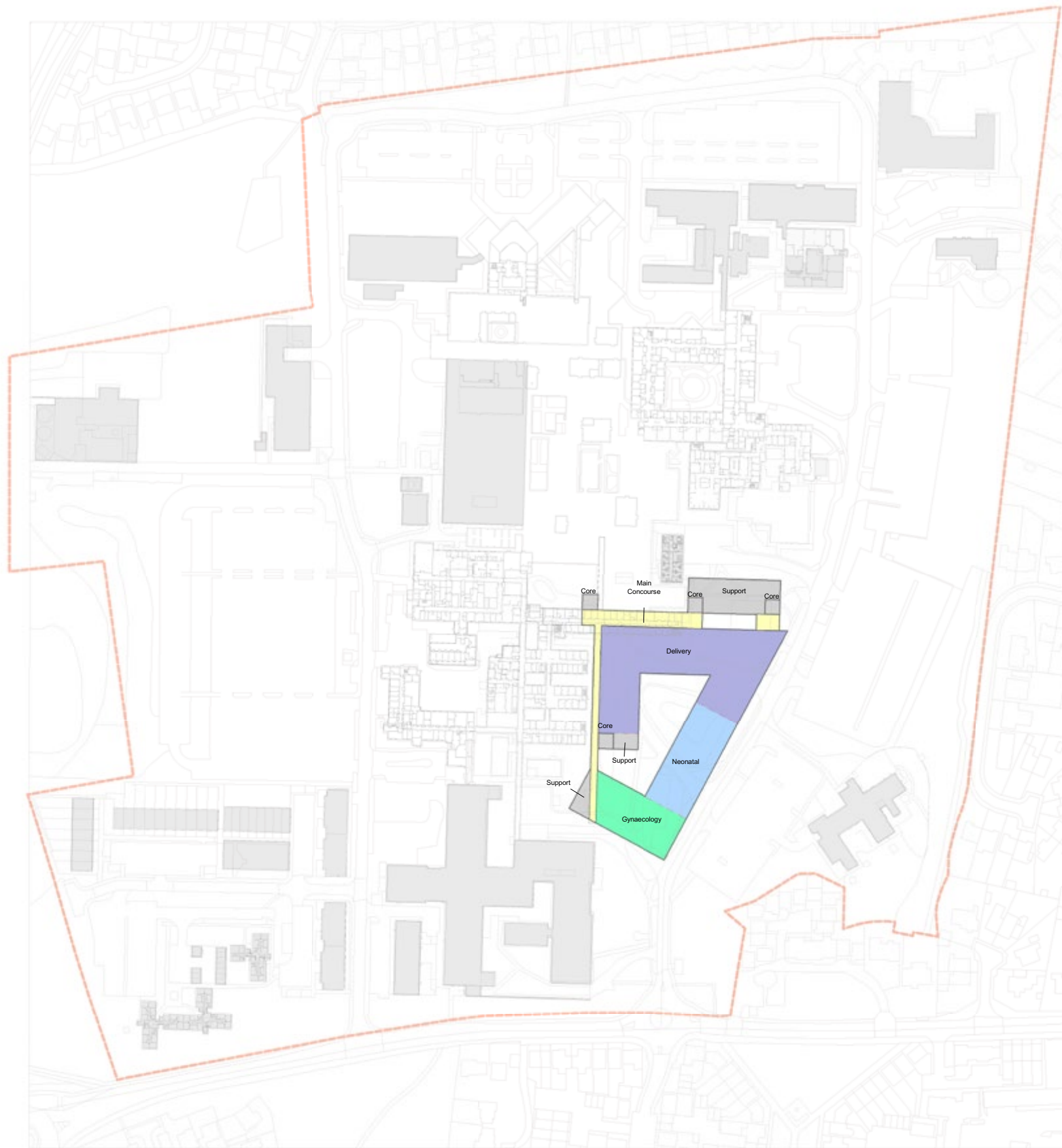
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rev  
P1

issue status

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**Department**



--- Indicates Site Boundary

- Delivery
- Gynaecology
- Main Concourse
- Neonatal
- Support

Rev	Initial Issue	Date	Dr	CP
original by	ETU	11/18/22	ETU	CP
date created		11/18/22	ETU	CP



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client name  
**Shrewsbury & Telford Hospitals NHS Trust**

project  
**Hospital Transformation Programme - Royal Shrewsbury hospital**

drawing  
**Level 02 - Site Wide Plan - Alternative Option**

computer file  
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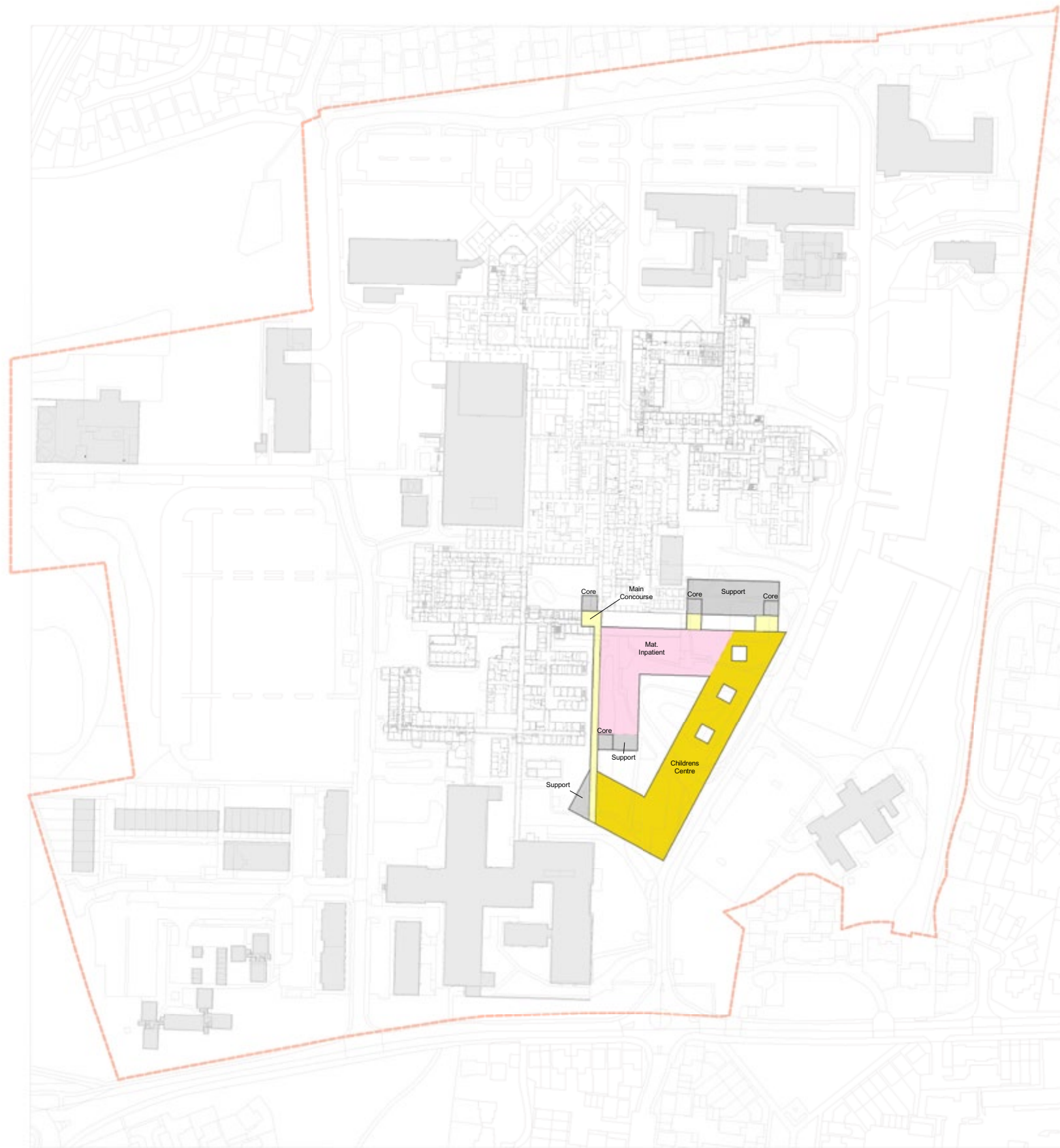
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**Department**



- Indicates Site Boundary
- Childrens Centre
- Main Concourse
- Mat. Inpatient
- Support

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Rev	Description	Date	Dr	App
original by	ETU	11/18/22	approved by	CP

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client name	Shrewsbury & Telford Hospitals NHS Trust
project	Hospital Transformation Programme - Royal Shrewsbury hospital
drawing	Level 03 - Site Wide Plan - Alternative Option
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**Department**



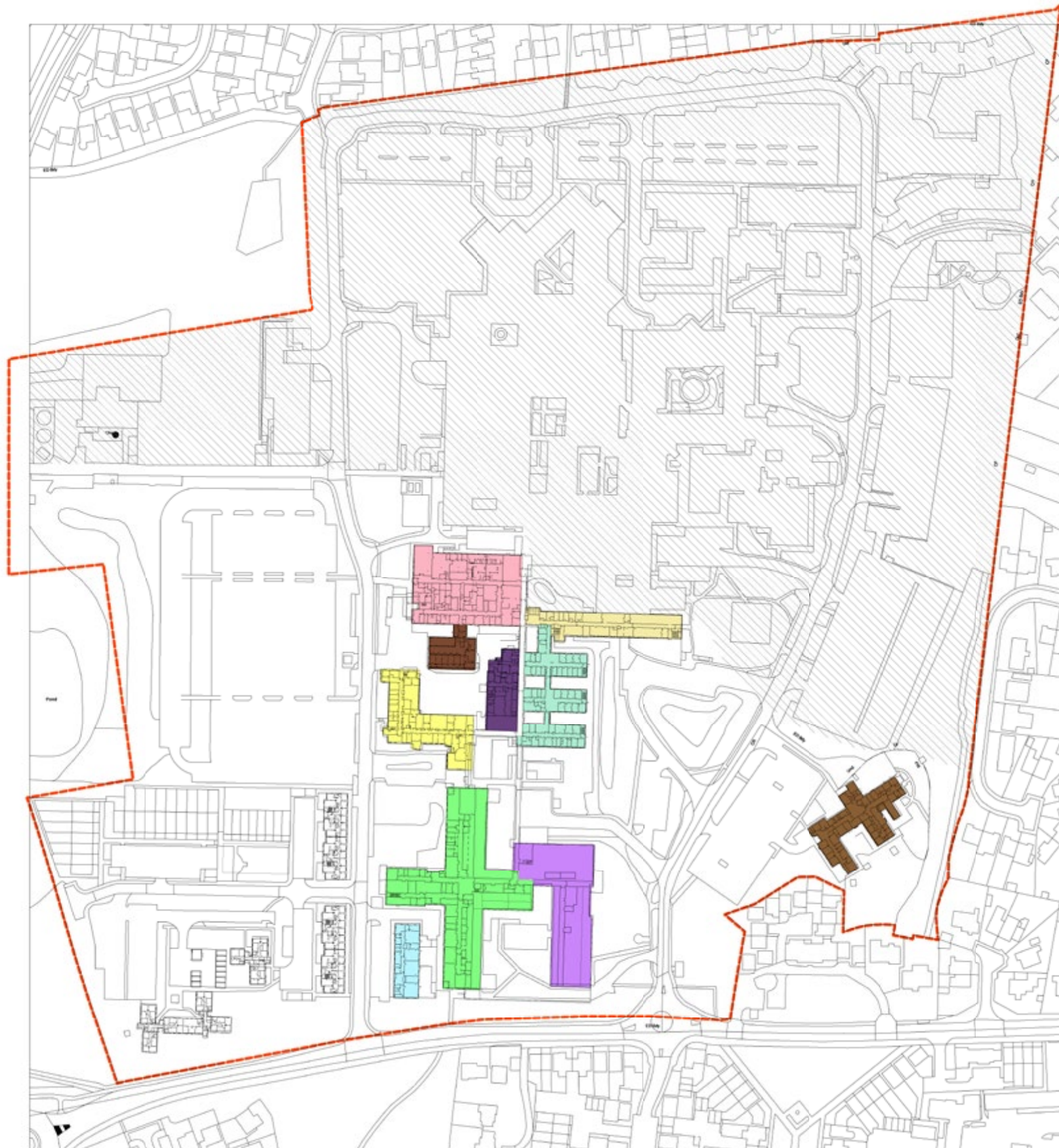
- Indicates Site Boundary
- Critical Care
- Inpatient
- Main Concourse
- Support

Rev	Initial Issue	Description	18.11.22	ETU	CP
original by	ETU	date created	11/18/22	approved by	CP

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client name	
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project	
Hospital Transformation Programme - Royal Shrewsbury hospital	
drawing	
Level 04 - Site Wide Plan - Alternative Option	
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**Department (Lv00)**

- Basement Wards
- Basement (Antenatal Clinic)
- Path Lab
- Cardiac Rehab Staff Support
- Pharmacy
- Mortuary
- Clinics 5-6-7-8
- Admin Level 0 (Medical Records)
- Mytton Oak Unit
- Nursery

P1	Initial Issue	18.11.22	ETU	CP
Rev	Description	Date	Dr	App
original by	date created	18/11/22	approved by	CP
ETU				

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client name	Shrewsbury & Telford Hospitals NHS Trust
project	Hospital Transformation Programme - Royal Shrewsbury hospital
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rev	P1
issue status	

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Department (Lv01)

- Antenatal
- Boiler House
- Catering
- Escalation
- Estates
- Faculty of Health
- Fert & EPAS
- Fracture Clinic
- GU Clinic
- Hamar Centre
- Hummingbird
- Learning Centre
- Maternity Generator
- Medical Assessment Unit
- Old Finance
- OPD
- Path Lab
- Radiotherapy
- Renal
- Shropdoc
- Stores
- Theatres
- Treatment Centre

Rev	Initial Issue	Description	Date	ETU	CP
original by	ETU		18/11/22	CP	
date created			18/11/22		CP

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client name	Shrewsbury & Telford Hospitals NHS Trust
project	Hospital Transformation Programme - Royal Shrewsbury hospital
drawing	Level 01 - Site Wide Plan - By Department
computer file	C:\Users\etw\Documents\2019-00606-00002\00002\00002.dwg
project number	2019.00606.006
drawing number	RSH-AHR-ZZ-01-DR-A-00002
scale	1 : 1000 @A1
rev	P1
issue status	

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**Department (Lv02)**

- Faculty of Health
- Haematology
- OPD (Admin Level)
- Shropdoc
- S&R  
Trauma & Ortho  
Care of Elderly
- Urology (Ward 21)
- Treatment Centre
- Ward Block  
(Entrance/ Offices/ Support)

Rev	Initial Issue	Description	Date	Dr by	ETU	CP
original by	ETU	date created	18/11/22	approved by	CP	

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client name  
Shrewsbury & Telford Hospitals NHS Trust

project  
Hospital Transformation Programme - Royal Shrewsbury hospital

drawing  
Level 02 - Site Wide Plan - By Department

computer file  
C:\work\Documents\RSH-AHR-ZZ-02-02-A-0000\_wlan.lvt

project number  
2019.00606.006

scale  
1 : 1000 @A1

drawing number  
RSH-AHR-ZZ-02-DR-A-00002

rev  
P1

status  
Issue Status

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**Department (Lv03)**

- Cardiology  
Endocrinology  
CCU
- Oncology  
Haematology

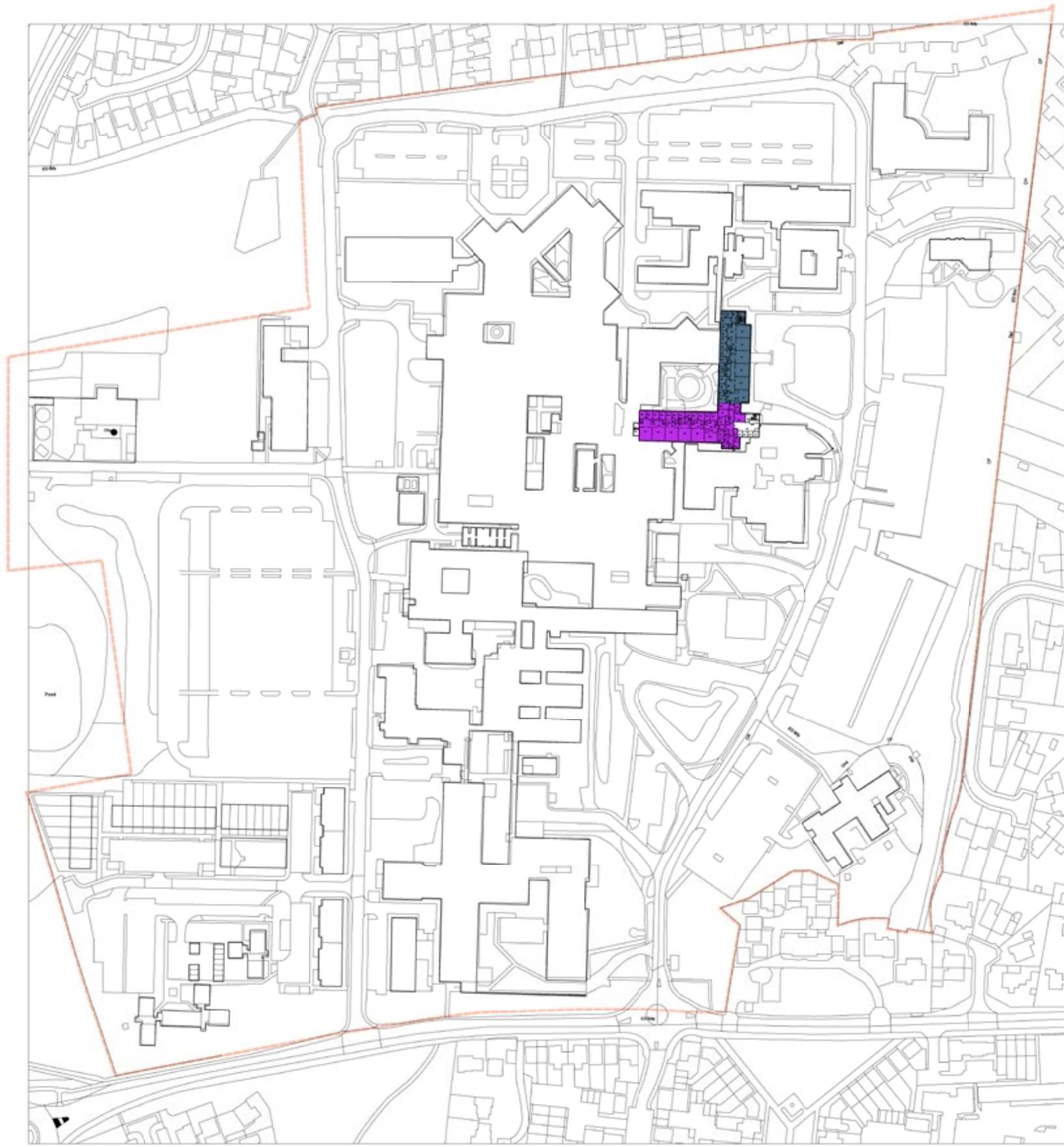
Rev	Initial Issue	Date	Dr	ETU	CP
original by	ETU	date created	18/11/22	Dr	App
				By	By
				approved by	approved by
				CP	CP

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client name	Shrewsbury & Telford Hospitals NHS Trust
project	Hospital Transformation Programme - Royal Shrewsbury hospital
drawing	Level 03 - Site Wide Plan - By Department
computer file	C:\Users\jdoonem@shrewsbury.nhs.uk\Documents\RSH-AHR-ZZ-03-DR-A-00002_wlan.rvt
project number	2019.00606.006
drawing number	RSH-AHR-ZZ-03-DR-A-00002
scale	1 : 1000 @A1
rev	P1
issue status	

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**Department (Lv04)**

- Colorectal Surgery
- Gastroenterology
- Urology
- Vascular

Rev	Initial Issue	Description	Date	Dr By	App By	CP
original by	ETU		date created	18/11/22	approved by	CP

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client name	Shrewsbury & Telford Hospitals NHS Trust
project	Hospital Transformation Programme - Royal Shrewsbury hospital
drawing	Level 04 - Site Wide Plan - By Department

computer file	C:\work\plan\Documents\RSH-AHR-ZZ-04-A-0000_ahp1.rvt	plot date	
project number	2019.00606.006	scale	1 : 1000 @A1
drawing number	RSH-AHR-ZZ-04-DR-A-00002	rev	P1
<small>This drawing is to be read in conjunction with all related drawings. All dimensions must be checked and verified on site before commencing any work or producing shop drawings. The originator should be notified immediately of any discrepancy. This drawing is copyright and remains the property of AHR.</small>		issue status	







**Department (Lv06)**

■ Roof Access

Rev	Initial Issue	Description	Date	Dr	App
original by	ETU		date created	18/11/22	approved by
				CP	CP

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client name  
**Shrewsbury & Telford Hospitals NHS Trust**

project  
**Hospital Transformation Programme - Royal Shrewsbury hospital**

drawing  
**Level 06 - Site Wide Plan - By Department**

computer file  
 C:\Users\et\Documents\2019\22\22-06-4-0000\_v06.dwg

project number  
**2019.00606.006**

scale  
**1 : 1000 @A1**

drawing number  
**RSH-AHR-ZZ-06-DR-A-00002**

rev  
**P1**

issue status  
**P1**

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**Departments (Lv01)**



- Key**
- - - Indicates Site Boundary
  - Departments - Existing**
  - Antenatal
  - Boiler House
  - Catering
  - Escalation
  - Estates
  - Faculty of Health
  - Fert & EPAS
  - Fracture Clinic
  - GU Clinic
  - Hamar Centre
  - Hummingbird
  - Learning Centre
  - Maternity Generator
  - Medical Assessment Unit
  - Old Finance
  - OPD
  - Path Lab
  - Radiotherapy
  - Renal
  - Shropdoc
  - Stores
  - Theatres
  - Treatment Centre
  - Departments - Proposed**
  - Acute Medical Unit
  - Communication Space
  - Entrance
  - Gynaecology
  - Plant Heating
  - Support

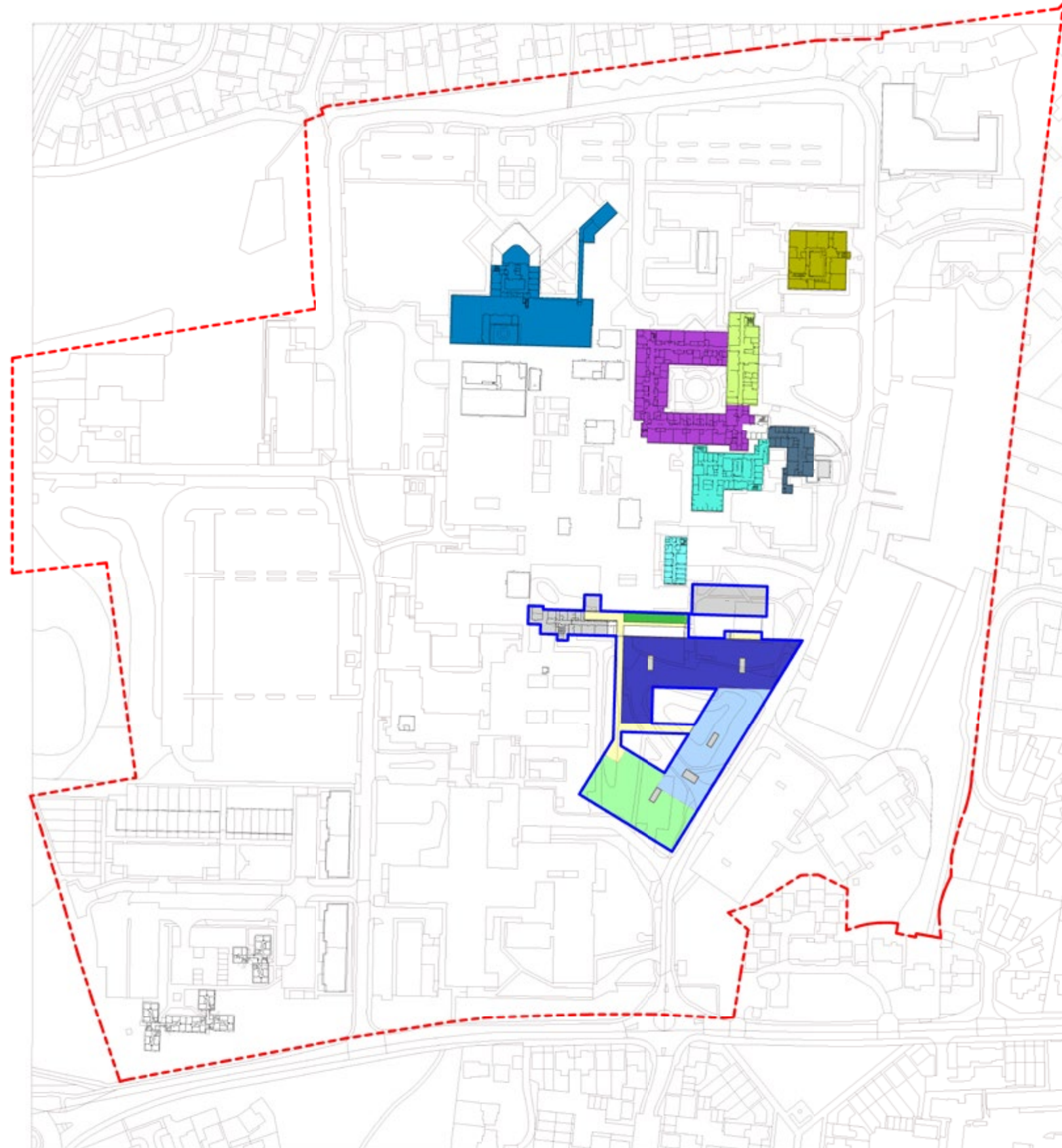
P2	Drawing updated	15.12.22	ETU	GB
P1	Initial Issue	18.11.22	ETU	CP
Rev	Description	Date	Dr	App
			By	By
original by		date created		approved by
ETU		11/18/22		CP

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client name	Shrewsbury & Telford Hospitals NHS Trust
project	Hospital Transformation Programme - Royal Shrewsbury hospital
drawing	Level 01 - Site Wide Plan - Alternative Option 2023
computer file	C:\Users\et\Documents\RSH-AHR-ZZ-01-A-0004.dwg
project number	2019.00606.006
drawing number	RSH-AHR-ZZ-01-DR-A-00004
scale	1 : 1000 @A1
rev	P2
issue status	

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**Departments (Lv02)**



- Key**
- - - Indicates Site Boundary
  - Departments - Existing**
  - Colorectal Surgery  
Gastroenterology
  - Urology  
Vascular
  - Departments - Proposed**
  - Communication Space (In Construction)
  - Birthing (In Construction)
  - Inpatient (In Construction)
  - Neonatal (In Construction)
  - Plant Heating (In Construction)
  - Walker Suite (In Construction)

P2	Drawing updated	15.12.22	ETU	GB
P1	Initial Issue	18.11.22	ETU	CP
Rev	Description	Date	Dr	App
			By	By
original by		date created		approved by
ETU		11/18/22		CP



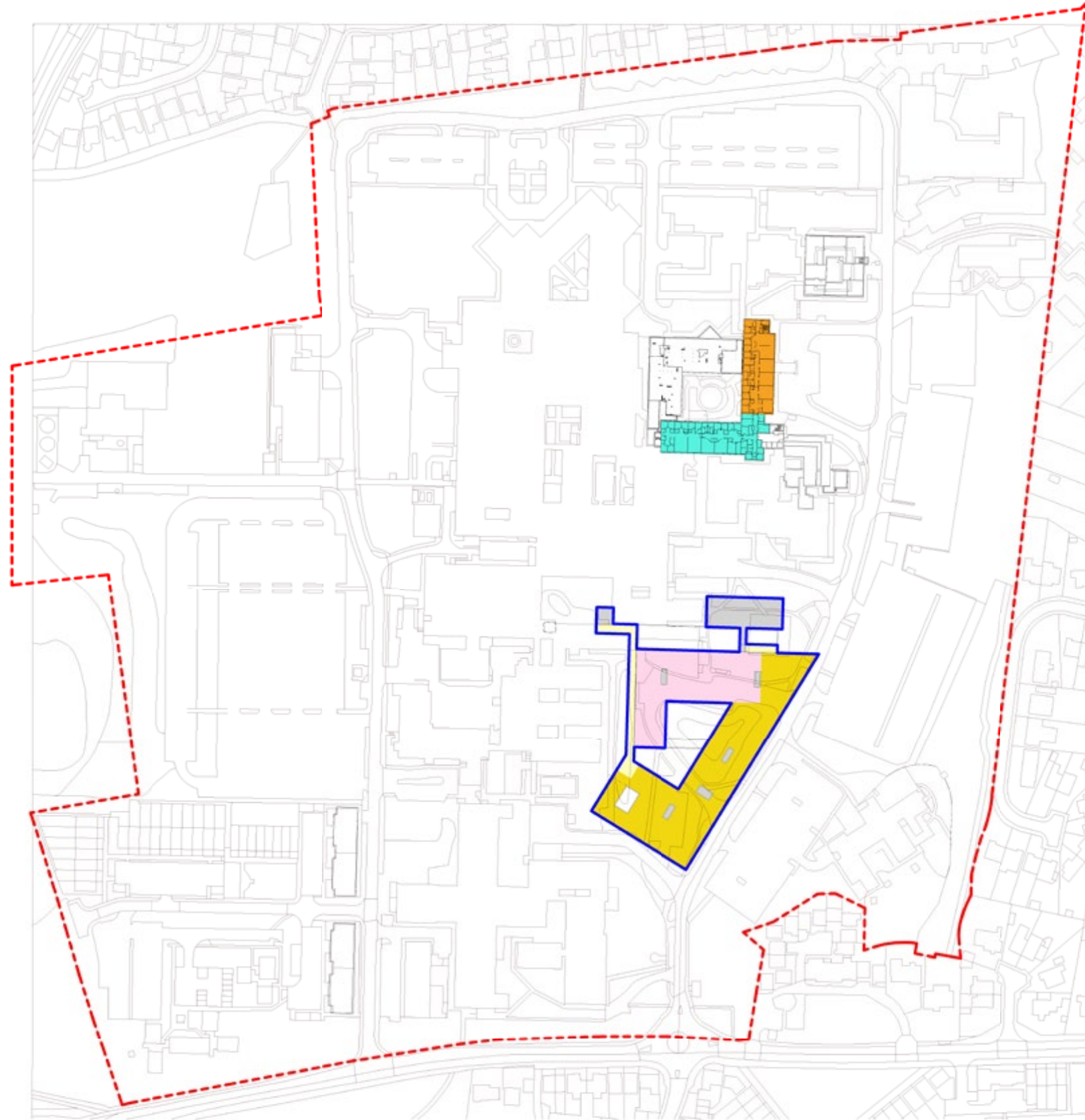
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client name	Shrewsbury & Telford Hospitals NHS Trust
project	Hospital Transformation Programme - Royal Shrewsbury hospital
drawing	Level 02 - Site Wide Plan - Alternative Option 2023
computer file	C:\Users\etj\Documents\SH-AHR-ZZ-02-A-0004.dwg
project number	2019.00606.006
drawing number	RSH-AHR-ZZ-02-DR-A-00004
scale	1 : 1000 @A1
rev	P2
issue status	

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**Departments (Lv03)**

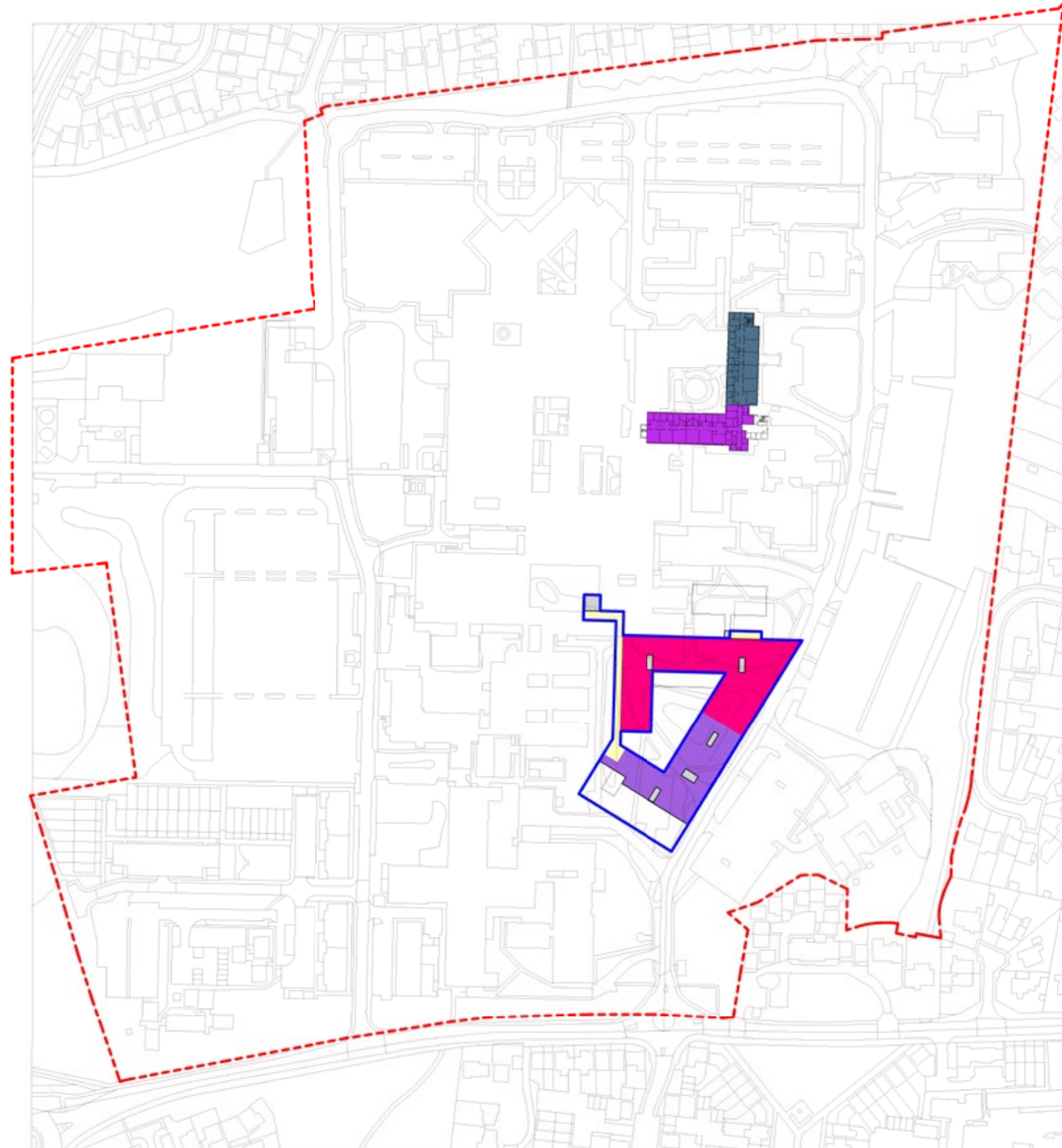


- Key**
- - - Indicates Site Boundary
  - Departments - Existing**
  - Cardiology  
Endocrinology  
Critical Care Unit
  - Oncology  
Haematology
  - Departments - Proposed**
  - Childrens Centre (In Construction)
  - Communication Space (In Construction)
  - Maternity Inpatients (In Construction)
  - Plant (In Construction)

P2	Drawing updated	15.12.22	ETU	GB
P1	Initial Issue	18.11.22	ETU	CP
Rev	Description	Date	Dr	App
			By	By
original by		date created		approved by
ETU		11/18/22		CP

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client name	Shrewsbury & Telford Hospitals NHS Trust		
project	Hospital Transformation Programme - Royal Shrewsbury hospital		
drawing	Level 03 - Site Wide Plan - Alternative Option 2023		
computer file	C:\clients\00unvest\04\03\22\04-0000_uk\ahs.lxd	plot date	
project number	2019.00606.006	scale	1 : 1000 @A1
drawing number	RSH-AHR-ZZ-03-DR-A-00004	rev	P2
		issue status	
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**Departments (Lv04)**



- Key**
- - - Indicates Site Boundary
  - Colorectal Surgery  
Gastroenterology
  - Urology  
Vascular
- Departments - Proposed**
- Communication Space (In Construction)
  - Critical Care Unit (In Construction)
  - Inpatient Haematology (In Construction)

P2	Drawing updated	15.12.22	ETU	GB
P1	Initial Issue	18.11.22	ETU	CP
Rev	Description	Date	Dr by	App by
original by	date created		approved by	
ETU	11/10/22		CP	

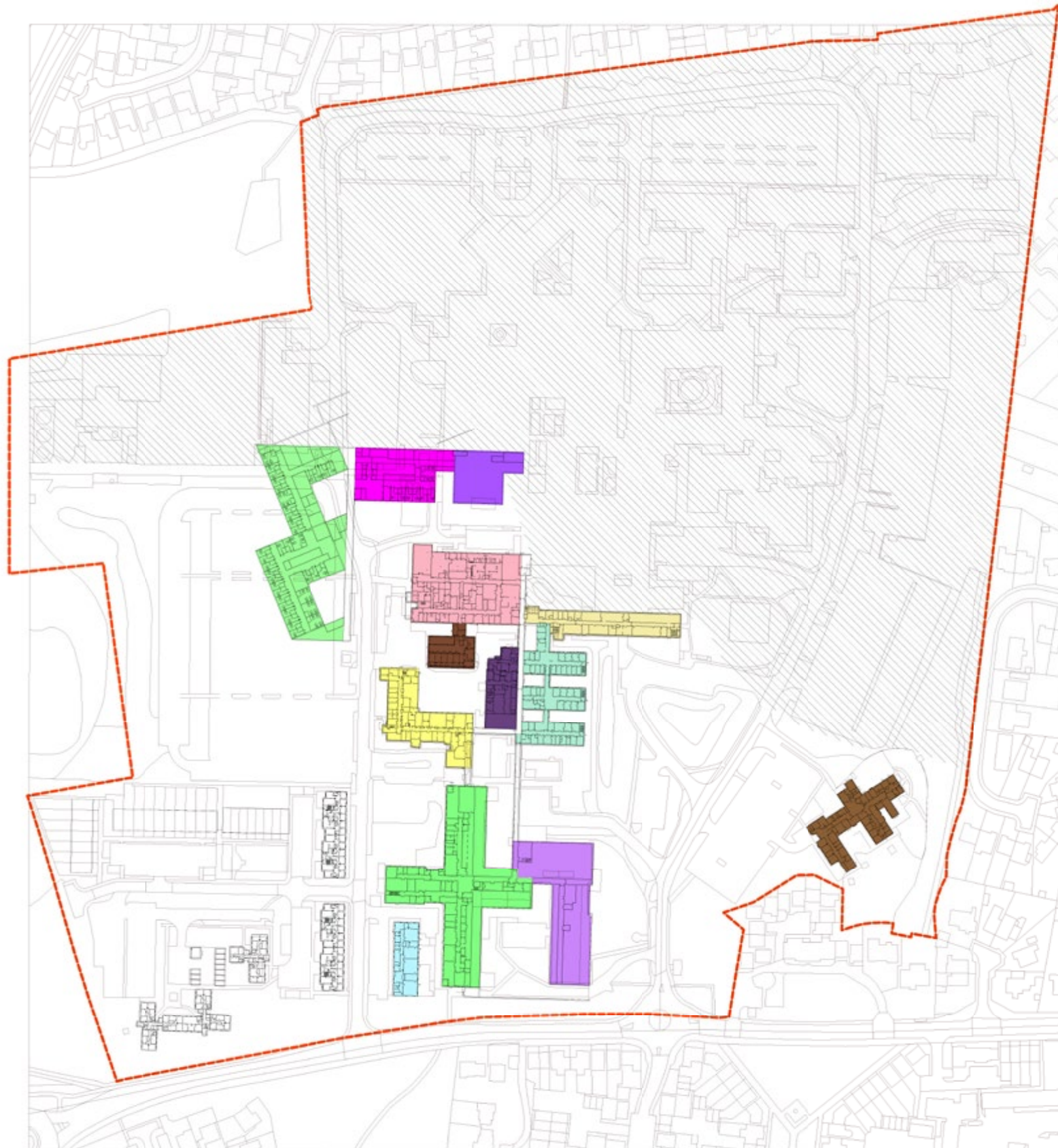


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client name	Shrewsbury & Telford Hospitals NHS Trust
project	Hospital Transformation Programme - Royal Shrewsbury hospital
drawing	Level 04 - Site Wide Plan - Alternative Option 2023
computer file	C:\Users\etw\Documents\RSH-AHR-ZZ-04-A-0004_04.dwg
project number	2019.00606.006
drawing number	RSH-AHR-ZZ-04-DR-A-00004
scale	1 : 1000 @A1
rev	P2
issue status	

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### Departments (Lv00)



- Key**
- Indicates Site Boundary
- Departments - Existing**
- Admin Level 0 (Medical Records)
  - Basement Wards
  - Basement (Antenatal Clinic)
  - Cardiac Rehab Staff Support
  - Clinics 5-6-7-8
  - Faculty of Health
  - Mytton Oak Unit
  - Nursery
  - Path Lab
  - Pharmacy
- Departments - Proposed**
- Stores
  - Inpatient Wards
  - Treatment

Rev	Initial	Description	Date	Dr By	CP
P1		Initial Issue	18.11.22	ETU	CP
original by	ETU		date created	18/11/22	approved by
				CP	



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client name	
Shrewsbury & Telford Hospitals NHS Trust	
project	
Hospital Transformation Programme - Royal Shrewsbury hospital	
drawing	
Level 00 - Site Wide Plan - SOC Option	
computer file	plot date
C:\Users\etun\Documents\RSH-AHR-ZZ-00-A-0003_splan.dwg	
project number	scale
2019.00606.006	1 : 1000 @A1
drawing number	rev
RSH-AHR-ZZ-00-DR-A-00003	P1
	issue status

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**Departments (Lv01)**



- Key**
- - - Indicates Site Boundary
- Departments - Existing**
- Antenatal
  - Boiler House
  - Catering (Demolished)
  - Escalation
  - Estates (Demolished)
  - Faculty of Health
  - Fert & EPAS
  - Fracture Clinic
  - GU Clinic
  - Hamar Centre
  - Hummingbird
  - Learning Centre
  - Maternity Generator
  - Medical Assessment Unit
  - Old Finance
  - OPD
  - Path Lab
  - Radiotherapy
  - Renal
  - Shropdoc
  - Stores (Demolished)
  - Theatres
  - Treatment Centre
- Departments - Proposed**
- ED
  - Inpatient Wards
  - MAU
  - Oncology & Adolescent

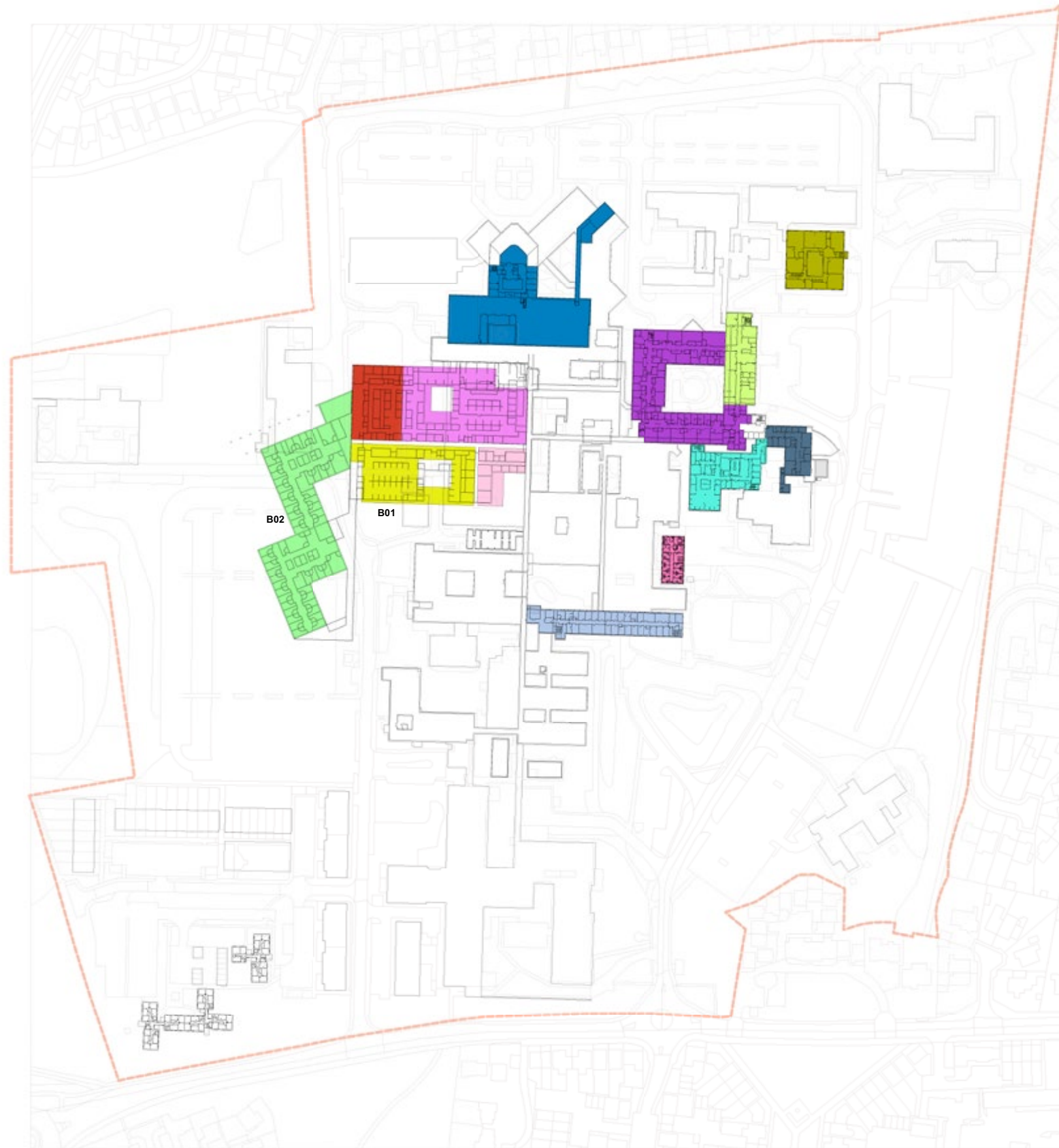
Rev	Initial Issue	Description	Date	Dr	App	CP
original by	ETU		date created	18/11/22	Dr	CP
					approved by	

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client name	Shrewsbury & Telford Hospitals NHS Trust		
project	Hospital Transformation Programme - Royal Shrewsbury hospital		
drawing	Level 01 - Site Wide Plan - SOC Option		
computer file	C:\Users\etw\OneDrive\AHR\ZZ-01-DR-A-00003_splan.dwg	plot date	
project number	2019.00606.006	scale	1 : 1000 @A1
drawing number	RSH-AHR-ZZ-01-DR-A-00003	rev	P1
		issue status	

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Departments (Lv02)



- Key**
- - - Indicates Site Boundary
- Departments - Existing**
- Faculty of Health
  - Haematology
  - OPD (Admin Level)
  - Shropdoc
  - S&R  
Trauma & Ortho  
Care of Elderly  
Urology (Ward 21)
  - Treatment Centre
  - Ward Block  
(Entrance/ Offices/ Support)
- Departments - Proposed**
- Delivery + MLU
  - Gynaecology
  - Neonatal Suites
  - Inpatient Wards
  - Theatres

Rev	Initial Issue	Date	ETU	CP
original by		date created	18/11/22	approved by
ETU				CP

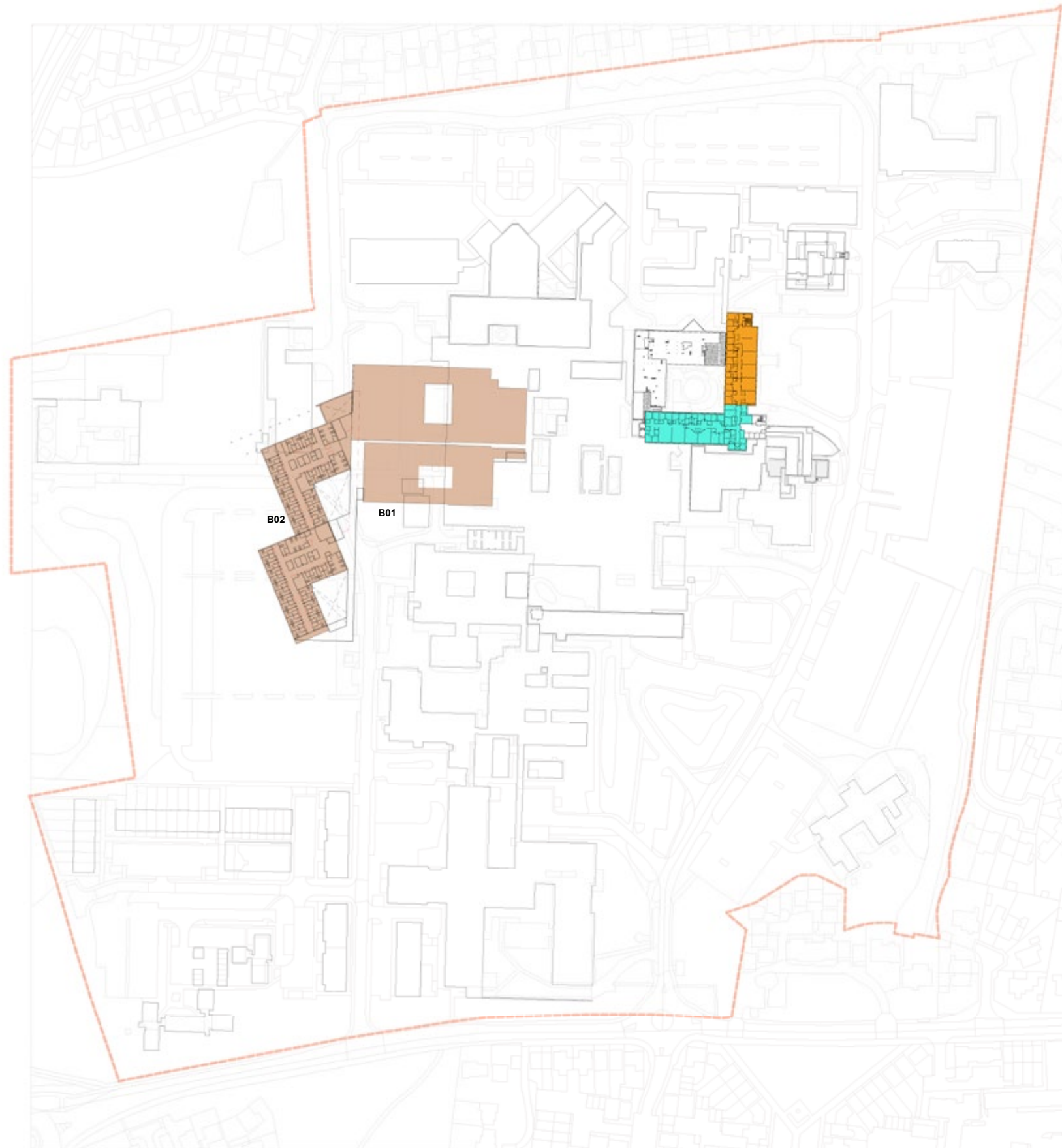



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client name	Shrewsbury & Telford Hospitals NHS Trust		
project	Hospital Transformation Programme - Royal Shrewsbury hospital		
drawing	Level 02 - Site Wide Plan - SOC Option		
computer file	C:\Users\jill\Documents\2019-00606-0000\2019-00606-0000.dwg		
project number	2019.00606.006	scale	1 : 1000 @A1
drawing number	RSH-AHR-ZZ-02-DR-A-00003	rev	P1
		issue status	

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



**Departments (Lv03)** 


**Key**

- - - Indicates Site Boundary

**Departments - Existing**

-  Cardiology
-  Endocrinology
-  CCU
-  Oncology
-  Haematology

**Departments - Proposed**

-  Maternity

Rev	Initial Issue	Description	Date	Dr by	App by	CP
original by	ETU	date created	18/11/22		approved by	CP

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client name	Shrewsbury & Telford Hospitals NHS Trust		
project	Hospital Transformation Programme - Royal Shrewsbury hospital		
drawing	Level 03 - Site Wide Plan - SOC Option		
computer file	C:\shrewsbury\Documents\RSH-AHR-ZZ-03-DR-A-0000_ahm1.rvt	plot date	
project number	2019.00606.006	scale	1 : 1000 @A1
drawing number	RSH-AHR-ZZ-03-DR-A-00003	rev	P1
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**Notes**

Key  
 - - - - - Indicates Site Boundary

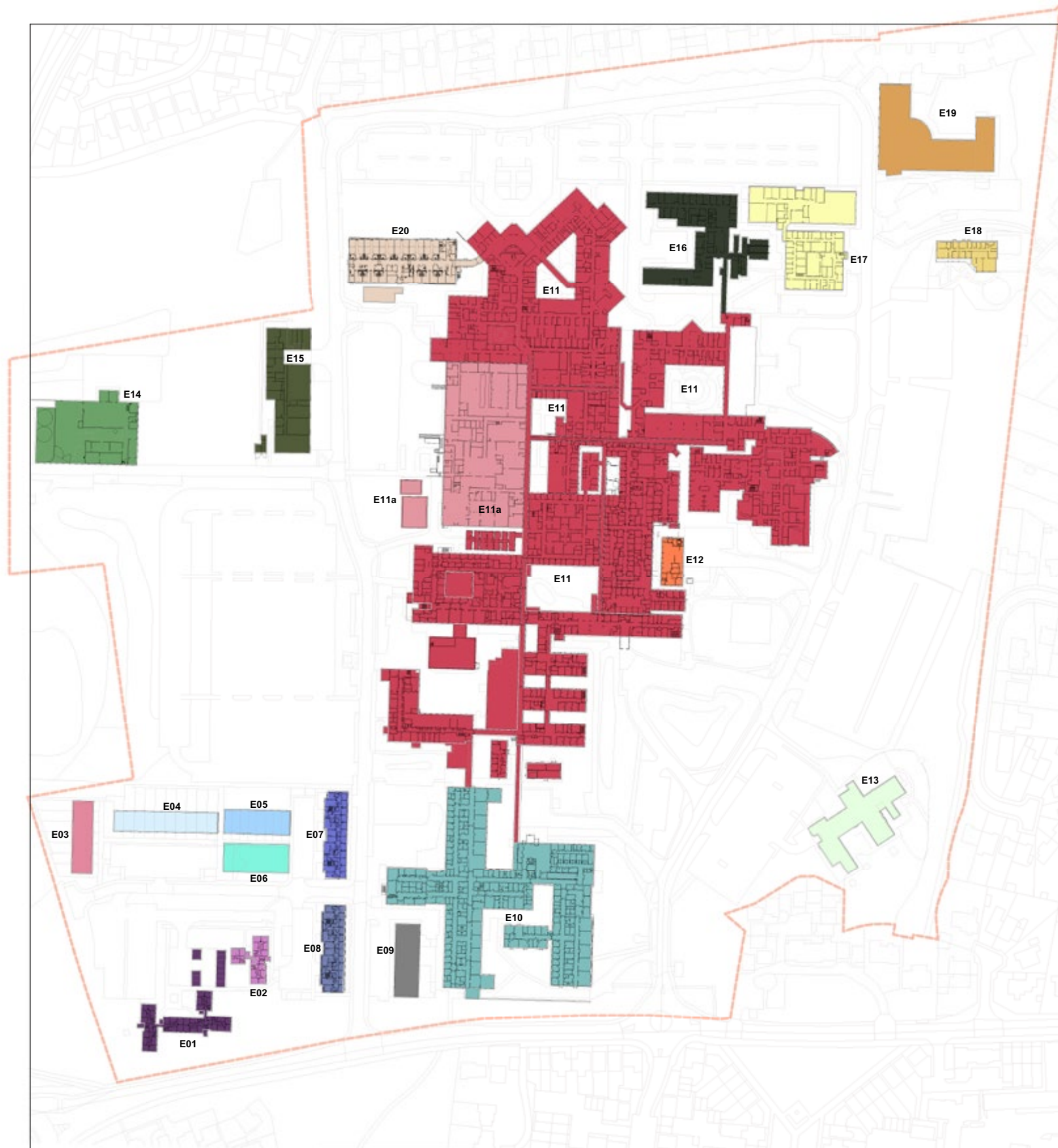
- Existing - Volumes**
- Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Stretton House - Block 1
  - Existing - Stretton House - Block 2
  - Existing - Daisy Chain Nursery
  - Existing - Copthorne Building
  - Existing - Main Building
  - Existing - Main Building Surveyors model volume to replace part of E11 once provided
  - Existing - Main Building
  - Existing - SDEC
  - Existing - Boiler House
  - Existing - Estates Building
  - Existing - Hummingbird Building
  - Existing - Faculty of Health & Learning Centre
  - Existing - Hamar Centre
  - Existing - Shropshire Education & Conference Centre
  - Existing - Ward 37 & Treatment Centre
- Proposed - Volumes**
- Proposed Building 01 - Treatment Volume (Includes Shell & Core Model and Interior Model Defined by Sequence Number)
  - Proposed Building 02 - Inpatient Volume (Includes Shell & Core Model and Interior Model Defined by Sequence Number)
  - Proposed Building 03 - Energy Centre
  - Proposed Building 04 - Multi-Storey Car Park

Rev	Initial Issue	Date	Dr by	App by	CP
ETU	original by	18/11/22	ETU	CP	
	date created	18/11/22		approved by	CP

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client name	Shrewsbury & Telford Hospitals NHS Trust		
project	Hospital Transformation Programme - Royal Shrewsbury hospital		
drawing	Level 00 - Site Wide Plan - By Existing Volumes		
computer file	C:\Users\j\Documents\SHR\2019\2019-00000_ahrl\lvt	plot date	
project number	2019.00606.006	scale	1 : 1000 @A1
drawing number	RSH-AHR-ZZ-00-DR-A-00001	rev	P1 issue status
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**Notes**

Key  
 - - - - - Indicates Site Boundary

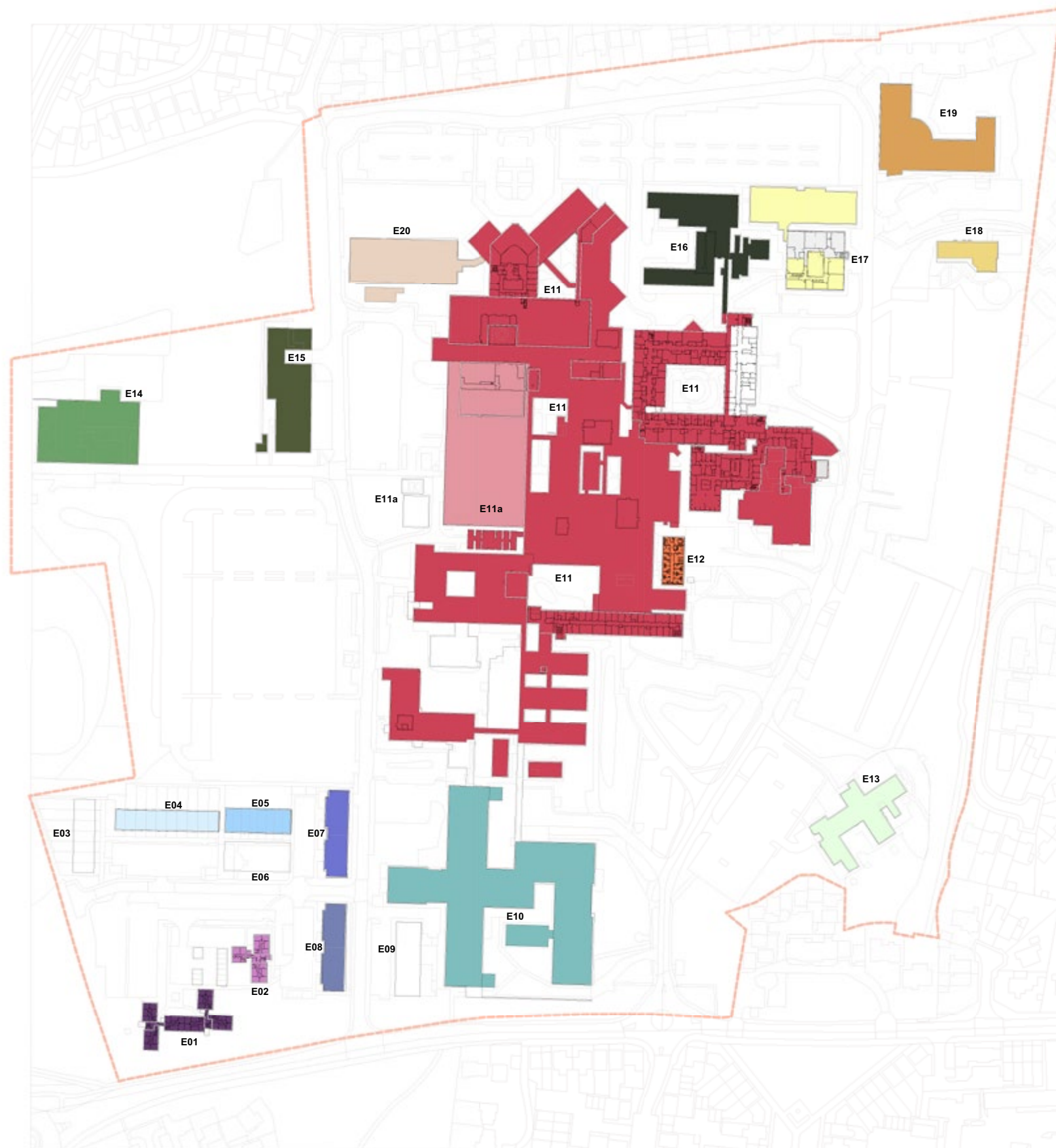
- Existing - Volumes**
- Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Stretton House - Block 1
  - Existing - Stretton House - Block 2
  - Existing - Daisy Chain Nursery
  - Existing - Copthorne Building
  - Existing - Main Building
  - Existing - Main Building Surveyors model volume to replace part of E11 once provided
  - Existing - Main Building
  - Existing - SDEC
  - Existing - Boiler House
  - Existing - Estates Building
  - Existing - Hummingbird Building
  - Existing - Faculty of Health & Learning Centre
  - Existing - Hamar Centre
  - Existing - Shropshire Education & Conference Centre
  - Existing - Ward 37 & Treatment Centre
- Proposed - Volumes**
- Proposed Building 01 - Treatment Volume (Includes Shell & Core Model and Interior Model Defined by Sequence Number)
  - Proposed Building 02 - Inpatient Volume (Includes Shell & Core Model and Interior Model Defined by Sequence Number)
  - Proposed Building 03 - Energy Centre
  - Proposed Building 04 - Multi-Storey Car Park

Rev	Initial Issue	18.11.22	ETU	CP
original by	ETU	date created	18/11/22	approved by
				CP

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client name	Shrewsbury & Telford Hospitals NHS Trust
project	Hospital Transformation Programme - Royal Shrewsbury hospital
drawing	Level 01 - Site Wide Plan - By Existing Volumes
computer file	C:\shrewsbury\Documents\RSH-AHR-ZZ-01-DR-A-00001.dwg
project number	2019.00606.006
scale	1 : 1000 @A1
drawing number	RSH-AHR-ZZ-01-DR-A-00001
rev	P1
issue status	

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Notes



- Key
- - - - - Indicates Site Boundary
- Existing - Volumes
- Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Accommodation Block
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  - Existing - Stretton House - Block 2
  - Existing - Daisy Chain Nursery
  - Existing - Copthorne Building
  - Existing - Main Building
  - Existing - Main Building Surveyors model volume to replace part of E11 once provided
  - Existing - Main Building
  - Existing - SDEC
  - Existing - Boiler House
  - Existing - Estates Building
  - Existing - Hummingbird Building
  - Existing - Faculty of Health & Learning Centre
  - Existing - Hamar Centre
  - Existing - Shropshire Education & Conference Centre
  - Existing - Ward 37 & Treatment Centre
- Proposed - Volumes
- Proposed Building 01 - Treatment Volume (Includes Shell & Core Model and Interior Model Defined by Sequence Number)
  - Proposed Building 02 - Inpatient Volume (Includes Shell & Core Model and Interior Model Defined by Sequence Number)
  - Proposed Building 03 - Energy Centre
  - Proposed Building 04 - Multi-Storey Car Park

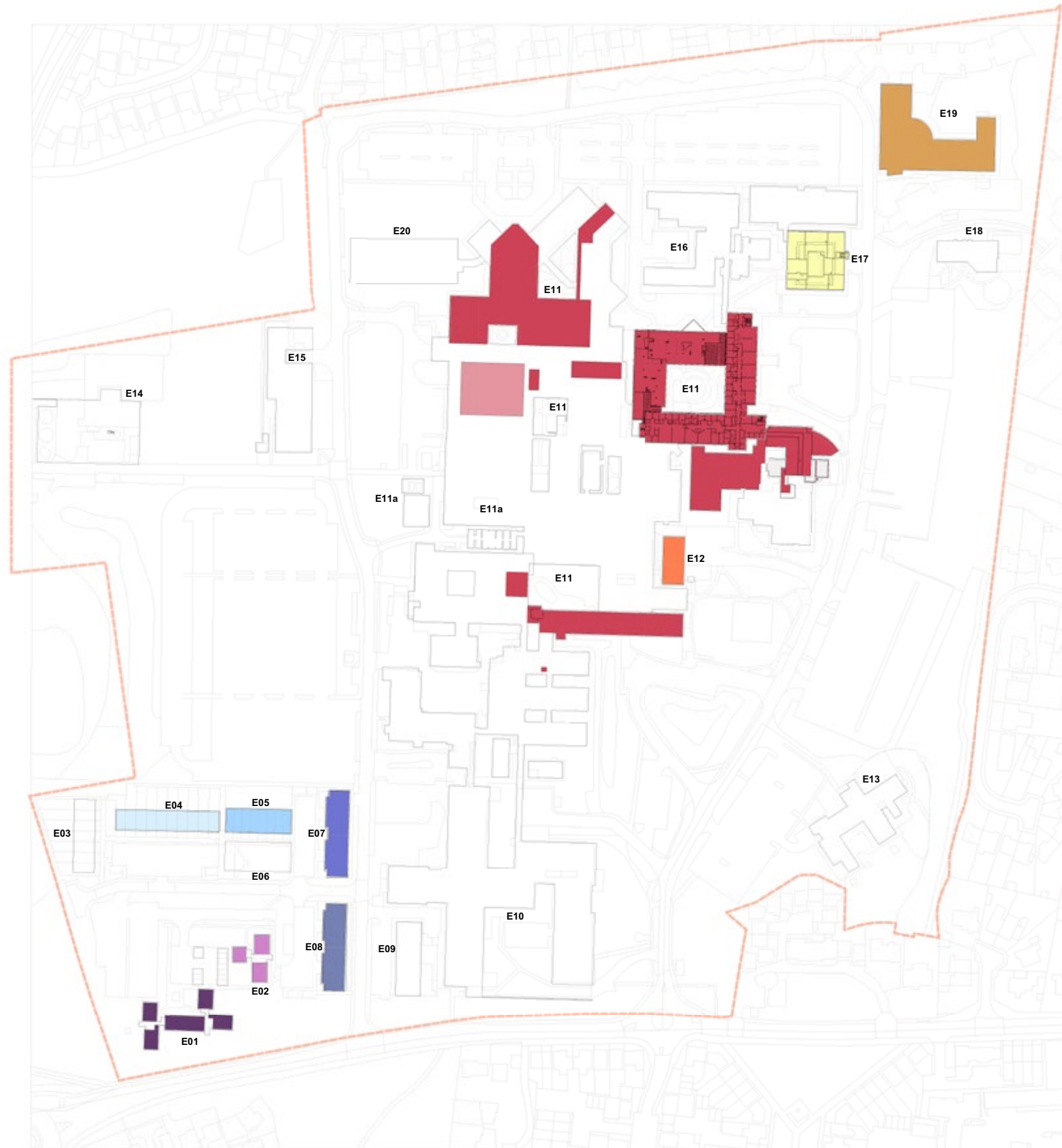
Rev	Initial Issue	Description	Date	Dr By	CP By
original by	ETU		18/11/22		CP

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client name	Shrewsbury & Telford Hospitals NHS Trust		
project	Hospital Transformation Programme - Royal Shrewsbury hospital		
drawing	Level 02 - Site Wide Plan - By Existing Volumes		
computer file	C:\Users\ellen@Documents\SH-AHR-ZZ-02-A-0000_ahm.dwg	plot date	
project number	2019.00606.006	scale	1 : 1000 @A1
drawing number	RSH-AHR-ZZ-02-DR-A-00001	rev	P1
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**Notes**



- Key**
- - - - - Indicates Site Boundary
  - Existing - Volumes
  - Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Accommodation Block
  - Existing - Stretton House - Block 1
  - Existing - Stretton House - Block 2
  - Existing - Daisy Chain Nursery
  - Existing - Copthorne Building
  - Existing - Main Building
  - Existing - Main Building Surveyors model volume to replace part of E11 once provided
  - Existing - Main Building
  - Existing - SDEC
  - Existing - Boiler House
  - Existing - Estates Building
  - Existing - Hummingbird Building
  - Existing - Faculty of Health & Learning Centre
  - Existing - Hamar Centre
  - Existing - Shropshire Education & Conference Centre
  - Existing - Ward 37 & Treatment Centre
  - Proposed - Volumes
  - Proposed Building 01 - Treatment Volume (Includes Shell & Core Model and Interior Model Defined by Sequence Number)
  - Proposed Building 02 - Inpatient Volume (Includes Shell & Core Model and Interior Model Defined by Sequence Number)
  - Proposed Building 03 - Energy Centre
  - Proposed Building 04 - Multi-Storey Car Park

Rev	Initial Issue	Date	Dr	ETU	CP
original		18/11/22	ETU	CP	
ETU		18/11/22	ETU	CP	



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client name	Shrewsbury & Telford Hospitals NHS Trust		
project	Hospital Transformation Programme - Royal Shrewsbury hospital		
drawing	Level 03 - Site Wide Plan - By Existing Volumes		
computer file	C:\shrewsbury\Documents\RSH-AHR-ZZ-03-A-0000_uklan.rvt	plot date	
project number	2019.00606.006	scale	1 : 1000 @A1
drawing number	RSH-AHR-ZZ-03-DR-A-00001	rev	P1

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Notes



Key

--- Indicates Site Boundary

Existing - Volumes

- Existing - Accommodation Block
- Existing - Accommodation Block
- Existing - Accommodation Block
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- Existing - Accommodation Block
- Existing - Accommodation Block
- Existing - Stretton House - Block 1
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- Existing - Main Building
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- Existing - Main Building
- Existing - SDEC
- Existing - Boiler House
- Existing - Estates Building
- Existing - Hummingbird Building
- Existing - Faculty of Health & Learning Centre
- Existing - Hamar Centre
- Existing - Shropshire Education & Conference Centre
- Existing - Ward 37 & Treatment Centre

Proposed - Volumes

- Proposed Building 01 - Treatment Volume (Includes Shell & Core Model and Interior Model Defined by Sequence Number)
- Proposed Building 02 - Inpatient Volume (Includes Shell & Core Model and Interior Model Defined by Sequence Number)
- Proposed Building 03 - Energy Centre
- Proposed Building 04 - Multi-Storey Car Park

P1	Initial Issue	18.11.22	ETU	CP
Rev	Description	Date	Dr	App
			by	by
original by		date created	18/11/22	approved by
ETU				CP



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client name	
Shrewsbury & Telford Hospitals NHS Trust	
project	
Hospital Transformation Programme - Royal Shrewsbury hospital	
drawing	
Level 04 - Site Wide Plan - By Existing Volumes	
computer file	plot date
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drawing number	rev
RSH-AHR-ZZ-04-DR-A-00001	P1
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Notes



Key  
 - - - - - Indicates Site Boundary

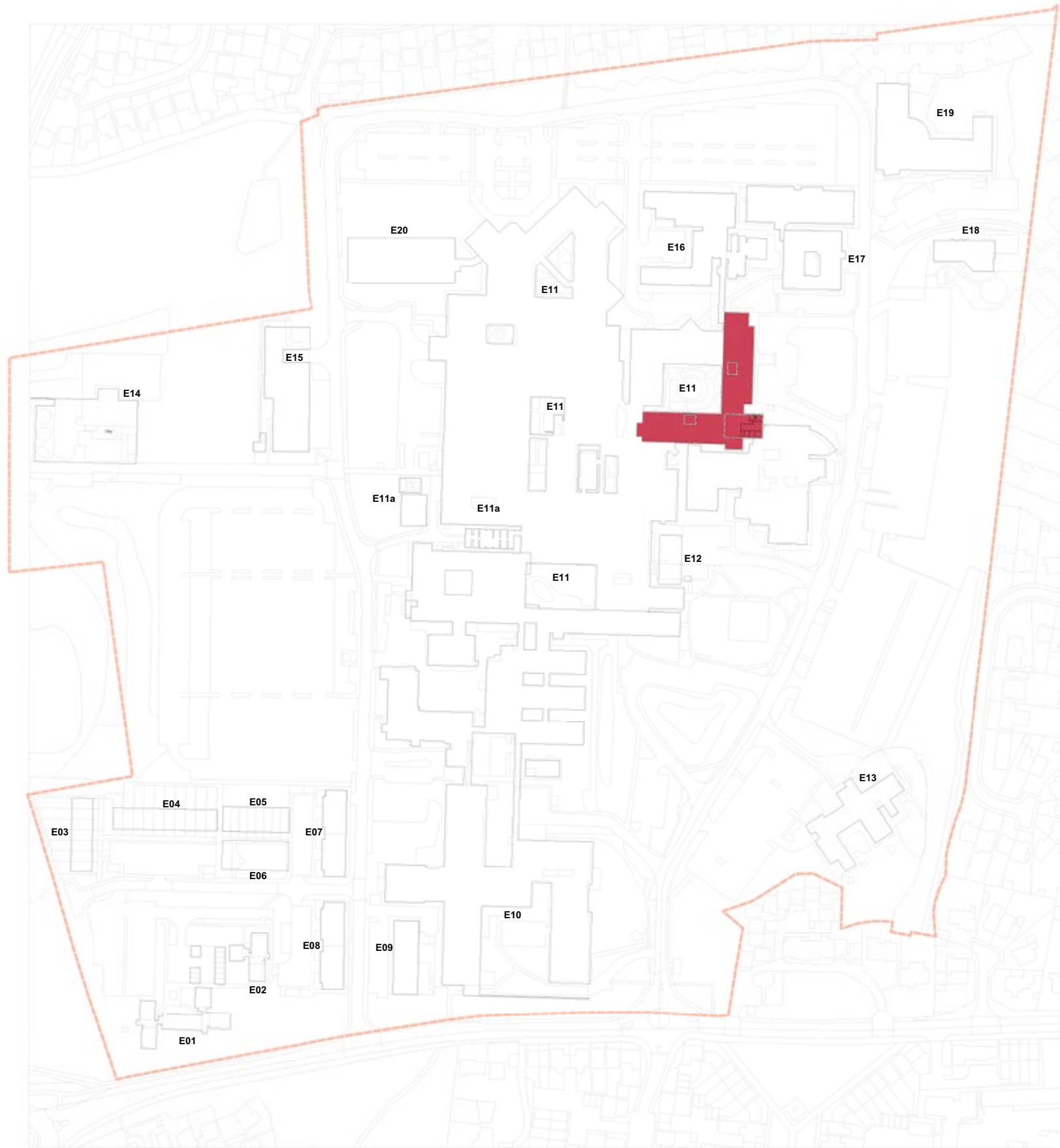
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Rev	Initial Issue	Date	ETU	CP
original by	ETU	18/11/22	Dr	App
date created	ETU	18/11/22	Dr	App
approved by	CP			



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 M2 4EW  
 United Kingdom

client name	Shrewsbury & Telford Hospitals NHS Trust		
project	Hospital Transformation Programme - Royal Shrewsbury hospital		
drawing	Level 05 - Site Wide Plan - By Existing Volumes		
computer file	C:\shrewsbury\Documents\RSH-AHR-ZZ-05-A-0001_wlan.rvt	plot date	
project number	2019.00606.006	scale	1 : 1000 @A1
drawing number	RSH-AHR-ZZ-05-DR-A-00001	rev	P1 issue status
<small>This drawing is to be read in conjunction with all related drawings. All dimensions must be checked and verified on site before commencing any work or producing shop drawings. The originator should be notified immediately of any discrepancy. This drawing is copyright and remains the property of AHR.</small>			



Notes



Key  
 - - - - - Indicates Site Boundary

- Existing - Volumes**
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  - Existing - Accommodation Block
  - Existing - Accommodation Block
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  - Proposed Building 04 - Multi-Storey Car Park

Rev	Initial Issue	Date	ETU	CP
original by	ETU	18/11/22	approved by	CP



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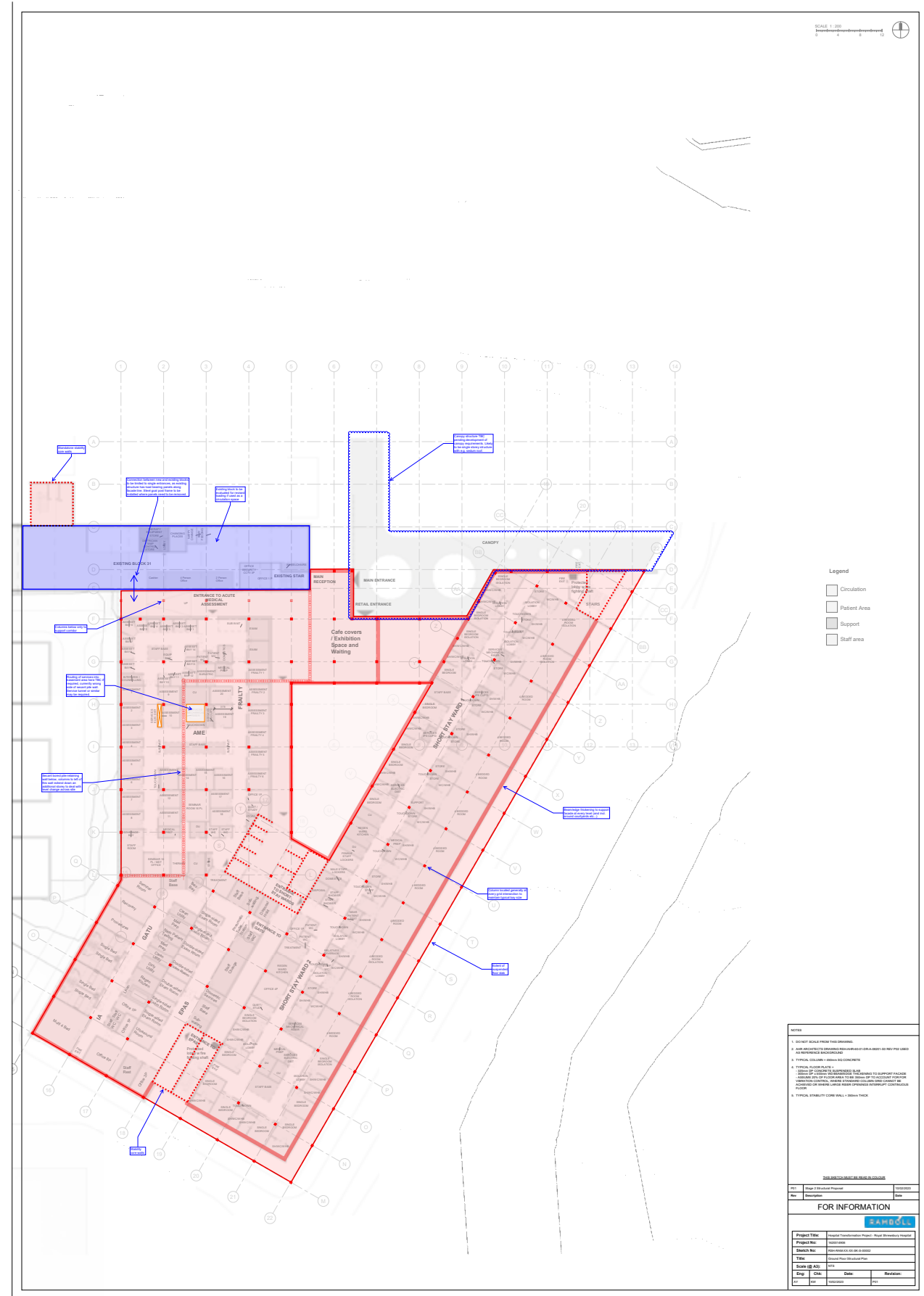
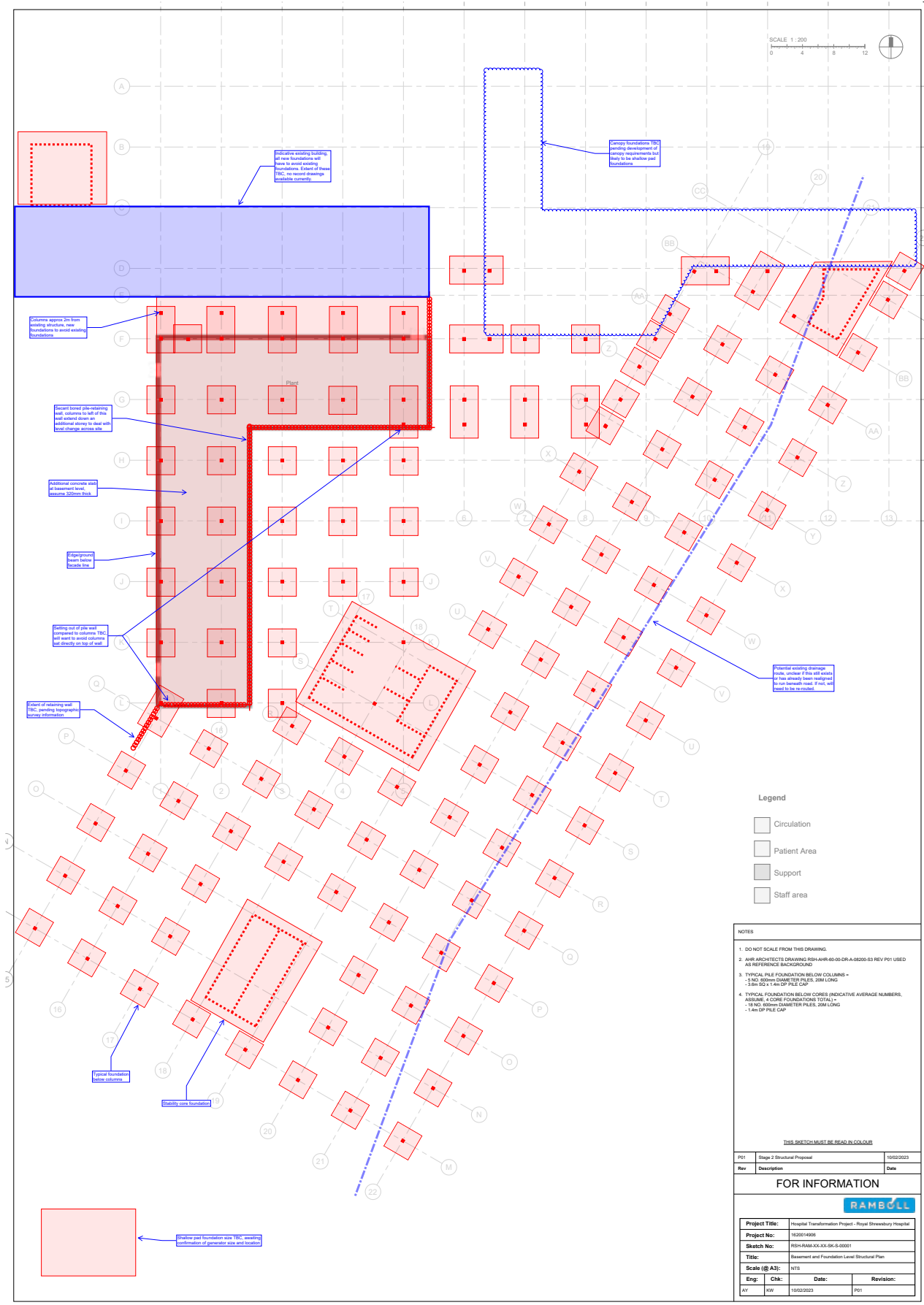
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project	Hospital Transformation Programme - Royal Shrewsbury hospital
drawing	Level 06 - Site Wide Plan - By Existing Volumes
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drawing number	RSH-AHR-ZZ-06-DR-A-00001
rev	P1
issue status	

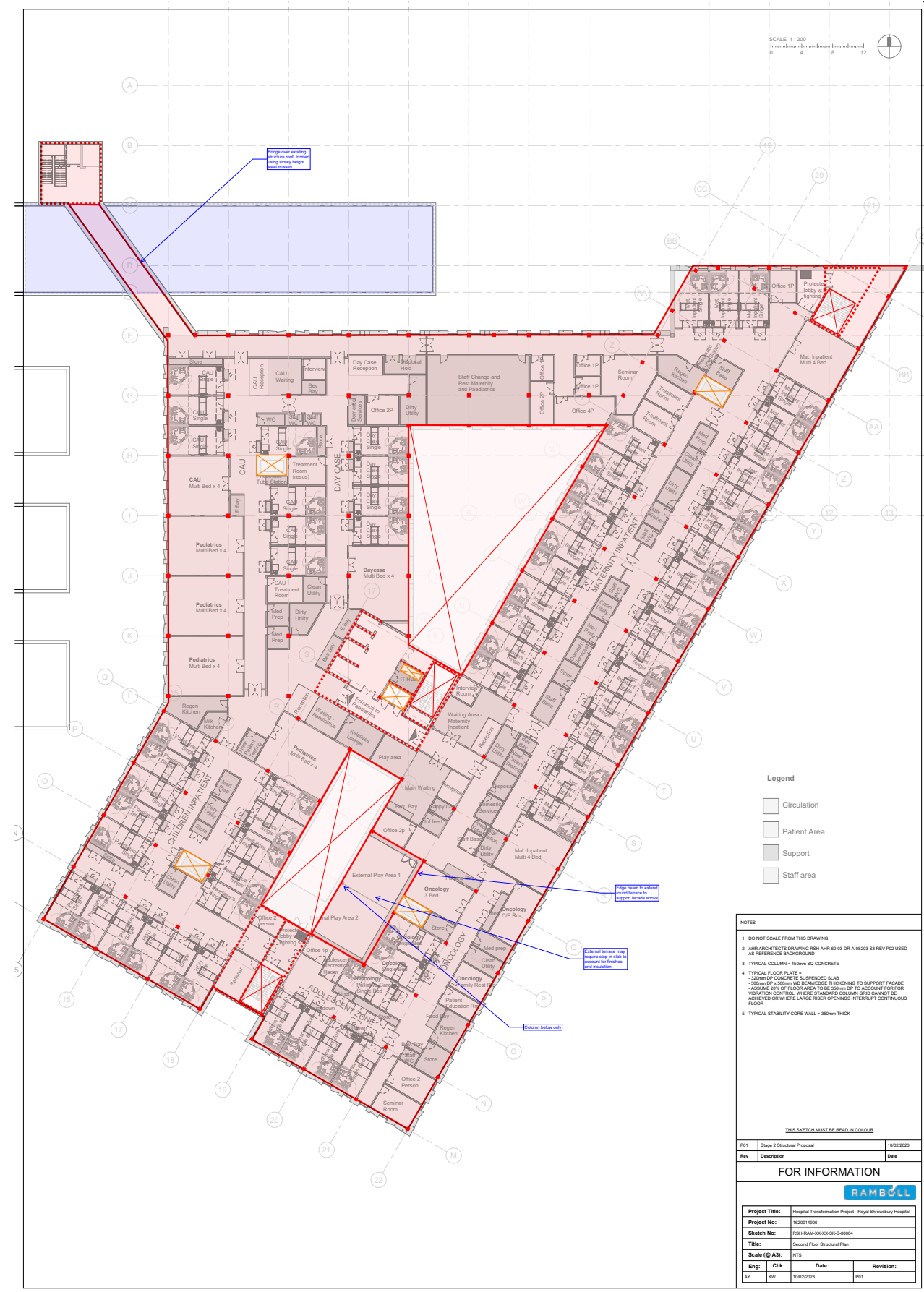
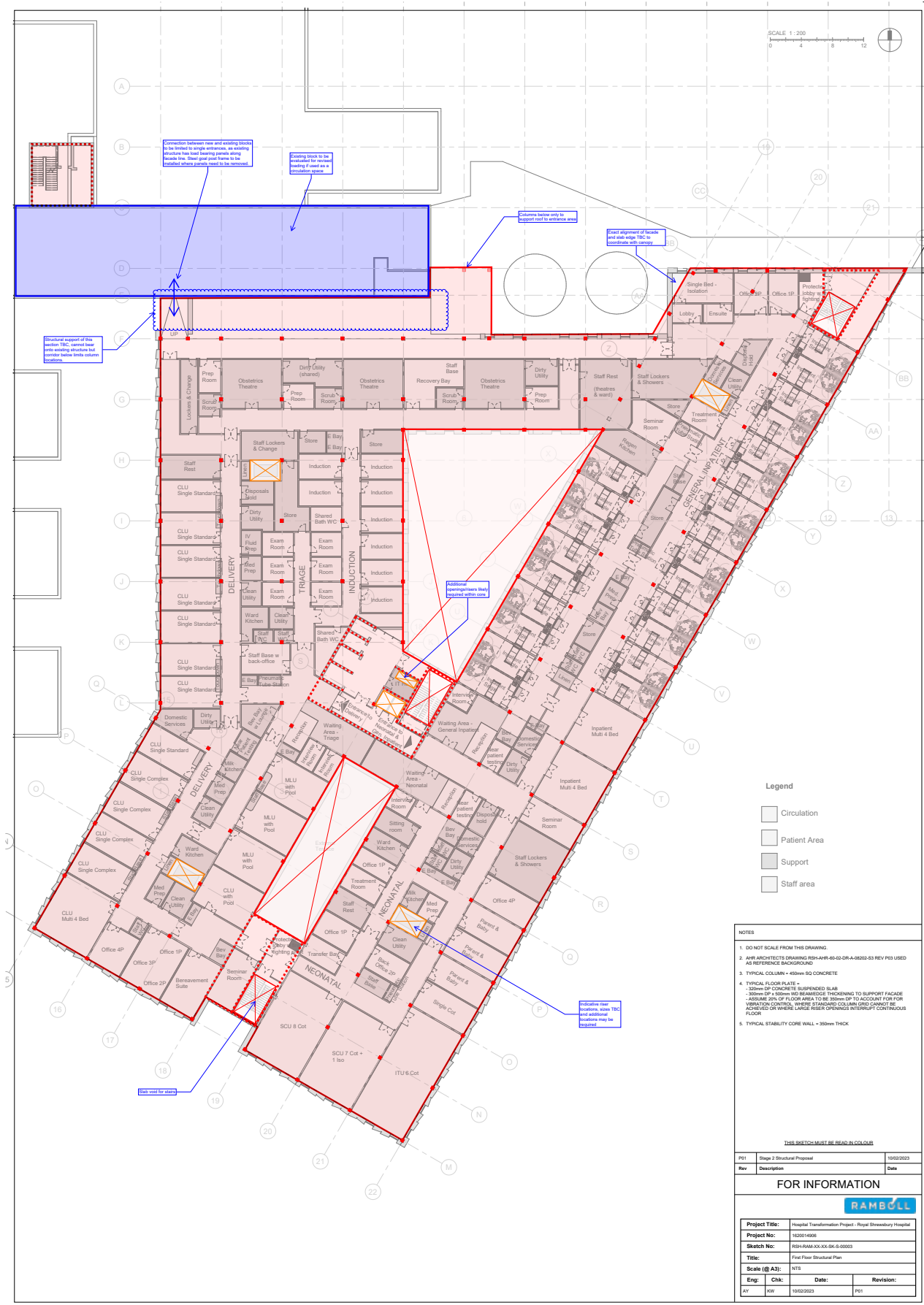
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# Appendix C

# Structural

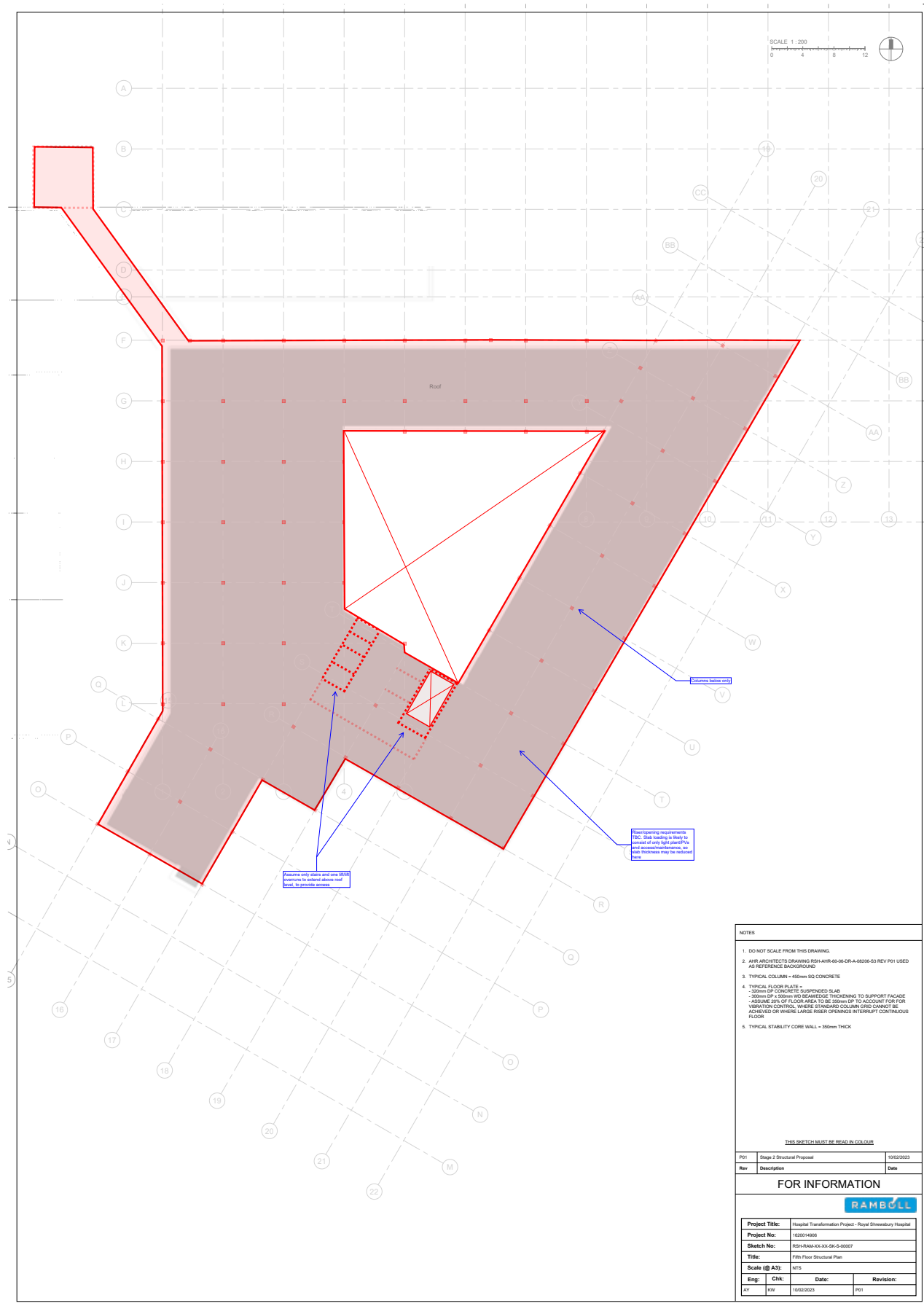












**NOTES**

- DO NOT SCALE FROM THIS DRAWING.
- ANY ARCHITECTS DRAWING RSH-AH40-00-OR-A800-03 REV P01 USED AS REFERENCE BACKGROUND.
- TYPICAL COLUMN = 400mm SQ CONCRETE.
- TYPICAL FLOOR PLATE =  
 - 300mm OF CONCRETE SUPPORTED SLAB  
 - 300mm DP x 80mm HD REBAR EDGE FRAMING TO SUPPORT FACIAE  
 - ASSUME 50% OF FLOOR AREA TO BE 300mm DP TO ACCOUNT FOR VIBRATION CONTROL, WHERE STANDARD COLUMN GRID CANNOT BE ACHIEVED OR WHERE LARGE REAR OPENING PERMIT CONTIGUOUS FLOOR
- TYPICAL STABILITY CORE WALL = 300mm THICK.

THIS SKETCH MUST BE READ IN COLOUR

Rev	Description	Date
P01	Stage 2 Structural Proposal	10/02/2023

**FOR INFORMATION**

**RAMBOLL**

Project Title:	Hospital Transformation Project - Royal Shrewsbury Hospital		
Project No:	162014906		
Sketch No:	RSH-RAM-XXX-00-06-00007		
Title:	Fifth Floor Structural Plan		
Scale (@ A3):	NTS		
Eng:	ChK:	Date:	Revision:
AV	KW	10/02/2023	P01



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T 01743 283 000



We approach every project with the same commitment to quality, excellence and integrity in all we do. Led by the principles of creating social value and promoting sustainability, we work to connect people, places and the environment.

## Hospital Transformation Programme

<b>Agenda item</b>				
<b>Report</b>	Procurement Process for the Appointments of the HTP Principal Supply Chain Partner			
<b>Executive Lead</b>	Director of Finance			
	<b>Link to strategic pillar:</b>		<b>Link to CQC domain:</b>	
	Our patients and community	√	Safe	
	Our people	√	Effective	√
	Our service delivery	√	Caring	
	Our partners	√	Responsive	
	Our governance	√	Well Led	
	<b>Report recommendations:</b>		<b>Link to BAF / risk:</b>	
	For assurance	√	<b>Link to risk register:</b>	
	For decision / approval			
	For review / discussion			
	For noting	√		
	For information	√		
	For consent			
<b>Presented to:</b>				
<b>Dependent upon</b> (if applicable):				
<b>Executive summary:</b>	<p>This paper summarises the procurement process for the appointment of the Principal Supply Chain Partner (PSCP) for the delivery of Hospital Transformation Programme.</p> <p>The ProCure23 (P23) design and construction framework is the chosen route to market and it is managed by NHSE and hosted by Crown Commercial Services.</p> <p>The framework encourages early informal engagement with PSCPs by Trust (Clients) to enable effective development of the</p> <p>The established process for competitive procurement under the framework considers both Qualitative and Price tenders from PSCPs and has a 15 step process leading to appointment and PSCP onboarding.</p>			
<b>Appendices:</b>	-			
<b>Lead Executive:</b>	HTP SRO			

### Contents

**1. P23 Call-Off Procedure**

**2. SaTH HTP Procurement decisions**

**1.0 P23 Call-Off Procedure**

# Lots 1 to 3 (P23)

# Schedule 04A Call Off Procedures

This schedule applies to Lots 1 to 3 (P23) and not schedule 04



## Contents

- 1. 3
- 2. 4
- 3. 10
- 4. 12
- 5. 13
- 6. 14
- 7. 14
- 8. 15



## Framework Call Off

- 1.1 If a Client wishes to purchase Works and Services under this Framework Agreement, it may do so in accordance with one of the following call-off procedures:
  - 1.1.1 for any Works and Services that are within the scope of this Framework Agreement, by way of conducting a Further Competition in accordance with the Further Competition Procedure;
  - 1.1.2 for certain additional Works and/or Services where the circumstances set out in paragraph 3 of this Schedule 4A (Call off Procedures) apply, by way of directly awarding a Project Agreement to the relevant PSCP in accordance with the relevant requirements set out in paragraph 3 of this Framework Schedule 4A (Call off Procedures);
  - 1.1.3 where the circumstances described in paragraph 4 of this Framework Schedule 4A (Call off Procedures) apply and a replacement contractor is needed on an urgent basis to carry out certain Works and Services covered by an Existing Scheme Agreement, by way of directly awarding a Scheme Agreement or Project Agreement to another PSCP in accordance with the relevant requirements set out in paragraph 4 of this Framework Schedule 4A (Call off Procedures);
  - 1.1.4 where the circumstances of extreme urgency described in paragraph 5 of this Framework Schedule 4A (Call off Procedures) apply, by way of directly awarding a Scheme Agreement or Project Agreement to a PSCP in accordance with the relevant requirements set out in paragraph 5 of this Framework Schedule 4A (Call off Procedures);
  - 1.1.5 when a Client awards a contract pursuant to this Framework Schedule 4A (Call off Procedures) it shall at all times be required to comply with the requirements under PCR 2015 (including the requirement to provide the necessary feedback to the Bidders in accordance with those regulations), as well as the provisions set out herein.
- 1.2 For the avoidance of doubt:-
  - 1.2.1 where the PSCP's appointment under the Framework Agreement has been suspended in accordance with Clause 14.14 of the Framework Agreement (including any such suspension which arises from a failure to meet KPI Performance Standards or from any failure that might give rise to a right of termination for the Authority under Framework Schedule 8 (Financial Distress)), the PSCP shall not be eligible to participate in any call-off procedure under this Framework Schedule 4A (Call off Procedures) which is initiated during the period of the relevant suspension;
  - 1.2.2 nothing in this Framework Schedule 4A (Call off Procedures) is intended to prevent a Client from choosing to award a contract to a PSCP via a procedure conducted outside the scope of this Framework Agreement where the Client is permitted to do so under the PCR, including in any exceptional circumstances of the kind contemplated by regulation 32 of the PCR.
- 1.3 Unless and to the extent expressly stated otherwise in any Client ITT Brief or similar documents issued by a Client in respect of a particular call-off procedure, all PSCPs who participate in any call-off procedure conducted pursuant to this Framework Schedule (Call off Procedures) 4A shall be fully responsible for all costs and

expenses (including the fees and disbursements of any external advisors) incurred in relation to such participation (including in relation to the preparation, submission and/or negotiation of any relevant tenders) and the Client shall not have any responsibility for payment or reimbursement of any such costs, expenses, fees and disbursements (including in circumstances where the Client, having initiated a particular call-off procedure, then decides at its discretion to terminate that procedure without awarding any contract under it).

- 1.4 All information supplied by a Client in connection with any call-off procedure shall be treated as being the Client's confidential information to which the provisions of Schedule 6 Part 1 shall apply, without prejudice to any additional confidentiality terms which may be specified by the Client in a Client ITT Brief or other documents issued by the Client in connection with the relevant procedure.
- 1.5 Where explicitly stated in the Project Brief, the PSCPs can collaborate and form a consortium or a non-incorporated special purpose vehicle in order to bid on call-off tender (see framework Schedule 18) for Lot 3 only.

## *1. Further Competition Procedure*

- 1.1 The procedure and other requirements set out in the following parts of paragraph 2 of this Framework Schedule 4A (Call off Procedures) shall be followed and complied with in relation to any Further Competition conducted by a Client. By way of overview:-
  - 1.1.1 each Further Competition shall in all cases incorporate a formal invitation to tender stage in which Initial Tenders are provided by the relevant PSCPs invited to participate in that stage and those Initial Tenders are then evaluated by the Client according to specified quality and price related criteria (as further described in paragraphs 2.4.4 and 2.5 below);
  - 1.1.2 the Client shall have the option, following the receipt of Initial Tenders provided in response to a formal invitation to tender of the kind described in paragraph 2.1.1 above, to incorporate one or more additional negotiation stages into the procedure and with or without provision for down-selection of participating PSCPs prior to or during these stages, before then inviting remaining PSCPs to submit Final Tenders for the purposes of the Client making its final award decision;
  - 1.1.3 the Client shall have the option, prior to commencing any of the stages described in paragraphs 2.1.1 and 2.1.2 above, to incorporate an initial down-selection stage into the Further Competition in accordance with the requirements described in paragraph 2.2 below.
- 1.2 If the Client wishes, at its option, to incorporate an initial down-selection stage into the Further Competition, the following requirements shall apply:-
  - 1.2.1 the Client shall identify, by applying the rules set out in paragraph 8 below, the relevant Lot or Sub-Lot from which a call-off should be made for the purposes of the Scheme in question;
  - 1.2.2 the Client shall identify all of the PSCPs in the relevant Lot Sub-Lot(as identified under paragraph 2.2.1 above) respect of the Scheme in question to provide a response, by way of an expression of interest in participating in

the relevant Further Competition, which the Client shall then evaluate and score for down-selection purposes (such response being an **EOI Response**);

- 1.2.3 for the purposes of inviting relevant PSCPs to provide an EOI Response, the Client shall prepare and issue to the relevant PSCPs a document which includes the following information:-
- (i) sufficient outline information about the Scheme to enable the relevant PSCPs to understand the nature of the opportunity represented by the Further Competition and inform their decision on whether or not they wish to participate in the Further Competition, such information to be proportionate, in terms of the level of detail provided, to the value and complexity of the Scheme;
  - (ii) indicative information about the likely further stage(s) of the Further Competition, including an indication of high level quality and price evaluation criteria likely to be applied in respect of such further stage(s);
  - (iii) specific questions to which each PSCP will be required to provide a response for the purposes of the EOI Response, together with information about how these responses will be evaluated and score by the Client for down-selection purposes;
  - (iv) the Client shall specify whether or not (at its option) the relevant down-selection decision will be based on an evaluation and scoring of responses to specified qualitative questions only or a combination of an evaluation and scoring of responses to specified qualitative questions, together with an evaluation and scoring of pricing information based either on relevant Tendered Rates and Fees or (at the Client's option) revised pricing submissions requested as part of the EOI Response. Where the Client chooses to apply a combination of qualitative and price related criteria, the relevant quality/price weighting ratio shall be within the range referred to in paragraph 2.5 below and, once established for the purpose of this EOI Response stage of the Further Competition, shall then be applied in respect of the Initial Tender and (if applicable) any subsequent stages of the Further Competition;
  - (v) information about the format and timescales within which the relevant responses are to be provided by the relevant PSCPs.
- 1.2.4 where, having received an invitation to submit an EOI Response, a PSCP does not wish to participate in the relevant Further Competition, it shall respond to the Client to this effect as soon as reasonably practicable. Where any PSCP responds in these terms and/or fails to provide any EOI Response by the relevant deadline for doing so, that PSCP shall then be excluded from further participation in the Further Competition;
- 1.2.5 following the relevant deadline for submission of EOI Responses, the Client shall evaluate and score all those EOI Responses received by such deadline by applying the evaluation criteria set out in the relevant invitation issued under paragraph 2.2.3 above;

- 1.2.6 according to the outcome of the evaluation process set out in paragraph 2.2.5 above, the Client shall identify by reference to the highest scoring EOI Responses the shortlist of PSCPs who will be invited to participate in the next stage of the Further Competition by way of being issued with a Client ITT Brief, together with those PSCPs (if any) who will not be shortlisted and who will accordingly be excluded from further participation in the Further Competition;
  - 1.2.7 the Client shall promptly notify those PSCPs (if any) who are to be excluded from further participation in the Further Competition;
  - 1.2.8 the next stage of the Further Competition, for those PSCPs shortlisted to participate in that stage, shall involve the preparation and issue of a Client ITT Brief in accordance with paragraph 2.4 below.
- 1.3 If the Client chooses not to incorporate an initial down-selection stage into the Further Competition, the following initial requirements shall apply:-
- 1.3.1 the Client shall identify, by applying the rules set out in paragraph 8 below, the relevant Lot Sub-Lot from which a call-off should be made for the purposes of the Scheme in question;
  - 1.3.2 the Client shall invite all of the PSCPs in the relevant Lot or Sub-Lot (as identified under paragraph 2.3.1 above) to whom the Client shall then issue a Client ITT Brief.
- 1.4 As the second stage of a Further Competition following an initial down-selection stage in accordance with paragraph 2.2 above or (as the case may be, where no such initial down-selection stage occurs) as the initial stage of a Further Competition, the Client shall prepare and issue to relevant PSCPs (as referred to in paragraphs 2.2.6 or 2.3.2, as applicable) a Client ITT Brief which, at a minimum, contains the following:-
- 1.4.1 information relating to the proposed Scheme, including a description of the Project(s) included in the Scheme, the Further Competition Requirements, the relevant Minimum Requirements and any existing design or estimated pricing information in respect of the Scheme;
  - 1.4.2 the relevant proposed form of Scheme Agreement and proposed form(s) of Project Agreement that will apply to (each of) the Project(s) included in the Scheme (each of which forms shall be substantially in the form of the relevant template documents set out in Framework Schedule 4 (Call off contracts etc.) but supplemented, refined and tailored for the purposes of the Scheme in such manner as the Client reasonably considers appropriate), together with instructions explaining the extent to which (if at all) participating PSCPs are permitted to propose any changes to such forms of agreement as part of their tender submissions;
  - 1.4.3 details of the procedure which the Client proposes to follow in respect of the Further Competition including in particular:-
    - (i) whether or not the Client proposes to engage with the market prior to tender and the nature and extent of such pre market engagement including any "Bidder Conference" session to which one or more



representatives of each relevant PSCP will be able to attend for the purposes of being provided with information about the Further Competition and of raising questions with the Client on an open forum basis;

- (ii) whether or not the Client reserves a right to make an award decision on the basis of its evaluation of Initial Tenders. Where the Client does not reserve such a right, then the Client shall reserve a right in accordance with sub-paragraph (iv) below to incorporate one or more additional negotiation stages into the Further Competition and then base its final award decision on Final Tenders submitted after the conclusion of such negotiation stage(s);
- (iii) whether or not the Client reserves a right to require relevant PSCPs to attend one or more interviews, following submission of their Initial Tenders, for the purposes of assisting with the moderation of scores to be awarded to each PSCP in respect of their Initial Tenders, Where the Client chooses (at its option) to incorporate an interview stage of this kind into the process, the Client shall specify in a clear and transparent manner how information communicated during the relevant interviews will be used for the purposes of moderating scores awarded in respect of Initial Tenders;
- (iv) whether or not (having regard to sub-paragraph (ii) above) the Client reserves a right, following the receipt and evaluation of Initial Tenders, to incorporate one or more additional negotiation stages into the Further Competition and, if so, whether or not the Client reserves the right to make one or more further down-selections of participating PSCPs before then inviting the remaining PSCPs to submit Final Tenders;

1.4.4 details of the evaluation criteria and scoring methodology which will be applied for the purposes of evaluating and scoring Initial Tenders, being details which shall include:-

- (i) details of the relevant quality related questions to which each PSCP must provide a response, having regard to the requirements of paragraph 2.5 below; and
- (ii) details of the pricing submissions to be made by each PSCP, having regard to the requirements of paragraphs 2.5 and 7 below;

1.4.5 where applicable, having regard to paragraph 2.4.3 above, details of the high level evaluation criteria likely to be applied in respect of tender submissions applicable to any subsequent down-selection or Final Tender stages of the Further Competition;

1.4.6 details of the format in which Initial Tenders must be submitted and the nature and extent of any supporting documentation, such as drawings, models or 3D images, which each PSCP is required or (as the case may be) permitted to provide;

1.4.7 details of any relevant page or word limit cap which will apply to Initial Tenders or particular elements of the Initial Tender;

- 1.4.8 details of the timetable for the submission of Initial Tenders, being a timetable which takes account of factors such as the complexity of the subject matter of the Client ITT Brief and the time PSCPs could reasonably be expected to need for the purposes of preparing their Initial Tenders;
- 1.4.9 other general instructions and requirements applicable to the Further Competition.
- 1.5 The approach to be adopted by the Client, and then described in the Client ITT Brief, in relation to the evaluation and scoring of Initial Tenders shall be consistent with the following requirements:-
- 1.5.1 evaluation shall be based on a mix of quality and price related criteria, with the quality/price criteria weighting ratio to be within the following range and (where applicable) the same as that established at the EOI Response stage of the Further Competition:-
- 80/20 (quality/price) to 60/40 (quality/price)
- 1.5.2 in respect of quality related criteria, the Client devise an appropriate series of quality related questions by reference to certain of the sub-criteria topics set out in the table below and shall determine the respective sub-weightings applicable to each of these sub-criteria topics together with an appropriate methodology to be applied in scoring responses to each of the relevant questions:-

Sub-Criterion Number	Quality Criteria
1	Client satisfaction
2	Health and Safety
3	Strength of team and leader
4	Net Zero Carbon and Sustainability
5	Working with your supply chain
6	Relevant experience
7	Delivery confidence
8	Governance
9	Working with us
10	Care, Quality and Productivity
11	Design and standardisation
12	Cost management
13	Stakeholder engagement (see 9?)
14	BIM
15	Innovation and sharing information
16	Smart Infrastructure and Modern Methods of Construction
17	Social Value
18	Whole life costing

- 1.5.3 in respect of price related criteria, the Client shall determine the relevant pricing submissions which are to be provided and the scoring methodology

to be applied in relation to these, but shall ensure that the approach which it adopts in this respect is (to the extent required under the PCR) consistent with the basis on which relevant Tendered Rates and Fees were originally established;

- 1.5.4 for the purposes of maintaining a record of the basis on which quality and price related scores are determined and calculated in relation to each Initial Tender, the Client may use the "P23 Call-off Tool", being a spreadsheet developed by the Authority for these purposes (and for the purposes of the call-off procedure generally).
- 1.6 In respect of all compliant Initial Tenders submitted in response to the Client ITT Brief, the Client shall evaluate and score such Initial Tenders in accordance with the relevant evaluation criteria and scoring methodology set out in the Client Brief.
- 1.7 Where the Client indicated in the Client ITT Brief that it reserved the right to make its final award decision on the basis of its evaluation of Initial Tenders and the Client then wishes to exercise this right, it shall award the Scheme Agreement to the PSCPs whose Initial Tender received the highest score through the Client's evaluation exercise.
- 1.8 Where the Client does not award a Scheme Agreement in accordance with paragraph 2.7 above, it shall proceed to negotiate with relevant PSCPs in relation to aspects of their Initial Tenders through one or more structured negotiation stages of the Further Competition. For these purposes:-
  - 1.8.1 where the Client indicated in the Client ITT Brief that it may carry out a down-selection exercise on the basis of its evaluation and scoring of Initial Tenders, the Client may limit participation in the relevant negotiation stages of the Further Competition to the relevant number of highest scoring PSCPs specified in the Client ITT Brief;
  - 1.8.2 prior to initiating any negotiation stage, the Client shall provide to all relevant participating PSCPs such further written instructions in relation to the conduct of that stage as may be appropriate at the time, including instructions relating to the following matters:-
    - (i) those aspects of each PSCP's Initial Tender in respect of which the Client wishes to negotiate and the basis (including the format and timetable for any negotiation sessions and confirmation of the confidentiality rules that will apply in relation to these sessions) on which those negotiations are to be conducted;
    - (ii) details of any further written submissions which participating PSCPs may be required to make prior to the Final Tender stage of the Further Competition;
    - (iii) detail of any further down-selection exercises which the Client may wish to conduct prior to the Final Tender stage of the Further Competition and the basis on which relevant written submissions will be evaluated for the purposes of any such exercise. All evaluation criteria applied for these purposes shall be consistent with, and represent a refinement of, the evaluation criteria applied in relation to the evaluation of Initial Tenders;

- 1.8.3 following the conclusion of the negotiation stage(s) of the Further Competition, the Client shall prepare and issue to all PSCPs who are still participating in the Further Competition an invitation to submit Final Tenders, such invitation to include details of the evaluation criteria and scoring methodology which will be applied for the purposes of evaluating and scoring Final Tenders. All such evaluation criteria shall be consistent with, and represent a refinement of, the evaluation criteria applied in relation to the evaluation of Initial Tenders.
- 1.9 In respect of all compliant Final Tenders submitted in response to the invitation issued by the Client in accordance with paragraph 2.8.3 above, the Client shall evaluate and score such Final Tenders in accordance with the relevant evaluation criteria and scoring methodology set out in the relevant invitation documents. Where the Client then wishes to award a Scheme Agreement via the relevant Further Competition (and nothing in this Framework Schedule 4A (Call off Procedures) shall require a Client to do so), the Client shall award the Scheme Agreement to the PSCP whose Final Tender received the highest score through the Client's evaluation exercise.
- 1.10 The Client shall design and implement each Further Competition in a manner which is appropriate and proportionate to the Scheme in question and the particular Works and/or Services which the Client wishes to procure in relation to that Scheme.
- 1.11 The Client shall ensure that every Further Competition that it conducts is compliant with relevant Laws.

## *2. Direct award for Additional works and Services*

- 2.1 A Client may directly award a Project Agreement to a PSCP in respect of certain additional Works and Services (the **Additional Works and Services**) if all of the following conditions are met:
- 2.1.1 the PSCP is party to an Existing Scheme Agreement;
- 2.1.2 the Works and Services under the Existing Scheme Agreement are on-going as at the date of the direct award under this paragraph 3 of Framework Schedule 4A (Call off Procedures);
- 2.1.3 the form of Project Agreement governing the Additional Works and Services will be in substantially the same form (including as to pricing terms) as the form of Project Agreement which is applicable to Projects carried out under the Existing Scheme Agreement, save only for any Necessary Modifications in respect of the Additional Works and Services. For these purposes, where the Existing Scheme Agreement provides for different forms of Project Agreement to apply to different Projects, the form of Project Agreement which governs the Additional Works and Services shall be the form that is the most appropriate in all the circumstances, as determined by the Client according to the nature and value of the Additional Works and Services, as compared to the nature and value of the different Projects governed by the Existing Scheme Agreement;
- 2.1.4 the value of the relevant Project Agreement governing the Additional Works and Services (the **Additional Project Agreement**) does not exceed more than 50% of the value of the Existing Scheme Agreement;



- 2.1.5 the aggregate of the value of the Additional Project Agreement and the value of the Existing Scheme Agreement does not exceed the value threshold of the relevant Lot or Sub-Lot under which the Existing Scheme Agreement was awarded; and
  - 2.1.6 either or both of the further conditions described in (respectively) paragraph 3.2 below (the **Economic and/or Technical Reasons Condition**) and paragraph 3.3 (the **Unanticipated Circumstances Condition**) apply.
- 2.2 For the purposes of paragraph 3.1.6 above, the Economic and/or Technical Reasons Condition is that for economic and/or technical reasons and to avoid any significant inconvenience or substantial duplication of costs for the Client, the Client reasonably consider that it is not appropriate for the Additional Works and Services to be carried out by an alternative contractor, including (but without limitation) where:-
- 2.2.1 the Additional Works and Services are a repetition of, and so substantially similar to, Works and Services (to be) carried out under the Existing Scheme Agreement and the Client reasonably considers that substantial additional cost and/or delays would be incurred if the Additional Works and Services were carried out by an alternative contractor;
  - 2.2.2 the Client reasonably considers that the Additional Works and Services need to be carried out at the same time as other Works and Services carried out under the Existing Scheme Agreement and technical difficulties and/or adverse costs consequences would arise in co-ordinating the Additional Works and Services if carried out by an alternative contractor; and/or
  - 2.2.3 the Client reasonably considers that the Additional Works and Services will need to interface and/or be integrated with other Works and Services carried out on the same site under the Existing Scheme Agreement and risk allocation difficulties would arise if the Additional Works and Services were carried out by an alternative contractor.
- 2.3 For the purposes of paragraph 3.1.6 above, the Unanticipated Circumstances Condition is that:-
- 2.3.1 the need for the Additional Works and Services was not anticipated by the Client at the time of conducting the Further Competition that led to the award of the Existing Scheme Agreement, including (but without limitation) where the Additional Works and Services are needed in respect of a new site only acquired by the Client after such time; and
  - 2.3.2 the overall nature of the Additional Works and Services is substantially similar to the overall nature of the Works and Services governed by the Existing Scheme Agreement.
- 2.4 Where paragraph 3.1 applies, the Client shall award the relevant Additional Project Agreement to the relevant PSCP in accordance with paragraphs 6 and 7. Below.
- 2.5 The Client shall ensure that every Direct Award that it makes is compliant with relevant Laws.

### *3. Direct award for replacement contractor*

3.1 Subject to paragraphs 4.2 and 4.3 below, the Client may award a Scheme Agreement or (as applicable) a Project Agreement (in either case, a **Replacement Agreement**) directly to a PSCP in the following circumstances:

3.1.1 another PSCP who is a party to an Existing Scheme Agreement is the subject of an event that would constitute an Insolvency Event under this Framework Agreement (had it occurred in relation to a Party);

3.1.2 an Existing Scheme Agreement or Existing Project Agreement is terminated by the Client on the grounds of a breach or other event of default on the part of the relevant other PSCP who is party to that Existing Scheme Agreement or Existing Project Agreement; and/or

3.1.3 the Client has become entitled to exercise step-in rights in respect of any Existing Scheme Agreement and/or Existing Project Agreement,

and in each case the Client consequently needs to appoint a replacement contractor to carry out particular Works and Services, whether relating to the delivery of all remaining elements of the relevant Scheme or Project or just certain elements only (as determined by the nature of the circumstances which have arisen) and such appointment needs to be made as a matter of urgency.

3.2 A Client may directly award a Replacement Agreement to a PSCP under this paragraph 4 if all of the following conditions are met:

3.2.1 the Replacement Agreement is (for the avoidance of doubt) for the continuation and (if applicable) completion of the Works and Services governed by the relevant Existing Scheme Agreement or Existing Project Agreement in respect of which one or more of the circumstances described in paragraph 4.1 above apply;

3.2.2 the PSCP meets the relevant Minimum Requirements of the Client in respect of the Existing Scheme Agreement or Existing Project Agreement, being those Minimum Requirements specified by the Client for the purposes of the original Further Competition relating to the Scheme or Project in question (the **Original Competition**);

3.2.3 the Replacement Agreement is in substantially the same form as the relevant Existing Scheme Agreement or Existing Project Agreement (as applicable) in respect of which one or more of the circumstances described in paragraph 4.1 above apply, save that the relevant pricing details included in the Replacement Agreement shall be those established in accordance with paragraph 7.2 below; and

3.2.4 the Replacement Agreement is directly awarded under the same Lot or Sub-Lot as the Existing Agreement.

3.3 The relevant PSCP to whom a Replacement Agreement may be awarded by the Client shall be determined according to the following procedure:-

- 3.3.1 the Client shall first identify the PSCP who was awarded the second highest score in the Original Competition and offer to enter into the Replacement Agreement with that PSCP;
- 3.3.2 if such PSCP refuses to confirm that it is willing to enter into the Replacement Agreement within a reasonable timeframe specified by the Client, the Client may proceed to approach the PSCP with the next highest score in the Original Competition and so on until it identifies a PSCP who confirms that it would be willing to enter into the Replacement Agreement.
- 3.4 Where paragraph 4.1 applies, the Client shall award the relevant Replacement Agreement to the relevant PSCP (as determined under paragraph 4.3 above) in accordance with paragraphs 6 and 7.

## *4. Emergency Response*

- 4.1 The Client may award a Scheme Agreement or Project Agreement to any PSCP, by way of directly awarding the relevant Scheme Agreement or Project Agreement in accordance with paragraph 5.2, where such direct award is permitted by regulation 32 of the PCR, including where such direct award is permissible under regulation 32 of the PCR as a response to an emergency situation which has arisen, such as (but without limitation):
  - 4.1.1 the occurrence of a major public health crisis; or
  - 4.1.2 where critical infrastructure has been damaged or destroyed by fire, explosion or other circumstances requiring an urgent response by way of disaster recovery.
- 4.2 Where the circumstances described in paragraph 5.1 apply:
  - 4.2.1 the Client may approach any PSCP (appointed to any of the Lots or Sub-Lots) who the Client considers may be capable of meeting its requirements in respect of the relevant Scheme Agreement or Project Agreement;
  - 4.2.2 where any such PSCP approached by the Client is willing and able to meet such requirements (and for the avoidance of doubt, the Client may approach multiple PSCPs, either concurrently or consecutively, for these purposes), the Client and the PSCP shall, acting reasonably and in good faith, seek to agree without delay an appropriate form of Scheme Agreement and related Project Agreement(s) or (as applicable) just an appropriate form of Project Agreement, which (in each case) shall be substantially in the form of the relevant template agreement set out in Framework Schedule 4 (Call off contracts etc.) and shall include pricing details established in accordance with paragraph 7.2.
- 4.3 Where paragraph 5.1 applies and the Client is then able to agree with a particular PSCP under paragraph 5.2 a form of Scheme Agreement (and related Project Agreement(s)) or (as applicable) just a Project Agreement with a particular PSCP, the Client shall award the relevant Scheme Agreement or Project Agreement to the relevant PSCP in accordance with paragraphs 6 and 7.

## *5. Formation of Contract*

- 5.1 If the Client proceeds with the award of a Scheme Agreement under paragraph 2, an Additional Project Agreement under paragraph 3, a Replacement Agreement under paragraph 4 or a relevant Scheme Agreement or Project Agreement under paragraph 5, it shall issue the relevant agreement to the relevant PSCP and invite it to sign and return such agreement to the Client.
- 5.2 On being issued with a relevant agreement under paragraph 6.1 above, the PSCP shall be required to sign such agreement in the form issued to it, and so without any further modification. No contract shall be formed between the relevant PSCP and the Client until the relevant agreement is subsequently signed and completed by the Client.

## *6. Tendered Rates and Fees*

- 6.1 For the purposes of any tender submission made by a PSCP pursuant to a Further Competition (including any Initial Tender or Final Tender), any pricing amounts (whether a rate, a fee percentage, an item of cost or otherwise) shall not exceed (but may be lower than) the applicable Tendered Rates and Fees specified in paragraph 7.3.
- 6.2 For the purposes of any Replacement Agreement to be awarded under paragraph 4 or any relevant Scheme Agreement or Project Agreement to be awarded under paragraph 5, relevant pricing amounts to be included in such agreement (whether a rate, a fee percentage, an item of cost or otherwise) shall be those agreed between the Client and the relevant PSCP at the time, provided always that:-
  - (a) such amounts shall not exceed the applicable Tendered Rates and Fees specified in paragraph 7.3 below; and
  - (b) in the absence of any agreement at the time to apply any lower amounts, the Client shall be entitled to require that the applicable Tendered Rates and Fees specified in paragraph 7.3 will apply and be included in the relevant agreement.
- 6.3 In any Project Agreement:
  - 6.3.1 which uses NEC4 ECC Option A (Priced Contract with Activity Schedule):
    - (a) the pricing of staff roles for People included in the Prices shall be based on and derived from rates which do not exceed the rates for such staff roles tendered by the PSCP in the Tendered Option A Rates; and
    - (b) the PSCP's Profit and Overhead for all priced activities comprising the Prices shall not exceed the Tendered Option A Fee Percentage; and
    - (c) the fee percentage shall not exceed the Tendered Option A Fee Percentage.
  - 6.3.2 which uses NEC4 ECC Option C (Target contract with Activity Schedule):
    - (a) the Defined Cost of people who are directly employed by the PSCP shall not exceed the Tendered Option C Rates;
    - (b) the fee percentage shall not exceed the Tendered Option C Fee Percentage.



6.3.3 which uses the NEC4 Short Contract:

- (a) rates for staff roles of People included in the Price List and the People Rates shall be based on and derived from rates which do not exceed the corresponding rates for such staff roles in the Tendered Short Contract Rates; and
- (b) the PSCP's Profit and Overhead included in the Prices shall not exceed the Tendered Short Contract Fee Percentage; and
- (c) the fee percentage shall not exceed the Tendered Short Contract Fee Percentage.

## *7. Rules relating to choice of Lot/Sub-Lot*

- 7.1 Acting in accordance with the PCR, the Client shall determine the particular Project or Projects which are to form part of a Scheme in respect of which the Client wishes to call-off a Scheme Agreement by way of conducting a Further Competition.
- 7.2 The particular Lot or Sub-Lot from which a call-off shall be made for the purposes of the relevant Further Competition shall be determined according to the following factors in respect of the Scheme in question:-
  - 7.2.1 the estimated value of each Project that forms part of the Scheme, where value for these purposes refers to the estimated consideration payable by the Client for the relevant Works and Services applicable to the Project in question;
  - 7.2.2 whether or not any of the Projects that form part of the Scheme are "Connected" to each other within the meaning of paragraph 8.3 below; and
  - 7.2.3 for Schemes that, by reference to the factors in sub-paragraphs 8.2.1 and 8.2.2 above, are covered by any of Sub-Lots 1 to 7, the location of the site(s) which are the subject of the relevant Project(s) that form(s) part of the Scheme.
- 7.3 For the purposes of this paragraph 8, a Project that forms part of a Scheme shall be treated as "Connected" to another Project that forms part of the same Scheme if the Client reasonably considers that:
  - 7.3.1 fulfilment of any of its "Principal Purposes" (as defined in paragraph 8.4 below) is dependent upon the successful completion of that other Project, such that the Project in question cannot reasonably be expected to meet one or more of its Principal Purposes without the completion of the other Project (and potentially vice versa);
  - 7.3.2 the Client reasonably anticipates that the two Projects will be constructed at the same time or that their planned construction periods will over-lap; and/or
  - 7.3.3 the Client reasonably anticipates that the relevant contractor appointed to carry out works in respect of the two Projects will make use of site set up and welfare facilities which are common to both Projects.

7.4 In this paragraph 8, the expression “Principal Purposes” as applied to a particular Project means the clinical or operational end purpose or purposes of that Project (including, where applicable, the purpose or purposes of the relevant new building or facility which is to be constructed or installed as an outcome of the Project), as distinct from the construction methodology or sequence adopted in relation to the Works and Services to be carried out in respect of that Project.

7.5 Where the relevant factors applicable to a particular Scheme are that:-

7.5.1 none of the Projects that form part of the Scheme have an estimated value equal to or in excess of £20,000,000 (twenty million pounds); AND

7.5.2 none of the Projects that form of part of the Scheme are Connected to each other OR where any two or more Projects that form part of the Scheme are Connected to each other, the aggregate, estimated value of the relevant Connected Projects is not equal to or in excess of £20,000,000 (twenty million pounds,

then the appropriate Lot or Sub-Lot from which a call-off for that Scheme shall be made shall be the applicable regional Sub-Lot, being the Sub-Lot for the region in which the sites which are the subject of the Projects in question are located. For these purposes, for any proposed Scheme where the relevant estimated values associated with that Scheme are within the thresholds referred to in paragraphs 8.5.1 and 8.5.2 above, the Client shall ensure that all Projects that form part of that Scheme relate to sites that are within the same region (by reference to the description of the regions which are applicable to each Sub-Lot).

7.6 Where the relevant factors applicable to a particular Scheme are that:-

7.6.1 none of the Projects that form part of the Scheme have an estimated value equal to or in excess of £70,000,000 (seventy million pounds);

7.6.2 none of the Projects that form of part of the Scheme are Connected to each other OR where any two or more of the Projects that form part of the Scheme are Connected to each other, the aggregate, estimated value of the relevant Connected Projects is not equal to or in excess of £70,000,000 (seventy million pounds); AND

7.6.3 according to the rules set out in paragraph 8.5 above, the appropriate Lot or Sub-Lot is not any of the regional Sub-Lots referred to in paragraph 8.5 above,

then the appropriate Lot from which a call-off for that Scheme shall be made shall be Lot 2.

8.7 Where the relevant factors applicable to a particular Scheme are that:-

8.7.1 one or more of the Projects that form part of the Scheme have an estimated value equal to or in excess of £70,000,000 (seventy million pounds); OR

8.7.2 any two or more of the Projects that form part of the Scheme are Connected to each other and the aggregate, estimated value of the relevant Connected Projects equal to or in excess of £70,000,000 (seventy million pounds);

then the appropriate Lot from which a call-off for that Scheme shall be made shall be Lot 3.

## 8.8 By way of illustration only, and without limitation:-

### Example of “Connected” Projects

A hospital is to undergo renewal in a Scheme under which there will be a phased sequence of Projects involving new build, fit out, refurbishment, M&E and civil engineering works, including refurbished wards, new build ITU and A&E facilities, ambulance bays, car parking and a new entrance hall. Any of these Projects will be Connected if:

- the facilities refurbished or constructed in one Project cannot be fully utilised without completion of another Project (for example, use of new ambulance bays may well be dependent on completion of new A&E facilities); or
- it is reasonably anticipated that the Projects in question will be undertaken at the same time or that their planned construction periods will overlap; or
- it is reasonably anticipated that relevant site set up and welfare facilities will be shared at any point between the Projects in question.

Examples of Schemes involving multiple Projects:

- 4 Projects each with estimated value of £10 million. All 4 Projects relate to the installation of combined solar “carport” and electric vehicle charging facilities (so essentially the same Works and Services) but at four completely different sites and so no dependency between any of them. None of these Projects is therefore Connected, meaning their respective values do not get aggregated for Lot selection purposes. Appropriate Lot is therefore Lot 1.
- 6 Projects each with estimated value of £5 million. Each Project relates to various new pandemic facilities across a single hospital site but at different locations including e.g. critical care wards, ITU, incineration and additional car parking/ambulance bay. These 6 are Connected Projects because they have the same principal operational purpose. Their aggregate value is £30 million. Appropriate Lot is therefore Lot 2.
- 5 Projects with values ranging from £10 to £65 million. 3 Projects relate to the refurbishment of the main hospital site and are valued at (A) £50, (B) £60 and (C) £65 million each. In order to maintain clinical services, temporary accommodation is provided in two Projects worth (D) £5 million and (E) £10 million. Although the three high value projects are not Connected because their facilities can be fully utilised on Project completion without completion of the other Projects, all three are dependent upon the temporary accommodation projects which means that Connected Projects are (A) + (D) + (E) = £65 million, (B) + (D) + (E) = £75 million and (C) + (D) + (E) = £80 million. Given that the aggregated value of the last two groups of Connected Projects is above £70 million, the appropriate Lot is therefore Lot 3.
- As for the example above, but the temporary accommodation projects (D and E) both have a value of £2 million, so aggregated value of Connected Projects C, D and E is £69 million (and therefore below £70 million threshold for Lot 3). Appropriate Lot is therefore Lot 2. For the purposes of any tender submission made by a PSCP pursuant to a Further Competition (including any Initial Tender or Final Tender), any pricing amounts (whether a rate, a fee percentage

## **2. SaTH HTP Procurement decisions**

### Pre-Tender Engagement with PSCPs

The session in November was an opportunity for us to outline this significant commercial opportunity to you.

The points covered were:

#### **Local Context & Background to HTP**

(Business Case & Approval status / NHSE + MP + Ministerial Support / Our approach)

#### **Leadership & Support for HTP within SaTH**

(Board, Exec Team & Senior Leadership / Clinical & Medical Support )

#### **Local System & the Integrated Care Board role**

(HTP is a major programme of the ICS > SaTH are the lead organisation for delivery)

#### **The Design & Construction Requirement**

#### **Procurement Process and next steps**

#### **Opportunity for the 8 PSCPs to feedback to us**

### PSCP Procurement Timetable

<b>Task</b>	<b>Date/time</b>
<b>Register schemes</b>	14 <sup>th</sup> Sept 2022
<b>Informal Pre-Tender Engagement Session: 8xPSCPs &amp; Trust Leads</b>	Weds 2 <sup>nd</sup> Nov 9am & Weds 15 <sup>th</sup> Feb 10am
<b>Issue CITTB **</b>	By 3 <sup>rd</sup> March (cop)
<b>PSCP Open day; i)-Intro &amp; Designer Forum 9-11am? ii)-RSH site walk iii)-PRH Telford site walk</b>	Weds 8 <sup>th</sup> March
<b>PSCPs to confirm to the Client and IA whether they will be bidding the Scheme</b>	Tues 14 <sup>th</sup> March (5pm)
<b>PSCP submit Initial Tender</b>	Thurs 6 <sup>th</sup> April (11am)
<b>Client to assess Initial Tender's</b>	Tues 11 <sup>th</sup> April to Fri 14 <sup>th</sup> April
<b>Moderation Interviews</b>	Friday 21 <sup>st</sup> April Monday 24 <sup>th</sup> April
<b>Down-selection and further negotiation with short-listed PSCP</b>	wc 24 <sup>th</sup> to 27 <sup>th</sup> April
<b>Evaluation Decision</b>	Friday 28 <sup>h</sup> April
<b>Trust Approvals Cycle including Appointment Recommendation to FPAC on 30<sup>th</sup> May Trust Board on 8<sup>th</sup> June [+ ICS Board ?]</b>	[ Mid-late May cycle]
<b>PSCP appointment</b>	Friday 26 <sup>th</sup> May 2023
<b>P23 Launch workshop</b>	w/c 29 <sup>th</sup> May 2023



## Key Procurement Decisions ahead of the Tender stage

Evaluation weighting ratio to be: **70 % Quality / 30% Price**

Sub-criteria weightings:

Weighting (max 100)	Total Marks (out of 70)	Quality Criteria
100	15.6%	Relevant experience
100	15.6%	Care, Quality and Productivity
100	15.6%	Stakeholder engagement
70	7.6%	Smart Infrastructure & Modern Methods of Construction
80	10%	Social Value
60	5.6%	Net Zero Carbon / Sustainability

Price scoring methodology: **Med-Max methodology**

Contract option to be used under P23: **NEC4 Option C**

eProcurement portal used for this process: **ATAMIS Health Family eCommercial system**

## Design & Construction Requirement – highlight details

- Design and construction costs circa £165m (gross costs circa £312m)
- GIFA = c. **109,313m2 for both sites** (Royal Shrewsbury = 61,400 m2, Princess Royal Telford = 47,913 m2)
- SOC approval is secured, OBC to be progressed with planned submission to NHSE in March 2023
- Design is currently in progress towards RIBA stage 2
- Existing designers/advisors are as follows:
  - o Architect = AHR Architects
  - o MEP = DSSR
  - o Structural = Ramboll
  - o Health Planner = Strategic Healthcare Planning LLP (SHP)

It is to be confirmed, but the current expectation is that not all of the incumbent designers are to be retained.

The PSCP are free to approach the incumbent team as they see fit to include within their bids

- Trust Cost Advisor = Edmond Shipway Construction Consultants
- NEC PM = SaTH Strategic Estates & NEC Supervisor = SaTH Strategic Estates

### Key success criteria for this procurement

- Cost Certainty from the outset.
- Time critical delivery.
- Reduced exposure to risk with a collaborative approach.
- Confidence that the successful contractor is proficient with health specific complex project design and construction.
- Detailed governance processes that stand up to the highest levels of scrutiny.

### What qualities are we looking for in our Principal Supply Chain Partner?

- Partnering
- Quality and continuity of personnel / actual people on site
- Scoping and pricing – needs to be realistic
- Ability to drive the pace (and help us take our people with us)
- Insights / best practice from similar projects
- Openness / trust
- Shared approach to risk
- Proactive and flexible delivery approach
- Constructive challenge and support
- No surprises



## TRANSPORT ASSESSMENT



**SYSTRA**

## TABLE OF CONTENTS

<b>1.</b>	<b>INTRODUCTION</b>	<b>6</b>
<b>2.</b>	<b>BACKGROUND</b>	<b>8</b>
<b>3.</b>	<b>TRANSPORT POLICY</b>	<b>10</b>
<b>3.1</b>	<b>NATIONAL POLICY</b>	<b>10</b>
<b>3.2</b>	<b>LOCAL POLICY</b>	<b>11</b>
<b>3.3</b>	<b>POLICY SUMMARY</b>	<b>14</b>
<b>4.</b>	<b>BASELINE CONDITIONS</b>	<b>15</b>
<b>4.1</b>	<b>INTRODUCTION</b>	<b>15</b>
<b>4.2</b>	<b>VEHICLE PARKING AT RSH</b>	<b>15</b>
<b>5.</b>	<b>DEVELOPMENT PROPOSALS</b>	<b>17</b>
<b>5.1</b>	<b>OVERVIEW</b>	<b>17</b>
<b>5.2</b>	<b>DEVELOPMENT PROPOSALS</b>	<b>17</b>
<b>5.3</b>	<b>STAFF AND INPATIENT BEDS</b>	<b>20</b>
<b>5.4</b>	<b>VEHICLE ACCESS</b>	<b>20</b>
<b>5.5</b>	<b>CONSTRUCTION COMPOUND AND ACCESS</b>	<b>21</b>
<b>6.</b>	<b>TRANSPORT ANALYSIS</b>	<b>22</b>
<b>6.1</b>	<b>PARKING ANALYSIS - STAFF PARKING</b>	<b>22</b>
<b>6.2</b>	<b>PARKING ANALYSIS – VISITOR / PATIENT PARKING</b>	<b>23</b>
<b>6.3</b>	<b>TRAFFIC IMPACTS</b>	<b>24</b>
<b>7.</b>	<b>TRANSPORT MITIGATION</b>	<b>25</b>
<b>7.1</b>	<b>EMBEDDED MITIGATION</b>	<b>25</b>
<b>7.2</b>	<b>OTHER MITIGATION MEASURES</b>	<b>25</b>
<b>7.3</b>	<b>USE OF PARK AND RIDE FACILITIES</b>	<b>25</b>
<b>8.</b>	<b>TRAVEL PLAN</b>	<b>27</b>
<b>8.1</b>	<b>OVERVIEW</b>	<b>27</b>
<b>8.2</b>	<b>MODAL SHARE</b>	<b>27</b>
<b>8.3</b>	<b>OBJECTIVES AND TARGETS</b>	<b>28</b>
<b>8.4</b>	<b>MEASURES</b>	<b>28</b>
<b>8.5</b>	<b>ACTION PLAN</b>	<b>29</b>
<b>9.</b>	<b>SUMMARY AND RECOMMENDATIONS</b>	<b>31</b>
<b>9.1</b>	<b>SUMMARY</b>	<b>31</b>



## LIST OF FIGURES

Figure 1.	RSH Car Parks	16
Figure 2.	Development Proposal	18
Figure 3.	MSCP and Helipad Plan View	19
Figure 4.	Site location Plan	19

## LIST OF TABLES

Table 1.	RSH Existing Parking Supply and Utilisation	16
Table 2.	Development proposal - changes to RSH parking capacities	20
Table 3.	Staff Parking Scenarios	23
Table 4.	Patient / visitor parking scenarios	24
Table 5.	Staff Modal Split	27
Table 6.	Potential Action Plan Measures	30

# 1. INTRODUCTION

- 1.1.1 SYSTRA has been commissioned by AHR Architects, on behalf of the Shrewsbury and Telford Hospital NHS Trust, to produce a Transport Statement to support a planning application at Royal Shrewsbury Hospital (RSH). A new four storey building is proposed adjacent to the main entrance of the RSH which will allow the RSH to expand some existing facilities on site and accommodate new facilities which will transfer from the Princess Royal Hospital (PRH). The proposed new building will accommodate the: Accident and Emergency Department; Women's and Children's Department; the Acute Medical Unit; and the Intensive Therapy Unit.
- 1.1.2 Healthcare service provision in this region needs to adapt to the changing needs of the population over the coming years. The case for change is driven by a number of key challenges including: people living longer; patterns of illness changing with long term conditions on the rise due to changing lifestyles; people rightly demanding the highest quality of care; new developments in science and technology; NHS budgetary constraints; access to services for populations living in two urban centres as well as more sparsely populated rural communities and the challenge of trying to maintain the quality of services across two hospital sites. The proposed development has been designed to address these challenges.
- 1.1.3 The proposed development will allow for an expansion of existing services at RSH including: the Accident and Emergency department; the Acute Medical Unit; and the Intensive Therapy Unit. In addition the Women's and Children's Services will transfer from PRH to RSH. Although not the subject of this application some services and facilities will relocate from RSH to PRH. This is important to mention as it will offset parking demand and traffic impact at RSH.
- 1.1.4 The major element of the application is the new four storey building which has a GFA of approximately 32,000 sqm. This will occupy land currently occupied by the helipad, 23 staff parking spaces and 37 patient visitor spaces. There is a need to maintain the helipad and therefore the application also includes the relocation of the helipad on the site currently occupied by Car Park 3 (see Figure 1 for location)s. The helipad has to be located adjacent to the Accident & Emergency Department to avoid any delay to emergency treatment for critically ill patients.
- 1.1.5 Relocating the helipad will displace 96 visitor parking spaces and these will need to be provided elsewhere. Therefore, the application also includes a proposal for a new Multi-Storey-Car-Park (MSCP) on the site occupied by Car Park 4 (see Figure 1 for location). The MSCP will have a total capacity of 463 spaces, will be accessible for patients and visitors only and will result in an overall net gain of parking for patients and visitors of approximately 200 parking spaces.
- 1.1.6 This Transport Assessment will provides further details of the proposed development, identifies transport impacts and also mitigation measures designed to minimise those impacts. The report will also provide an overview of relevant policy considerations and baseline transport conditions.
- 1.1.7 The remainder of this report is structured as follows.
- **Section 2, Background** - provides an overview of the need for the proposed development.
  - **Section 3, Transport Policy** - sets out the national and local policy framework which has informed the proposed development and assessment.
  - **Section 4, Baseline Conditions** – provides an overview of the existing local transport network including access and parking for all modes to the RSH and within the RSH site.

- **Section 5, Development Proposals** – provides a detailed description of the development proposals including drawings, access, and changes to staffing numbers.
- **Section 6, Transport Analysis and Mitigation** – provides an overview of transport impacts.
- **Section 7, Mitigation** – sets out proposed transport mitigation measures.
- **Section 8, Travel Plan** – provides a summary of the existing Travel Plan and sets out a number of additional Travel Plan measures.
- **Section 9, Summary and Recommendations.**

## 2. BACKGROUND

- 2.1.1 The Shrewsbury and Telford Hospital (SaTH) NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford & Wrekin and mid Wales. The Princess Royal Hospital (PRH) in Telford and the Royal Shrewsbury Hospital (RSH) in Shrewsbury are the Trust's main service locations, accounting for 99% of its activity. Both hospitals provide a wide range of acute hospital services including accident & emergency, outpatients, diagnostics, inpatient medical care and critical care, in which operations are coordinated across the sites.
- 2.1.2 Health care services in Shropshire, Telford and Wrekin have evolved over many years to meet the needs and expectations of the populations they serve. However, those needs are changing and are forecast to change further in the future. In addition medicine is becoming more sophisticated, expectations are changing and all the time the Trust has to operate within a constrained economic environment. Consideration of all of these factors means now is the time to examine how services are designed so that healthcare provision in Shropshire meets the needs of the population for the next 20 years.

### Key Challenges

- 2.1.3 The Trust faces a number of challenges which are largely outside of the Trust's control but nevertheless services must adapt to meet these challenges which are set out below.
- 2.1.4 **Changes in population profile** – welcome improvements in life expectancy of older people across the UK is even more pronounced in Shropshire were the population over 65 has increased by 25% in just 10 years with this growth set to continue over the next decade. Consequently, demand for services has shifted towards helping frailer people, often with long term conditions.
- 2.1.5 **Changing patterns of illness** – long term illnesses are on the rise as a result of changing lifestyles. Consequently, emphasis is shifting away from short term illnesses and infections to long term earlier interventions to improve health.
- 2.1.6 **Higher expectations** – the population demands high quality care and greater convenience of care. Accordingly, there is a push towards 7-day provision or extended for some services which require a redesign of operations.
- 2.1.7 **Clinical Standards and developments in medical technology** – specialisation and advances in medical technology and clinical training has meant that it is no longer possible to use generalists to staff some services. Where accepted professional standards are not being met some staff are choosing to move elsewhere where standards are being met which then makes it more difficult to attract new staff to the service. Accordingly, services need to be offered whereby clinical staff, which are a scarce resource, can be deployed to the greatest effect.
- 2.1.8 **Economic Challenges** – NHS budgets are constrained and yet changing patterns of population and associated need, increasing costs of improving medical technology and the difficulty in driving productivity improvements in a service that is 75% staff costs and that works to deliver care to people through people, mean that without changing the basic pattern of services then costs will rapidly outstrip available resources and services will face chaos.
- 2.1.9 **Opportunity costs in quality of services** – in Shropshire, Telford and the Wrekin the inherited pattern of services, especially hospital services, across multiple sites means that services are struggling to avoid fragmentation and are incurring additional costs of duplication and additional pressures in funding. Shropshire has a large enough population to support a full



range of acute general hospital services, but splitting these services over two sites is increasingly difficult to maintain without compromising the quality and safety of the service.

2.1.10 Most pressingly, the Acute Trust currently runs two full A&E departments and does not have a consultant delivered service 16 hours/day 7 days a week. Even without achieving Royal College standards the Trust currently has particular medical workforce recruitment issues around A&E services, stroke, critical care and anaesthetic cover. All of these services are currently delivered on two sites though stroke services have recently been brought together on an interim basis. This latter move has delivered measurable improvements in clinical outcomes.

2.1.11 **Impact on accessing services for populations living in two urban centres and much more sparsely populated rural communities** – in Shropshire, Telford and the Wrekin there is a responsibility to deliver health care needs for distinctive populations including those in the two major urban centres and those in sparsely populated rural parts of the county and Mid Wales. Improved and timely access to services is one the public sees as a high priority.

### **Call to Action**

2.1.12 In November 2013 the NHS ran a major consultation exercise with the public and clinicians under the national call to action for the NHS. There was real consensus between the public and clinicians on the following:

- An acceptance of there being a case for making significant change;
- A belief that this should be clinically-led and with extensive public involvement;
- A belief that there were real opportunities to better support people in managing their own health and to provide more excellent care in the community and at home;
- An agreement that hospitals are currently misused. This is not deliberate but as a result of poor design of the overall system and the lack of well understood and properly resourced alternatives;
- A belief that it is possible to design a new pattern of services that can offer excellence in meeting the distinctive and particular needs of the rural and urban populations of this geography - but to succeed SaTH NHS Trust must avoid being constrained by history, habit and politics.

2.1.13 The proposed development is a transformative scheme that will support SaTH NHS Trust in the delivery of healthcare services for the people of Shropshire Telford and Wrekin for the coming years and decades.

## 3. TRANSPORT POLICY

### 3.1 National Policy

#### National Planning Policy Framework, July 2021

- 3.1.1 The revised *National Planning Policy Framework (NPPF)* was published in July 2021 and replaces the previous National Planning Policy Framework published in March 2012, and revised in July 2018 and February 2019. The document sets out the Government's planning policies for England and how these should be applied. It provides a framework within which locally-prepared plans for housing and other development can be produced.
- 3.1.2 The NPPF sets out a number of transport objectives designed to facilitate sustainable development and contribute to a wider sustainability by giving people a greater choice about how they travel.
- 3.1.3 The NPPF states that transport issues should be considered from the earliest stages of plan-making and development proposals, so that:
- The potential impacts of development on transport networks can be addressed;
  - Opportunities from existing or proposed transport infrastructure, and changing transport technology and usage, are realised – for example in relation to the scale, location or density of development that can be accommodated;
  - Opportunities to promote walking, cycling and public transport use are identified and pursued;
  - The environmental impacts of traffic and transport infrastructure can be identified, assessed and taken into account – including appropriate opportunities for avoiding and mitigating any adverse effects, and for net environmental gains; and
  - Patterns of movement, streets, parking and other transport considerations are integral to the design of schemes, and contribute to making high quality places.
- 3.1.4 In assessing sites that may be allocated for development in plans, or specific applications for development, it should be ensured that:
- Appropriate opportunities to promote sustainable transport modes can be – or have been – taken up, given the type of development and its location;
  - Safe and suitable access to the site can be achieved for all users; and
  - Any significant impacts from the development on the transport network (in terms of capacity and congestion), or on highway safety, can be cost effectively mitigated to an acceptable degree.
- 3.1.5 Development should only be prevented or refused on highways grounds if there would be an unacceptable impact on highway safety, or the residual cumulative impacts on the road network would be severe.
- 3.1.6 Within this context, applications for development should:
- Give priority first to pedestrian and cycle movements, both within the scheme and with neighbouring areas; and second – so far as possible – to facilitating access to high quality public transport, with layouts that maximise the catchment area for bus or other public transport services, and appropriate facilities that encourage public transport use;
  - Address the needs of people with disabilities and reduced mobility in relation to all modes of transport;

- Create places that are safe, secure and attractive – which minimise the scope for conflicts between pedestrians, cyclists and vehicles, avoid unnecessary street clutter, and respond to local character and design standards;
- Allow for the efficient delivery of goods, and access by service and emergency vehicles; and
- Be designed to enable charging of plug-in and other ultra-low emission vehicles in safe, accessible and convenient locations.

**National Planning Practice Guidance ‘Travel Plans, Transport Assessments and Statements in Decision-Taking’ (March 2014)**

3.1.7 The National Planning Practice Guidance (NPPG) sets out that all developments that generate significant amounts of transport movement should be supported by a Transport Statement or Transport Assessment.

3.1.8 The document states:

Transport Assessments are thorough assessments of the transport implications of development, and Transport Statements are a ‘lighter-touch’ evaluation to be used where this would be more proportionate to the potential impact of the development (ie in the case of developments with anticipated limited transport impacts).

3.1.9 It also states that local planning authorities must make a judgement as to whether a development proposal would generate significant amounts of movement on a case by case basis, and in determining whether a Transport Assessment is needed for a proposed development local planning authorities should take into account the following considerations:

- The Transport Assessment and Statement policies (if any) of the Local Plan;
- The scale of the proposed development and its potential for additional trip generation (smaller applications with limited impacts may not need a Transport Assessment or Statement);
- Existing intensity of transport use and the availability of public transport;
- Proximity to nearby environmental designations or sensitive areas;
- Impact on other priorities/ strategies (such as promoting walking and cycling);
- The cumulative impacts of multiple developments within a particular area; and
- Whether there are particular types of impacts around which to focus the Transport Assessment or Statement (e.g. assessing traffic generated at peak times).

3.1.10 Based on the above statements, in particular the size and impact of the development in transport terms, this study is reported in the form of a Transport Assessment which also includes an update to the existing Travel Plan.

## 3.2 Local Policy

### Draft Shropshire Local Plan 2016-2038

3.2.1 The Draft Shropshire Local Plan covers the period between 2016 and 2038, and is designed to inform decision making at a local level. Once adopted the Local Plan will replace the existing Shropshire Core Strategy Development Plan (2011).

3.2.2 The Draft Local Plan seeks to provide a sustainable pattern of growth, responding to the varying scales, needs and functions of the County’s hierarchy of settlements. The Local Plan, doesn’t sit in isolation, but is supported by a number of other strategies.

3.2.3 In regard to sustainable development, the Draft Local Plan states:

‘Shropshire Council takes a positive approach to considering development proposals, reflecting the presumption in favour of sustainable development contained in the National Planning Policy Framework (NPPF). Where appropriate, Shropshire Council will work proactively with applicants to jointly find solutions which mean that proposals can be approved wherever possible.’

3.2.4 In addition the Draft Local Plan states that new developments should:

‘Deliver high quality design by ensuring the creation of better places in which to live and work, improving sustainability, supporting active and healthy lifestyles and ensuring individual and community well-being.’

3.2.5 The Draft Local Plan also highlights the desire for Shropshire to improve its communications infrastructure and transport networks whilst moving towards reduced car dependency and managing the impacts of transport on communities and the environment. This is something which correlates with the proposed development, in which the SaTH NHS Trust will provide mitigation measures, including encouraging use of active and sustainable travel modes, as well as agile/remote working practices to reduce peak travel demand of staff.

3.2.6 As part of the Draft Local Plan Allocations, a new Sustainable Urban Extension development, including 1500 dwellings, will be delivered within the Bowbrook area of Shrewsbury (SHR 158 and SHR 060), located to the east of the A5, and bounded by B4386 Mytton Oak Road to the north and A488 Hanwood Road to south. The RSH is located adjacent to these proposals and north of the B4386 Mytton Oak Road.

3.2.7 To the north of the site, an opportunity is provided for the enhancement of the town’s existing Park and Ride facilities (SHR161), situated between proposed housing developments, north of B4386 Mytton Oak Road (SHR 177 and SHR 057) and the Sustainable Urban Extension. The development will also create and enhance pedestrian and cycle links both within the site and through the Bowbrook area, as well as from the site into the town centre.

**Shropshire Local Transport Plan 2011-2026**

3.2.8 The third Local Transport Plan (LTP) for Shropshire sets out how Shropshire County Council and its partners intend to maintain, manage and improve transport provision across the County over the period 2011-2026.

3.2.9 The document states:

‘The role of the Local Transport Plan is to guide the development of the transport system in Shropshire in a way which will maximise the benefits travel can bring while minimising the disadvantages and costs to our wider society.’

3.2.10 The document highlights key transport network and connectivity issues across the region, including:



- Lack of rail coverage in some areas of the county;
- Traditional road system with single carriageway trunk roads and constrained street patterns in towns and villages;
- Sparse population in rural areas limits the scope for efficient public transport use; and
- Opportunity to build on a tradition of walking and cycling within towns.

3.2.11 In reference to location and design of new developments, policy E11 states:

‘We will ensure that new developments are located, designed and served by transport in ways that enhance accessibility and reduce car dependency.’

#### **Shropshire Adopted Core Strategy Development Plan (2011)**

3.2.12 The Core Strategy Development Plan acts as the principal document of the Shropshire Local Development Framework (LDF). The LDF is a series of documents that outline policies relating to the use and development of land in Shropshire.

3.2.13 The Core Strategy sets out the Council’s vision, strategic objectives and spatial strategy to guide future development and growth in Shropshire during the period to 2026. It is based on an understanding of Shropshire’s unique characteristics, its relationship with adjoining areas, knowledge of past trends and how things are likely to change in the future.

3.2.14 The strategy states in relation to developments and transport that:

It will also be important to provide integrated transport infrastructure and services to meet local needs whilst minimising the impacts of transport and traffic on communities and the environment. This will primarily be achieved by influencing the location of development that generates significant volumes of traffic and will emphasise the importance of transport assessments in the development management process. These assessments will help to evaluate the suitability of the location of proposed developments in relation to their transport demands.

3.2.15 This statement therefore supports the role of transport assessments in the development management process to mitigate any transport impacts of proposed developments.

#### **Shrewsbury Big Town Plan (2018)**

3.2.16 The Big Town Plan is an ambitious and bold plan designed to revolutionise movement around Shrewsbury and put people at the heart of the town, creating a greater place for people to live, visit, work and invest.

3.2.17 The Big Town Plan vision supports the Local Plan and has been prepared in coordination with individuals, organisations, decision-makers, business leaders, Council officers and local experts, in which it sets out how they want to shape the evolution of Shrewsbury Town over the next two decades.

3.2.18 The Plan sets out Ten Goals for Shrewsbury Town, the first of which is to:

‘make it much better for the pedestrian and cyclist, especially in the town centre. This means shifting the balance of priority given to movement across the town from the private car to walking and cycling and greater use of rail and bus.’

3.2.19 Additionally, as part of the framework for the plan, one of the principles is ‘Making Movement Better’, in which the three priorities for this principle, include:

- pedestrian priority in the town centre;
- a better pedestrian and cycle network across the town; and,
- measures to reduce through traffic in the town centre

3.2.20 The Plan recognises the need to better sustainably connect places located on the edge of the Town including the RSH and states:

‘At a town-wide level our proposal is to strengthen and extend the network of cycleways, primarily located on road but with the aim of creating off-road routes. This would involve the reapportionment of existing road space in favour of pedestrians and cyclists over other road users. The town needs radial as well as arterial routes to link places like the hospital, edge of town employment sites and other destinations.’

3.2.21 Existing priority projects within the Big Town Plan focus on regeneration in Shrewsbury Town Centre. However, it is understood that as a result of these development schemes, that opportunities for connections to wider destinations will be improved, including RSH.

### **3.3 Policy Summary**

3.3.1 A review of the relevant national and local transport policy documentation has been outlined in the section above, which sets out the requirement for this Transport Assessment, as well as the role new development should play in encouraging sustainable transport.

## 4. BASELINE CONDITIONS

### 4.1 Introduction

- 4.1.1 A baseline transport conditions report has recently been produced and this is included in Appendix A of this report. This baseline report includes details of parking, access by all modes, and road traffic accident analysis. The baseline report provides an analysis at both SaTH sites but for this development proposal the RSH site is most relevant.
- 4.1.2 As parking is a major element of the development proposals we have conveniently summarised below key aspects of parking at RSH including, for different users, existing parking supply and utilisation.

### 4.2 Vehicle Parking at RSH

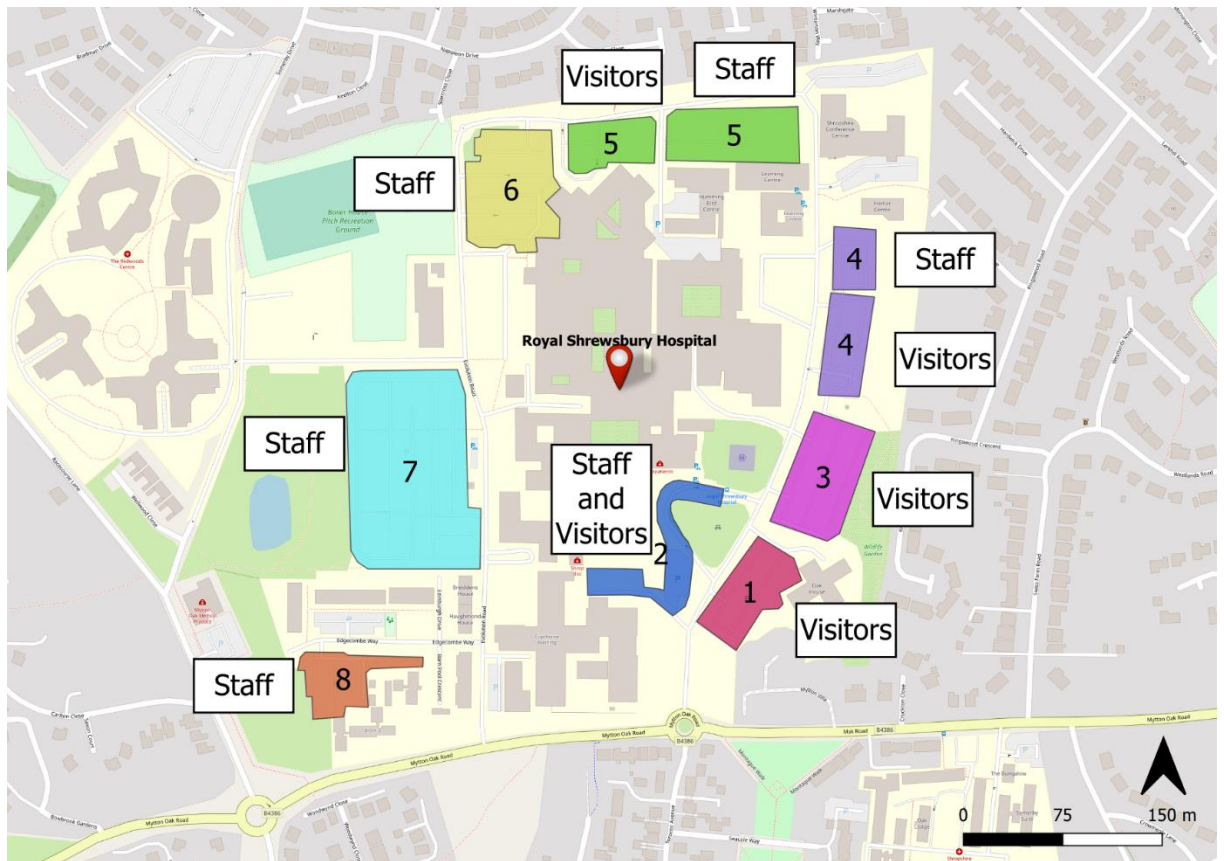
- 4.2.1 A site visit was conducted on the 1<sup>st</sup> December 2022 between 10:00 – 11:30 hours to examine parking supply and utilisation. The timing of the survey coincided with day shift clinical staff parking on site at the same time as non-clinical administration staff. The majority of non-clinical staff work day time hours only i.e. 9-5 and post Covid weekdays Tuesday to Thursday are noticeably busier than Mondays and Fridays. In addition, during the run up to Christmas, very few staff would take leave. Therefore, whilst the survey only represents a brief snapshot of parking activity at RSH, the timing does coincide with a high level of staff parking utilisation on site. For the patients and visitor car parks the timing is also significant as they were undertaken during the winter period when typically more people are suffering with illnesses and require medical care and support.
- 4.2.2 Table 1 below summarises parking supply and utilisation on site whilst Figure 1 shows a map of existing car parking at RSH. Table 1 provides details of each car park, user type, parking supply (with accessible spaces identified in brackets), the number of free spaces observed during the time of the site visits and whether or not (yes or no) users were observed parking in unallocated spaces. Table 1 shows that parking is fully utilised during busy periods (typically weekday afternoons and early evenings) at RSH for both staff and patient / visitor parking.

CAR PARK	USER	NUMBER OF SPACES PROVIDED	NUMBER OF FREE SPACES	UNALLOCATED PARKING OBSERVED
Car Park 1 – Mytton Oak Centre	Visitors	110	3	Y
Car Park 2 – Outpatients	Staff and Visitors	23 staff 62 visitors	4	N
Car Park 3 – Adjacent to A&E Department	Visitors	199	0	Y

Car Park 4 – Ward Block	Staff and Visitors	67 Staff 113 Visitors	1	Y
Car Park 5 – The Learning Centre	Staff and Visitors	145 Staff 42 Visitors	0	Y
Car Park 6 – The Treatment Centre	Staff	231	3	Y
Car Park 7 – Western Car Park	Staff	530	0	Y
Car Park 8 – Edgcombe Way	Staff	60	2	Y

**Table 1. RSH Existing Parking Supply and Utilisation**

4.2.3 Table 1 shows that there are 1056 staff parking spaces and 526 patient / visitor spaces and in total 1,534 spaces including 79 accessible parking spaces. Table 1 also shows that parking is fully utilised at RSH for both staff and patient / visitor parking.



**Figure 1. RSH Car Parks**



## 5. DEVELOPMENT PROPOSALS

### 5.1 Overview

- 5.1.1 The SaTH NHS Trust are preparing to consolidate hospital services at both PRH and RSH sites to allow for operations at the Trust to run more efficiently. This will result in the reconfiguration of services at both sites. The development proposals outlined in this section are as a result of this rearrangement.
- 5.1.2 The RSH development proposals will be home to a number of Departments and services including but not limited to Accident and Emergency and Women and Children's. Both will be the sole Accident and Emergency and Women and Children's Departments across both Shrewsbury and Telford Hospital sites. The proposals also include the movement of the Same Day Emergency Care (SDEC) department at RSH from its existing location next to the A&E department to a vacant site adjacent to the inpatient tower to provide a discharge lounge. Additionally, the development will result in the repositioning of the existing helipad and construction of a new MSCP and other parking provision. More details are set out below.
- 5.1.3 It is important to recognise that the catchment area for RSH includes the whole of Shropshire, Telford and the Wrekin and Mid Wales. In these areas private vehicle is the only realistic means of access especially in an emergency. Therefore, sufficient parking needs to be provided on site to ensure visitors can park on site.
- 5.1.4 Many RSH staff will live in locations where public transport accessibility is not an option. Clinical staff will be required to work different shifts where the start and end times mean public transport access is often limited or even non-existent. Critically staff need to be able to get to work on time to ensure the hospital operates effectively and efficiently for patients and other clinicians.

### 5.2 Development Proposals

#### New hospital facilities

- 5.2.1 Figure 2 below shows the location and of the new proposed development at RSH. The building has a GFA of approximately 32,000 sqm. The proposed development will be home to the following departments: Accident and Emergency; Women's and Children's; the Acute Medical Unit; and the Intensive Therapy Unit. The Same Day Emergency Care will be relocated to a site adjacent to the inpatient tower.
- 5.2.2 The proposed development will occupy land that includes 23 staff parking spaces and 37 patient / visitor spaces. However, the proposed development also includes 13 additional patient visitor spaces meaning the net loss of patient / visitor spaces is 24, see Table 2 and Figure 2 for details. Figure 2 also shows the new drop off facilities, which replaces the existing drop off facility.
- 5.2.3 Cycle parking is a feature of the development proposal and is estimated that covered cycle parking facilities will be able to accommodate 80 cycles. The new facilities also include changing rooms and shower facilities.
- 5.2.4 As a result of the development and ongoing changes it is expected that the number of staff at the RSH will increase from 3,747 to 3,997 an increase of 250 staff or a percentage increase of approximately 7%. All staff numbers are expressed in terms of Full Time Employees (FTEs).

#### Relocation of Helipad

- 5.2.5 The proposed new building will occupy land currently occupied by the helipad, 23 staff parking and 37 visitor and parking spaces and soft landscaping. There is a need to maintain the helipad and therefore the application also includes the relocation of the helipad on the site currently occupied by Car Park 3. The helipad has to be located adjacent to the Accident & Emergency Department to avoid any delay to emergency treatment for critically ill patients.
- 5.2.6 The helipad will have a raised deck. Figure 2 and Figure 3 below shows the new location of the helipad which will displace 96 patient / visitor parking spaces leaving a residual of 103 spaces. These residual spaces will be used as premium patient and visitor parking including accessible parking for blue badge holders and spaces for electric vehicle charging.



**Figure 2. Development Proposal**

**New Parking Facilities**

**Multi Storey Car Park**

- 5.2.7 Relocating the helipad will displace 96 car parking spaces from Car Park 4 at a time when demand for parking will increase. Consequently, additional parking is required alongside other sustainable transport measures (see Section 7 for details). Therefore, the proposals include a new MSCP on land occupied by Car Park 4. The new MSCP will provide 463 spaces in total with 5% allocated to accessible parking spaces. The MSCP will be utilised by patients / visitors only. Figure 3 shows the location and layout of the MSCP. Appendix B provides more details of the MSCP including layout, access, and configuration.

PREFERRED OPTION SITE PLAN

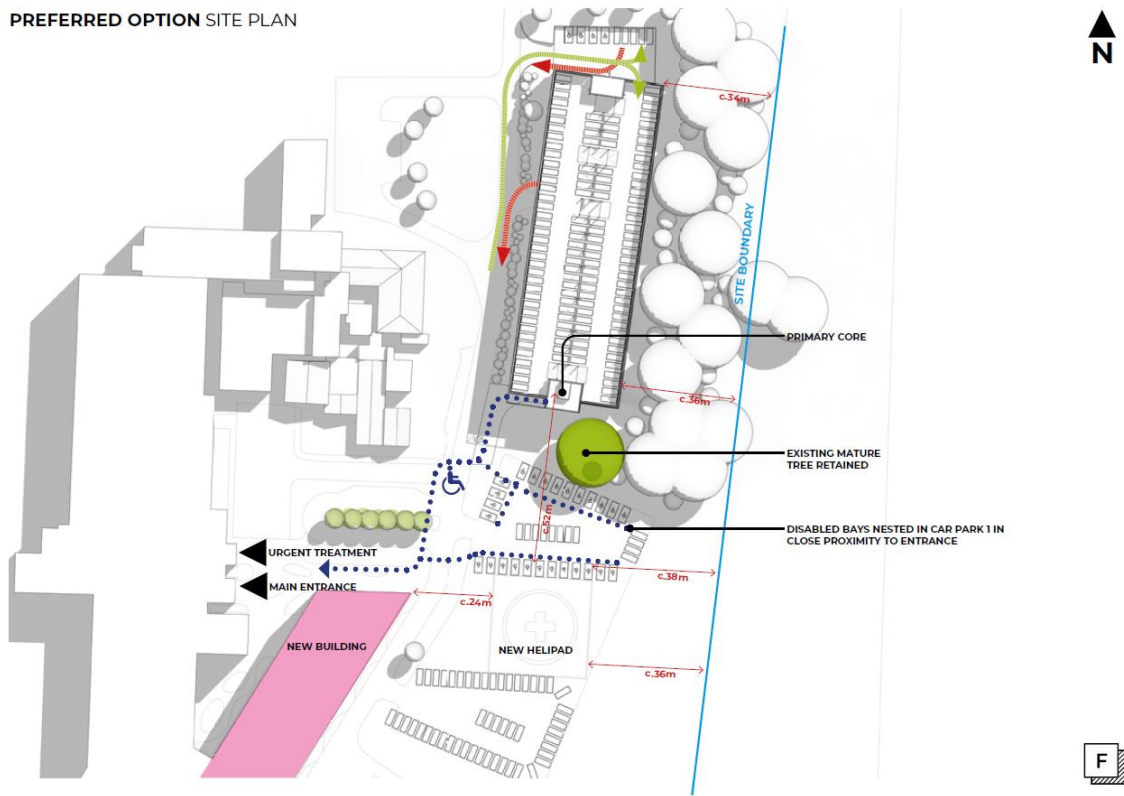


Figure 3. MSCP and Helipad Plan View

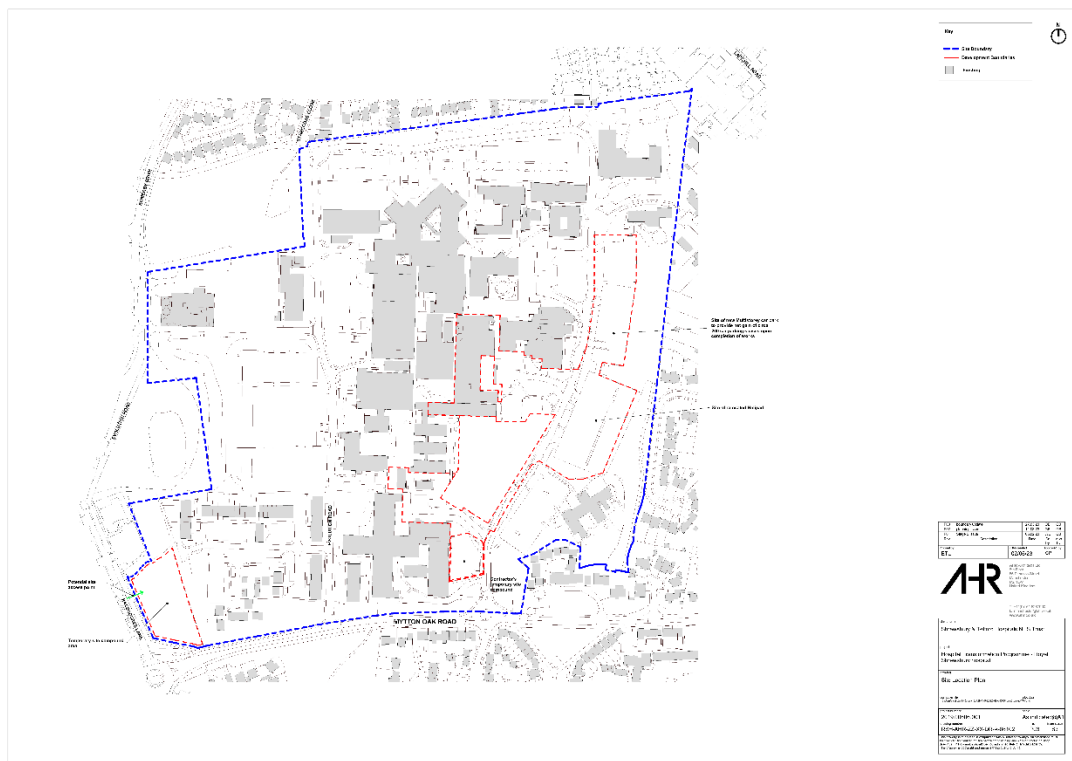


Figure 4. Site Location Plan

## Parking Summary

5.2.8 Table 2 below provides a summary of changes to the parking for both staff and patients and visitors at RSH.

PARKING PROPOSALS	STAFF PARKING	PATIENT / VISITOR PARKING
Car Park 2 – development proposal removes 23 staff spaces and 62 visitor spaces and includes 13 new visitor spaces	-23	-24
Car park 3 - repositioning of helipad to Car Park 3		-96
Car Park 4 – new MSCP displaces all existing except 13 spaces	-67	-104
New MSCP on Car Park 4 site		+463
Car Park 5 – reallocate existing 42 visitor spaces to staff parking	+42	-42
<b>TOTAL NET PROVISION</b>	<b>-48</b>	<b>197</b>

**Table 2. Development proposal - changes to RSH parking capacities**

5.2.9 Table 2 shows that at RSH there will be a net loss of 48 parking spaces for staff (without further mitigation) and an increase of 197 patient / visitor spaces. To ensure that there is no net reduction in staff parking SaTH Trust will undertake an exercise to identify a further circa 48 spaces on site for staff. SaTH and their appointed consultants will work with the highway authority to deliver these plans.

### 5.3 Staff and inpatient beds

5.3.1 RSH currently employs the equivalent of 3,747 full time staff. Over the next ten years the number of employees is expected to increase by a further 250 full time staff representing a percentage uplift of 7%. Existing hospital beds number 400 and whilst the proposed development will result in a reorganisation of inpatient hospital beds, there will be no net increase at the RSH site.

### 5.4 Vehicle Access

5.4.1 There are no plans to change existing vehicle access arrangements at RSH. Staff, patients and visitors will continue to use the two main vehicle entrance points from the B4386 Mytton Oak Road.



## 5.5 Construction compound and access

- 5.5.1 It is proposed that the construction compound will be located on land in the southwestern corner of the site on land that is bordered to the west by Racecourse Lane and to the south by the B4386 Mytton Oak Road. The land is currently green open scrub land. It is proposed that construction vehicles will access the construction compound via a new temporary priority T-junction on Racecourse Lane, the approximate location is shown on Figure 4 above. Assuming planning permission is granted SaTH and their appointed consultants and contractors will work with the highway authority to deliver the new temporary access. This will include preparation and submission of a Construction Traffic Management Plan which will set out further details of the management of construction traffic including construction access.

## 6. TRANSPORT ANALYSIS

### 6.1 Parking Analysis - staff parking

#### Baseline Scenario

- 6.1.1 At RSH there are currently 1,056 parking spaces and 3,747 Full Time Employees (FTEs). This means that the ratio of staff parking spaces to FTEs is 1 space for every 3.5 FTEs. The parking ratio reflects both the 24 hour a day / 7 days a week operation of the hospital where clinical staff work shift patterns, which include three different shifts a day including weekdays and weekends. The majority of non-clinical staff typically work standard working hours however many are able to work from home during the working week and therefore they are not always on site. Table 3 below provides a breakdown of these metrics and ratios.
- 6.1.2 On sites surveys of the staff car parks at RSH indicate that staff parking is at capacity and there is no practical reserve capacity on site.

#### Proposed Development Scenario – includes development proposals plus growth in staff numbers

- 6.1.3 The development proposals show that staff parking at RSH will reduce by 48 spaces, representing a 4.5% reduction in staff parking numbers. Full time employees are expected to increase by 250, representing an overall increase of 7%. An increase in staffing numbers will increase the demand for staff parking. Table 2 below shows that with the proposed development in place the ratio of staff parking spaces to FTEs is 1 space for every 4 FTEs, compared to a ratio of 3.5 in the baseline. Further mitigation is required in order to, as a minimum, maintain the existing ratio of parking spaces to FTEs.
- 6.1.4 In order to better manage existing parking facilities and provide additional parking for staff the Trust intend to implement two further mitigation measures:
- Provide additional on site parking of at least 48 spaces for staff to ensure that there is no net reduction in parking on site. This will be done by reconfiguring existing staff parking facilities to provide further capacity.
  - The Trust will make use of nearby off site park and ride site where staff can park and then continue their journey to the RSH by foot, cycle or bus.
- 6.1.5 Further details of use of Park and Ride is set out in Section 7 of this report.

SCENARIO	ROYAL SHREWSBURY HOSPITAL		
	Parking supply	FTE	Ratio (Parking Spaces/FTE)
Baseline	1056	3747	3.5
Proposed Development	1008	3997	4.0
Proposed Development plus mitigation	Minimum Target - 1142	3997	3.5

**Table 3. Staff Parking Scenarios**

## 6.2 Parking analysis – visitor / patient parking

### Baseline Scenario

- 6.2.1 At RSH there are currently 526 visitor / patient parking spaces and 400 hospital beds. This means that the ratio of patient / visitor parking spaces to hospital beds is 1 space for every 1.3 hospital beds. Table 4 below provides a breakdown of these metrics and ratios.
- 6.2.2 An onsite survey of the car parks at RSH indicates that patient / visitor parking is at capacity and there is minimal practical reserve capacity on site during busy periods.

### Proposed Development Scenario – includes development proposals

- 6.2.3 The development proposals show that patient / visitor parking at RSH will increase by 197 parking spaces to 723 spaces, representing an overall increase of 37%. There is no increase in hospital beds but there is a 7% increase in hospital staff.
- 6.2.4 The 37% increase in parking supply is a substantial increase in parking compared to changes in the number of hospital staff and beds. This in part reflects the need to address the existing baseline issues, where the car parks are full. This also reflects the development proposals and the changing services and facilities at RSH, in particular RSH will provide A&E services and Women and Children’s services for not only people in Shropshire but also Telford.

SCENARIO	ROYAL SHREWSBURY HOSPITAL			
	Parking			
	Supply (% increase)	FTE (% increase)	Hospital Beds (% increase)	Ratio (Parking Spaces / FTEs)
Baseline	526	3,747	400	1.3
Proposed Development	723 (37%)	3,997 (7%)	400 (0%)	1.8

**Table 4. Patient / visitor parking scenarios**

### 6.3 Traffic Impacts

6.3.1 Vehicle access to RSH is currently via two junctions on the B4386 Mytton Oak Road in the vicinity of the Hospital. It is recognised that expansion of hospital facilities will result in traffic impacts at these and other junctions and that each will have to be assessed to determine the level of such impacts. We are unable to provide the assessment as part of this Transport Assessment (TA) as baseline data is not available however we intend to submit a further addendum to the TA which will include a junction modelling assessment of the following junctions:

- B4386 Mytton Oak Road / Toronto Avenue / Hospital Access;
- B4386 Mytton Oak Road / Evolution Road; and
- B4386 Mytton Oak Road / Racecourse Lane.

6.3.2 Whilst the proposed development will result in traffic impacts it is considered that these impacts will not be substantial during the typical AM and PM peak hours. Like all major hospitals RSH operates 24 hours a day, seven days a week meaning clinical staff work shift patterns with start and end times that avoid peak hours. Furthermore patients access the hospital throughout the day and night at A&E and at other departments during the hours 07:00 – 21:00. Visiting times are between 11:30 – 20:00 with the busiest times typically between 15:00 – 16:00 and 18:00-19:00. Finally, a number of mitigation measures will be introduced designed to reduce traffic impacts and parking demand and these are outlined in more detail in the next two chapters.



## 7. TRANSPORT MITIGATION

### 7.1 Embedded Mitigation

7.1.1 The proposed development already includes embedded transport mitigation. That is mitigation that is part of the development proposals designed to minimise adverse transport impacts such as traffic generation, traffic congestion onsite and offsite, parking offsite on neighbouring streets, and other environmental effects.

7.1.2 The embedded proposed development on site mitigation includes:

- Additional on site parking for patients and visitors
- Premium parking provision opposite new A&E facility with further provision for Accessible parking and Electric Vehicle parking and charging.
- New cycle storage facilities with anticipated provision for a further 80 bikes. Proposed development will also include changing facilities and showers.

### 7.2 Other Mitigation measures

7.2.1 This embedded mitigation is further complimented by other mitigation measures set out below:

- A Parking Management Plan (PMP) will be implemented to more effectively manage staff parking on site. The PMP will adopt two new policies:
  - An agile working policy for non-clinical staff to reduce parking demand on peak days (Tuesday to Thursday) by implementing a system which more evenly spreads on site parking use across five days Monday to Friday; and
  - Introduction of a permit system to efficiently manage use of on site parking and parking off site at the nearby Park and Ride site.
- Continued implementation of Green Travel Plan measures set out in the associated Travel Plan Action Plan (see Appendix C)

7.2.2 Details of the existing Travel Plan measures are set out in the following chapter.

### 7.3 Use of Park and Ride facilities

#### Oxon Park and Ride

7.3.1 The Oxon Park and Ride site is located approximately 1.5km from the RSH. The walk time from the site to RSH is approximately 20 minutes and there are footpaths in place along the entire length of route. Alternatively, the cycle journey time would be less than 10 minutes. The existing bus route does not passby the RSH.

7.3.2 The Park and Ride facility has approximately 500 spaces. Parking is free all day if a £2 bus ticket is purchased with concessionary fares available to certain groups such as pensioners and students.

7.3.3 The operating times are Monday to Saturday between the hours 07:20 - 18:45. Admittedly this would make it difficult for some shift workers, with start and end times outside these hours, but such restrictions would not be a barrier to those working a typical 09:00-17:00 shift.

7.3.4 Clearly there are some challenges to be addressed such as the lack of public transport connectivity and the existing operational hours. Therefore, The Trust would work with the

planning authorities and operators to, wherever reasonably possible, reduce barriers to RSH staff usage of the Oxon Park and Ride facility.

### **Proposed Park and Ride Site**

- 7.3.5 Page 272 of the Draft Local Shropshire Plan<sup>1</sup>, site allocation for 'Land between Mytton Oak Road and Hanwood Road, Shrewsbury' states the following:

*Land between Mytton Oak Road and Hanwood Road, Shrewsbury - To the north of the site, opportunities for the enhancement of the town's Park and Ride offer will be delivered, linked to the Council's Park and Ride Strategy. A minimum of 5 hectares of employment land will be provided, utilizing opportunities associated with the creation of any new Park and Ride facility..... Appropriate vehicular access points will be provided from both Mytton Oak Road and Hanwood Road and will support the creation of a circular link road sufficient to sustain a bus route, potentially linked to the creation of a new Park and Ride facility to the north of the site*

- 7.3.6 The proposed park and ride site is better located both in terms of distance and accessibility which as noted in the Draft Local Plan is from the B4386 Mytton Park Road. Therefore, the proposed Park and Ride site, if delivered in a timely manner, has the potential to be more suitable for RSH staff than the Oxon Park and Ride site. The Trust will engage with the planning authorities to support the delivery of the proposed park and ride site and make representations on the plans and proposals so that they facilitate the intensification of the RSH site.

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<sup>1</sup> <https://www.shropshire.gov.uk/media/21100/sd002-draft-shropshire-local-plan.pdf>

## 8. TRAVEL PLAN

### 8.1 Overview

- 8.1.1 A framework travel plan was originally produced for the SaTH NHS Trust in 2014, which covered a five-year period up until 2019. Subsequently, the travel plan was updated in 2019 as an extension to the original document for a two-year period up until 2021. No further updates have occurred, in which the 2019 travel plan acts as the most-current plan for the Trust. The Travel-Plan Coordinator (TPC) for the Trust is based within the Facilities Management team, overseen by the Trust's Logistics Manager.

### 8.2 Modal Share

- 8.2.1 The Trust has undertaken staff travel surveys across SaTH sites since 2011, in which the 2018 travel survey forms the basis for the 2019 travel plan. Data from the 2019 travel plan has been extracted to illustrate the change in modal share for staff across hospital sites between 2011 and 2018. This is recorded in Table 5 below. Whilst the data recorded does not solely apply to RSH, it provides a useful indication of how staff travel to the sites.

Table 5. Staff Modal Split

TRAVEL MODE	MODE SHARE %		
	2011	2015/16	2018
Walk	4.7%	7.8%	7.8%
Cycle	1.3%	5.5%	3.8%
Cycle/Train	N/A	0.6%	0.3%
Bus	1.6%	2.8%	3.1%
Train	1.2%	1.2%	0.4%
Motorcycle	0.1%	0.3%	0.4%
Car share – drop and ride	N/A	N/A	0.6%
Taxi	N/A	N/A	0.5%
Car share	4.6%	3.3%	5.3%
SOV – Single Occupancy Vehicle	86.5%	73.1%	77.8%

- 8.2.2 As seen in Table 5, the transport mode showing highest usage is single occupancy vehicles. As referenced in this report and highlighted within the Travel Plan, this is strongly linked to the rural labour market catchment area of the SaTH sites and limited public transport accessibility. Nonetheless, modal share of single occupancy vehicles has decreased since the 2011 survey by 8.7%, despite increasing 4.7% since the 2015/16 travel survey.

- 8.2.3 Additionally, the transport modes showing highest growth amongst staff include bus use and car sharing, indicating that in order to improve sustainable travel to the site and reduce parking demand for staff, the Trust and TPC should focus on measures which encourage staff to travel by bus or car share. Since 2011, bus use amongst staff has increased 1.5% to 2018, whilst car sharing increased 0.7% to 2018, despite showing a decrease of 1.3% in the 2015/16 travel survey.
- 8.2.4 Contrary to this, travel modes such as train use and cycling have seen decreases in modal share since the 2011 survey, including a 0.8% decrease in train use since the 2011 survey and a 0.3% decrease in cycling since the 2015/26 survey. As mentioned previously, although this data does not solely apply to the situation at RSH; based on the location of the hospital and the distance from Shrewsbury Train station, we can assume that there is rationality to these figures in relation to RSH.

### 8.3 Objectives and Targets

- 8.3.1 As part of the Travel Plan, the Trust have outlined objectives and targets they plan to achieve in relation to transport.
- 8.3.2 These objectives and targets are part of a holistic approach that the Trust is implementing, in which they have been included in previous plans and strategies such as the Travel and Transport Strategy (2012), The Good Corporate Citizen and Sustainable Development Management Plan (2014) and the planning consent for the WCC (2012).
- 8.3.3 The objective and targets include:
- To reduce overall business travel by 25%;
  - Increase the proportion of travel undertaken in pool cars rather than grey fleet;
  - Achieve a score of 'excellent' in Travel standard by the Good Corporate Citizen model (now superseded by the SDU Sustainable Development Assessment Tool);
  - Reduce the percentage of staff accessing PRH by Single Occupancy Vehicle (SOV) to 90% from the 95% baseline (currently c.93%);
  - Carrying out an annual staff survey to monitor transport modes;
  - Develop a plan to reduce travel and traffic, improve local air quality and travel experience for our patients, visitors and staff;
  - To ensure BREEAM requirements are carried out for all new developments; and
  - Encouraging activity in all people in contact with the NHS by encouraging Active Travel to the Trust's sites.

### 8.4 Measures

- 8.4.1 The 2019 travel plan outlines a series of measures to reduce travel and transport issues across SaTH sites. Some of these measures are relevant to the interventions outlined in Section 7, and should be developed further to mitigate transport impacts at RSH.
- 8.4.2 The measures include:
- Achieve 5% mode share by active travel;
  - Focus on Car Sharing;
  - Pursue Flexible Working;
  - Marketing and Promotion of travel options; and
  - Reform the Grey Fleet.
- 8.4.3 A summary of these measures and how the Trust plans to achieve them is provided below.



### **Achieve 5% mode share by active travel**

- 8.4.4 To achieve 5% mode share in active travel, the Trust have outlined the need for investment in walking and cycling across SaTH sites. In particular this includes the identification of improving walking access to the site through regular site audits with staff and patient representatives. This ensures that routes which currently discourage walking are improved and better used. Additionally, as part of the measure, the Trust state that additional cycling facilities are required including improvement to cycle storage capacity and these are included in the development proposal.

### **Focus on Car Sharing**

- 8.4.5 A Liftshare scheme is currently operated across the Trust, enabling staff to find partners for common journeys. Included in this, is between 15-25 dedicated parking spaces at each site for car-sharing journeys, but which can be increased if there is sufficient demand.
- 8.4.6 As part of the Travel Plans measures, the Trust have identified that car sharing is a fundamental approach to mitigating impacts of parking demand relating to any future reconfiguration process; and that non-clinical staff can benefit most from this scheme due to their standardised working times. There is also recognition that car sharing schemes should be combined with additional incentives to increase uptake. This measure will be considered as part of the proposed parking management strategy designed to make more efficient use of parking facilities.

### **Pursue Flexible Working**

- 8.4.7 The Trust recognises that agile working policies could be a significant opportunity to reduce the parking impacts on site, by allowing non-clinical staff to either start or finish later or work from home, allowing a reduction in traffic and parking demand at peak hours.

### **Marketing and Promotion**

- 8.4.8 The Trust already partake in the marketing and promotion of travel and transport information to staff, patients and visitors; but recognise the importance of developing their existing approaches.
- 8.4.9 The measures that the Trust have emphasised to improve marketing and promotion, includes making available their travel options guide in both hard copy and electronic version to staff, and also including it as part of their corporate induction package. Moreover, there is recognition to develop and expand both their physical promotional materials located at SaTH sites, as well as their online travel information platform.

### **Reform the Grey Fleet**

- 8.4.10 The Trust have identified that their current administrative control of fleet vehicles represents a significant cost, due to their paper-based system, which provides a lack of control over vehicle and mileage usage for staff. As such, the Trust plan to implement a centralised booking system, which will support in the controlling of fleet vehicles.

## **8.5 Action Plan**

- 8.5.1 Included as part of the 2019 Travel Plan, a three-year Action Plan was developed based on the 2018 travel survey, to reduce single-occupancy vehicle levels across SaTH sites. In addition to this, the full Action Plan is also included in the Travel Plan, which sets out measures designed to tackle car parking congestion, improve air quality and reduce the need to travel.

The three year single occupancy vehicle Action Plan and full Action Plan are provided in Appendix C.

8.5.2 Further to the action plan measures outlined in Appendix C, additional potential measures to mitigate the transport impact at RSH as a result of the development proposals have been provided. These actions are outlined below.

**Table 6. Potential Action Plan Measures**

<b>ACTION</b>	<b>RESPONSIBILITY</b>	<b>TIMESCALE</b>	<b>COST</b>
Use of Park and Ride	SaTH	Within three years	Medium
Additional Electric Vehicle charging spaces	SaTH	On completion of new facility – circa 3 years from planning submission	Medium
Additional car sharing spaces	SaTH	On completion of new facility – circa 3 years from planning submission	Low
Additional cycle parking / storage racks	SaTH	On completion of new facility – circa 3 years from planning submission	Low
Agile working policy to allow spreading of non-clinical staff during peak days/hours	TPC/ HR	TBC	Medium

# 9. SUMMARY AND RECOMMENDATIONS

## 9.1 Summary

- 9.1.1 This TA report has set out details of the expansion of RSH site which includes new hospital facilities, a new MSCP and a re-organisation of other parking facilities. The hospital expansion will be home to the: Accident and Emergency Department; Women’s and Children’s Department; the Acute Medical Unit; and the Intensive Therapy Unit. The proposed 463 space MSCP will cater for the increase demand for parking from patients and visitors and the net gain in parking capacity for patients and visitors will be circa 200 spaces.
- 9.1.2 There will be no net gain in parking for staff on site. The Trust will undertake an exercise to find circa 50 more spaces on site to ensure that there is no net loss in parking capacity for staff. The increase in staff at RSH of 250 FTEs will increase demand for parking and to accommodate additional staff the Trust propose to make use of nearby PnR facilities, either at Oxon or a proposed PnR site in the Bowbrook area assuming the latter is delivered.
- 9.1.3 This report has set out the policy framework, provided an overview of baseline transport conditions, set out details of the proposed development, provided an overview and analysis of how parking will be managed for all users and provided an update to the existing Green Travel Plan. The proposed development is compliant with existing policy and guidance.
- 9.1.4 The TA recognises that the highway authority will require additional transport analysis, in particular the junction impact assessment. We intend to submit an addendum to the TA setting out the results of the analysis at selected impacted junctions. We will work with the highway authority to deliver this task and any other requirements.
- 9.1.5 It is further recognised that other tasks will be required at certain stages of the planning process and these could be conditioned by the planning authority. These include but are not limited too: a construction traffic management plan; a parking management strategy and details of the reorganisation of staff parking facilities to create an additional circa 50 spaces. On these tasks and any others we will work with the highway authority to ensure that deliverables are compliant and fit for purpose.







## BASELINE REPORT



**SYSTRA**

## TABLE OF CONTENTS

<b>1.</b>	<b>INTRODUCTION</b>	<b>5</b>
<b>1.1</b>	<b>BACKGROUND</b>	<b>5</b>
<b>1.2</b>	<b>REPORT STRUCTURE</b>	<b>5</b>
<b>2.</b>	<b>EXISTING CONDITIONS</b>	<b>6</b>
<b>2.1</b>	<b>CONTEXT</b>	<b>6</b>
<b>2.2</b>	<b>ROYAL SHREWSBURY HOSPITAL</b>	<b>6</b>
<b>2.3</b>	<b>PRINCESS ROYAL HOSPITAL</b>	<b>18</b>
<b>3.</b>	<b>STAFF POSTCODES</b>	<b>29</b>
<b>3.1</b>	<b>ROYAL SHREWSBURY HOSPITAL</b>	<b>29</b>
<b>3.2</b>	<b>PRINCESS ROYAL HOSPITAL</b>	<b>30</b>
<b>4.</b>	<b>SUMMARY AND CONCLUSIONS</b>	<b>33</b>
<b>4.1</b>	<b>SUMMARY</b>	<b>33</b>

## LIST OF FIGURES

Figure 1.	RSH Site Location	6
Figure 2.	RSH – Collision Data	8
Figure 3.	RSH Unallocated Parking Observation 1	10
Figure 4.	RSH Unallocated Parking Observation 2	11
Figure 5.	RSH Unallocated Parking Observation 3	12
Figure 6.	RSH Unallocated Parking Observation 4	13
Figure 7.	RSH Cycle Parking	15
Figure 8.	RSH Accessibility Map	17
Figure 9.	PRH Site Location	18
Figure 10.	PRH – Collision Data	20
Figure 11.	PRH Unallocated Parking Observation 1	22
Figure 12.	PRH Unallocated Parking Observation 2	23
Figure 13.	PRH Unallocated Parking Observation 3	24
Figure 14.	PRH Unallocated Parking Observation 4	25
Figure 15.	PRH Cycle Parking	26
Figure 16.	PRH Accessibility Map	28
Figure 17.	RSH Postcode Map	29
Figure 18.	RSH Postcode Map w/ Bus Routes	30
Figure 19.	PRH Postcode Map	31
Figure 20.	PRH Postcode Map w/ Bus Routes	32

**LIST OF TABLES**

Table 1.	RSH Main Car Parks	9
Table 2.	Former Staff Parking Charges	14
Table 3.	RSH Bus Service Summary	16
Table 4.	RSH Rail Service Summary	16
Table 5.	PRH Main Car Parks	21
Table 6.	PRH Bus Service Summary	27
Table 7.	PRH Rail Service Summary	27

# 1. INTRODUCTION

## 1.1 Background

1.1.1 SYSTRA Limited has been commissioned by AHR Architects, on behalf of the Shrewsbury and Telford Hospital NHS Trust (SaTH) to provide a review of baseline conditions for the Royal Shrewsbury Hospital (RSH) and the Princess Royal Hospital (PRH) sites.

## 1.2 Report Structure

1.2.1 This Baseline Report identifies the existing transport situations at both hospital sites and within the vicinity of the sites.

1.2.2 This report is structured as follows:

- **Section 2** - Review of the existing conditions at the sites and surrounding transport networks. In particular this focuses on the accessibility of the site by non-car means and the prevalence of public transport services, whilst also understanding demand for car parking at the sites;
- **Section 3** – Review of staff home postcodes to understand where staff are travelling from to both sites;
- **Section 4** - Summary of the findings of the report.



## 2. EXISTING CONDITIONS

### 2.1 Context

2.1.1 This chapter examines the baseline conditions at each site, which have been highlighted both through desk-based analysis, and observations undertaken during site visits to each respective site as set out below:

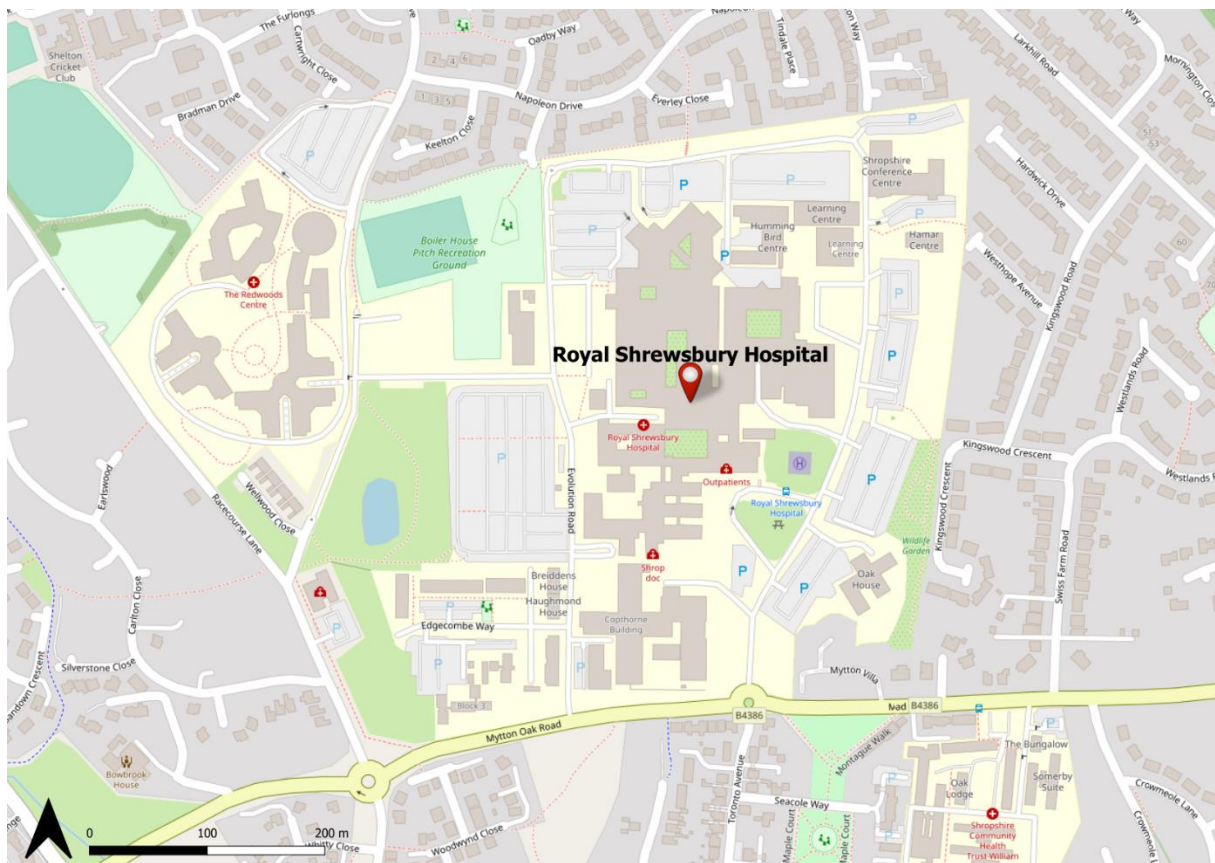
- RSH – Thursday 1<sup>st</sup> December 2022, 10:00 – 11:30am
- PRH – Thursday 1<sup>st</sup> December 2022, 13:00 – 14:30pm

2.1.2 The notes made during the sites visits are recorded in Appendix A.

### 2.2 Royal Shrewsbury Hospital

2.2.1 The RSH is located approximately 2.5km west of Shrewsbury Town Centre, and forms the Shrewsbury Site of the SaTH. The site is situated within the residential area of Bowbrook, toward the west of Shrewsbury’s urban-rural fringe.

Figure 1. RSH Site Location



## Access

- 2.2.2 Access to the site can be achieved via the northern arm of the Mytton Oak Road (B4386) / Toronto Avenue roundabout and the priority junction of Evolution Road / Mytton Road, both of which are located along the site's southern perimeter.
- 2.2.3 The site is served internally by Evolution Road and Edgecombe Way to the southwest, and an unnamed access road, which encircles the main buildings of the hospital and is accompanied by a substantial provision of allocated parking spaces around the sites perimeter.

## Local Highway Network

### Mytton Oak Road (B4386)

- 2.2.4 Mytton Oak Road (B4386) provides connections from the site, westwards towards the A5, which in turns provides linkages north towards Oswestry and east towards Telford. East of the site, Mytton Oak Road becomes Copthorne Road which provides a route towards the centre of Shrewsbury. In the vicinity of the hospital site the road is subject to a 30mph speed limit. Footway provision is continuous along each side of the road, and is lit throughout.

## Road Safety

- 2.2.5 Collision data for the local highway network has been analysed for the period between 2017 and 2021, to determine if there are any clusters or trends which could potentially be exacerbated by increases in traffic at the site.
- 2.2.6 The Department for Transport (DfT) Crash Map database has been used to analyse the collisions near to the site. The collisions have been categorised as 'slight', 'serious' and 'fatal'. Definitions from the Crash Map website are as follows:
- **Slight injury** - An injury of a minor character such as a sprain (including neck whiplash injury), bruise or cut which are not judged to be severe, or slight shock requiring roadside attention. This definition includes injuries not requiring medical treatment.
  - **Serious injury** - An injury for which a person is detained in hospital as an "in patient", or any of the following injuries whether or not they are detained in hospital: fractures, concussion, internal injuries, crushing, burns (excluding friction burns), severe cuts, severe general shock requiring medical treatment and injuries causing death 30 or more days after the accident. An injured casualty is recorded as seriously or slightly injured by the police on the basis of information available within a short time of the accident. This generally will not reflect the results of a medical examination, but may be influenced according to whether the casualty is hospitalised or not. Hospitalisation procedures will vary regionally.
  - **Fatal injury** - A collision which caused fatality.
- 2.2.7 The figure overleaf identifies the collisions over the most recent five-year period in the vicinity of the site. A total of five collisions occurred within the study area between 2017 and 2021 consisting of one 'serious' collisions, and four 'slight' collisions.

**Figure 2. RSH – Collision Data**



- 2.2.8 A total of five collisions have occurred in the vicinity of RSH over the period between 2017 and 2021.
- 2.2.9 One of these collisions occurred within the internal road network of the hospital, which involved a collision between a car and pedal cycle, resulting in a minor injury to the cyclist.
- 2.2.10 Additionally, three collisions are identified near the Evolution Road junction which connects to the hospital, including the only 'serious' accident. The serious collision involved a car and pedal cycle, however this occurred during the evening when it was dark, which may have affected the visibility of involved parties.
- 2.2.11 Despite the three collisions that have occurred near the Evolution Road junction, it can be concluded that there is no correlation between the collisions and therefore the highway network operates in a safe manner.

### **Car Parking**

- 2.2.12 Demand for parking at RSH is very high, including at both staff and visitor car parks, with incidences of unallocated parking found across most car parks at the site.
- 2.2.13 At RSH, there are more measures to discourage unallocated parking than at PRH. Double yellow lines along internal access roads were coned to limit overflow parking, whilst grass verges and footways were typically surrounded by cones, fences or high kerbs. However, despite the measures provided, it was observed that more unallocated parking occurs at RSH than at PRH.
- 2.2.14 A breakdown of the main car parks at RSH are provided overleaf.

**Table 1. RSH Main Car Parks**

CAR PARK	USER	NUMBER OF SPACES PROVIDED
Car Park 1 – Mytton Oak Centre	Visitors	110
Car Park 2 – Outpatients	Visitors	37
Car Park 3 – Adjacent to A&E Department	Visitors	199
Car Park 4 – Ward Block	Staff and Visitors	67 Staff 113 Visitors
Car Park 5 – The Learning Centre	Staff and Visitors	145 Staff 42 Visitors
Car Park 6 – The Treatment Centre	Staff	231
Car Park 7 – Western Car Park	Staff	530
Car Park 8 – Edgecombe Way	Staff Overflow	60

### **Mytton Oak Centre (Car Park 1) –Visitor Parking**

2.2.15 The majority of parking for visitors is located to the east of the site, in three separate car parks. The most southern car park (Car Park 1), for the Mytton Oak Centre, comprises a total of 110 spaces, 3 of which were free at the time of the site visit, in which all three were disabled spaces. There were incidences of unallocated parking on double yellow lines, footways and verges at this car park.

### **Outpatient Parking (Car Park 2) – Visitor Parking**

2.2.16 Car Parking for Outpatients, located to the east of the site is provided for disabled users only. This is split into two sections of parking, which includes car parking directly outside the Main Outpatients Entrance to the north and a rectangular car park to the south, which is also referred to as ‘Car Park 2’. At the time of the site visit, 3 free spaces were recorded at the northern section and 1 free space at the southern section.

### **A&E Department (Car Park 3) – Visitor Parking**

2.2.17 The second of the three visitor car parks (Car Park 3), located opposite the Accident & Emergency Department and Helipad, comprises a total of 199 spaces. At the time of the site visit, no free spaces were observed in this car park. There were however incidences of unallocated parking on double yellow lines at this car park.



**Figure 3. RSH Unallocated Parking Observation 1**



#### **Ward Block (Car Park 4) – Visitor Parking**

- 2.2.18 Car park 4, also known as Ward Block, comprises a total of 113 spaces, none of which were free at the time of the site visit.

#### **Ward Block (Car Park 4) – Staff Parking**

- 2.2.19 The northern section of car park 4 includes a provision for 67 staff vehicles. 1 free space was observed at the time of the site visit, in which this space was disabled only. Moreover, there were incidences of unallocated parking on double yellow lines at the car park.

#### **The Learning Centre and Treatment Centre (Car Park 5 and 6) – Staff Parking**

- 2.2.20 Approximately 356 spaces are provided for staff to north of the main hospital site, formed of the Treatment Centre (231) and Learning Centre Car Parks (145). The car park was partly closed at the time of the site visit but it was observed that 3 free spaces were recorded at the car park, all of which were disabled only, along with incidences of unallocated parking, predominantly on grass verges.

**Figure 4. RSH Unallocated Parking Observation 2**



#### **The Learning Centre (Car Park 5) – Visitor Parking**

- 2.2.21 Approximately 42 spaces for visitors are provided to the north of the site, in two small car parks adjacent to the Treatment Centre. No free spaces were recorded at the time of the site visit.

#### **Western Car Park (Car Park 7) – Staff Parking**

- 2.2.22 The main staff car park is situated to the west of the site, off Evolution Road, and is comprised of 530 spaces. At the time of the site visit, no free spaces were observed, which correlates with high incidences of unallocated parking on footways and verges witnessed.

#### **Edgecombe Way (Car Park 8) – Staff Overflow Parking**

- 2.2.23 Overflow staff parking comprising of 60 spaces is provided to the south-west of the site. During the site visits there were two spaces available with incidences of unallocated parking provided.



**Figure 5. RSH Unallocated Parking Observation 3**



#### **Additional Parking and Comments**

- 2.2.24 Additional minor car parks situated across the remainder of the site were busy, yet typically well managed. However, there were observations of unallocated parking recorded outside the Lingen Davies Centre and Maternity & Children's Unit, with vehicles parked on hatched lines and verges at these locations.

**Figure 6. RSH Unallocated Parking Observation 4**



### **Charging and Fees**

2.2.25 There is a tiered charging system for visitors on site offering a ranges of rates according to the length of stay:

- Blue Badge Holders: Free
- 0-20 minutes: Free
- 20 minutes to 2 hours: £3.50
- 2 hours to 3 hours: £4.50
- 3 hours to 4 hours: £5.50
- 4 hours to 5 hours: £6.50
- 5 hours up to 24 hours: £8.50

2.2.26 Prior to the COVID-19 Pandemic, members of staff were able to purchase a staff parking permit through payroll. However, these permits were removed during the pandemic and have not been reintroduced by the Trust. The table overleaf illustrates the former staff parking charges dependent on their employment type.



Table 2. Former Staff Parking Charges

LEVEL OF EMPLOYMENT	£ PER ANNUM(MONTH)
Band 1-3	£90 (£7.50)
Band 4-5 F1/F2	£144 (£12)
Band 6-7	£216 (£18)
Band 8 a-c	£288 (£24)
Band 8d, 9 non A4C	£360 (£30)
Medical Registrar	£288 (£24)
Medical Consultants	£360 (£30)

2.2.27 To improve the existing parking demand at both hospital sites, further consideration should be given to reintroducing staff parking permits/fees as per the above table, in which currently without these parking charges, high levels of single occupancy vehicle travel is being encouraged to the sites.

2.2.28 Additionally, one way to improve usage of the staff car park would be through greater parking enforcement. In reference to the SaTH website, the following rules apply:

- All vehicles must be parked within the marked bays only.
- No parking on double yellow lines or yellow cross-hatched boxes.
- No parking on the grass.
- Only holders of a blue registered disabled badge are allowed to park in the designated disabled parking spaces. They must display their blue badge.
- Any vehicle parked on the Trust's sites that causes an obstruction for emergency vehicles risks being damaged and will be issued with a Parking Charge Notice.
- The owner of any vehicle that causes damage to Trust property will be liable for the full cost of repair/reinstatement of the damaged property.
- Anyone who parks in breach of the rules is liable to be issued, without warning, with a Parking Charge Notice by CP Plus on behalf of the Trust.

### Non-Motorised Users

2.2.29 The site is reasonably well connected internally for NMUs and is generally well lit, with signage provided and well-placed for users.

#### Pedestrians

2.2.30 Tactile paving is present on Mytton Oak Road which runs directly to the south of the site. Moreover, pedestrian refuge crossing zones, along with a signalled pedestrian crossing point are situated to the west of the main entrance on Mytton Oak Road. Pavements, crossing points and tactile paving also exist throughout the hospital grounds, providing good access for pedestrians.

## Cyclists

- 2.2.31 Local traffic free cycle routes exist to the south and west of the site. National Cycle Route 81 also runs along the north-east of the site as a traffic free. The cycle routes provide strong connections to the centre of Shrewsbury.
- 2.2.32 Cycle shelters were also available on site, all of which accommodated bicycles at the time of the site visit. The largest and most widely used cycle shelter is situated adjacent to Car Park 7. This contains 'Sheffield Stands' with the ability to accommodate 18 bicycles. At the time of the site visit, 3 bicycles were parked in this shelter.

**Figure 7. RSH Cycle Parking**



## Public Transport

### Bus

2.2.33 There are six bus services within close proximity of the RSH as detailed in the table below. Services 11, 74, 552/553 and 558 go directly into the site.

**Table 3. RSH Bus Service Summary**

ROUTE	DAYTIME FREQUENCY	EVENING FREQUENCY
X5 – Oswestry to Telford via Shrewsbury	1 p/h	No evening services
11 – Shrewsbury to Gains Park	3 p/h	2 p/h
12 – Shrewsbury to Cophorne	1 p/h	No evening services
74 – Shrewsbury to Llanfyllin	3 services	No evening services
X75 Shrewsbury to Rhayadar	6 services	No evening services
552/553 – Shrewsbury to Bishops Castle	1 p/h	No evening services
558 - Shrewsbury to Montgomery	4 services	No evening services

### Rail

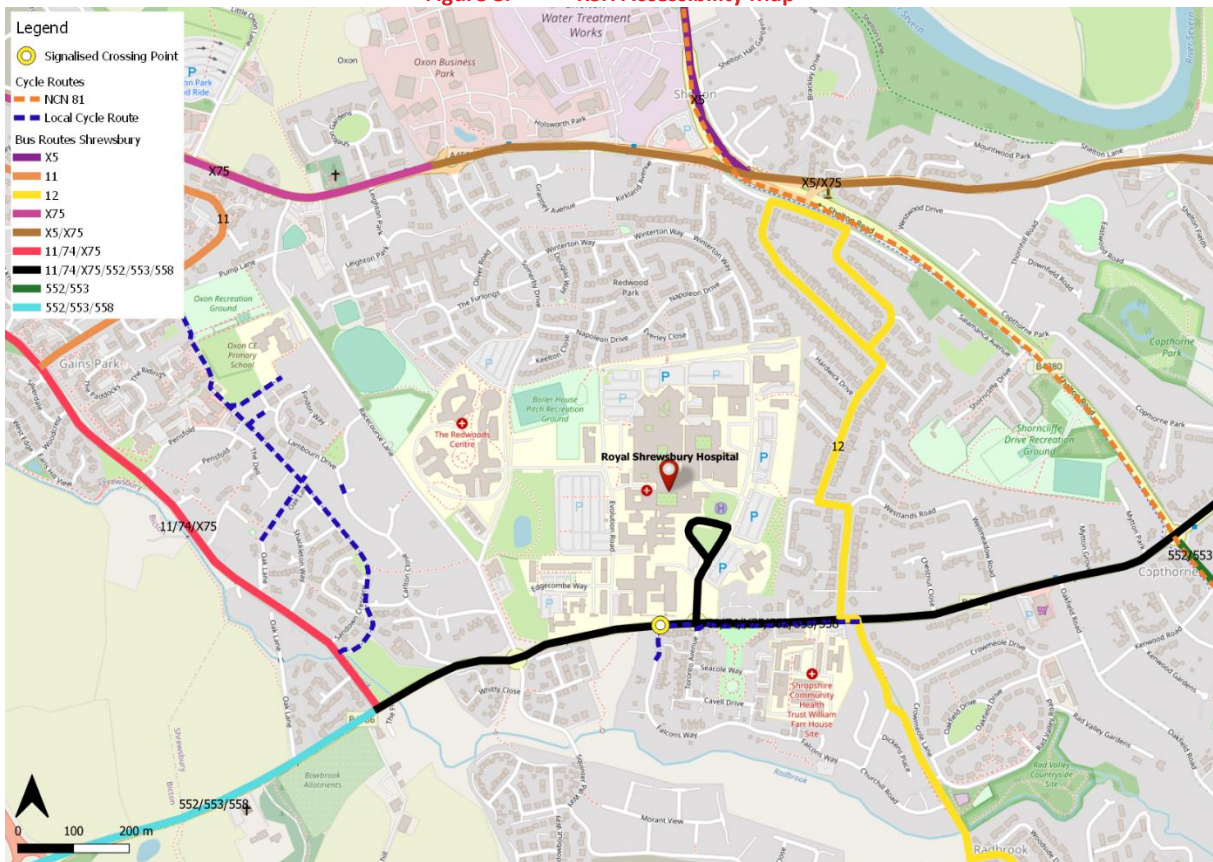
2.2.34 Shrewsbury Train Station is the closest to the RSH, approximately 10 minutes by car and 40 minutes via walking. Table 4 provides a summary of direct rail services from Shrewsbury Train Station.

**Table 4. RSH Rail Service Summary**

ROUTE	DAYTIME FREQUENCY	EVENING FREQUENCY
Shrewsbury - Aberystwyth	1 every 1-2 hours	1 p/h
Shrewsbury – Cardiff	1-2 p/h	1-2 p/h
Shrewsbury - Carmarthen	1 every 2 hours	No evening services
Shrewsbury - Crewe	1-2 p/h	1-2 p/h

Shrewsbury - Holyhead	1p/h	1-2 p/h
Shrewsbury - Llanelli	1 every 30 – 90 minutes	No evening services
Shrewsbury - Manchester	1 p/h	1 p/h
Shrewsbury – Swansea	1 every 30 – 90 minutes	No evening services
Shrewsbury – Wolverhampton	2 p/h	2 p/h

**Figure 8. RSH Accessibility Map**

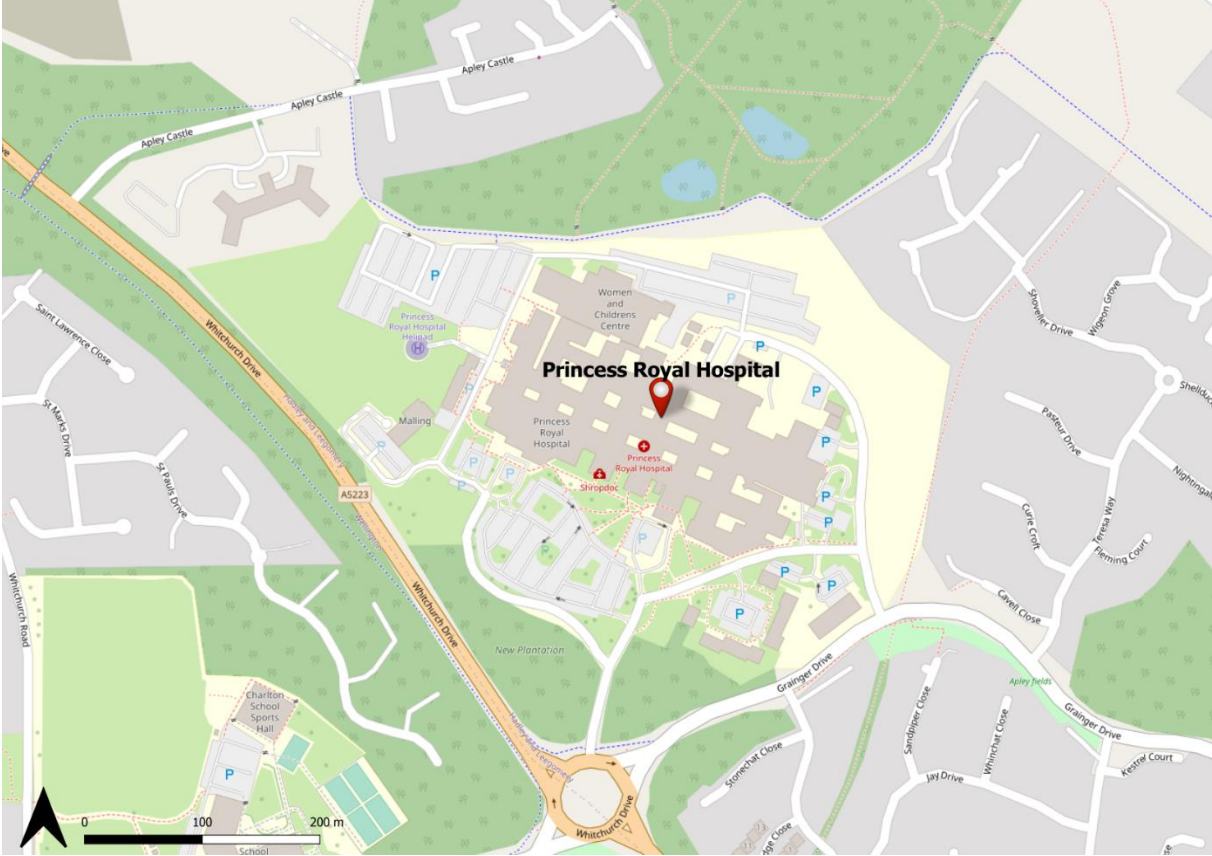




## 2.3 Princess Royal Hospital

2.3.1 The PRH is located in Apley, approximately 5.5km northwest of Telford Town Centre. It forms the Telford site of the SaTH, providing a range of acute hospital services, mainly for people from Telford, Shropshire, and mid Wales. Apley is a suburban residential area, on the edge of Telford’s rural-urban fringe.

Figure 9. PRH Site Location



### Access

2.3.2 Access to the site can be achieved via the priority junction with Grainger Drive and the northern arm of the Apley Roundabout which serves Whitchurch Drive, Apley Avenue and Grainger Drive. Upon visiting the site free-flowing traffic conditions were observed at each of the access points to the site.

2.3.3 The site is served internally by an unnamed access road, which encircles the main buildings of the hospital and is accompanied by a substantial provision of allocated parking spaces around the perimeter of the buildings.

### Local Highway Network

#### Grainger Drive

2.3.4 Grainger Drive is a single-carriageway road, subject to a 30mph speed limit. The road provides a link through the residential areas of Apley and Leegomery towards Leegate Avenue.

2.3.5 In the vicinity of the hospital site, footway provision is continuous along each side of the road, and is lit throughout.

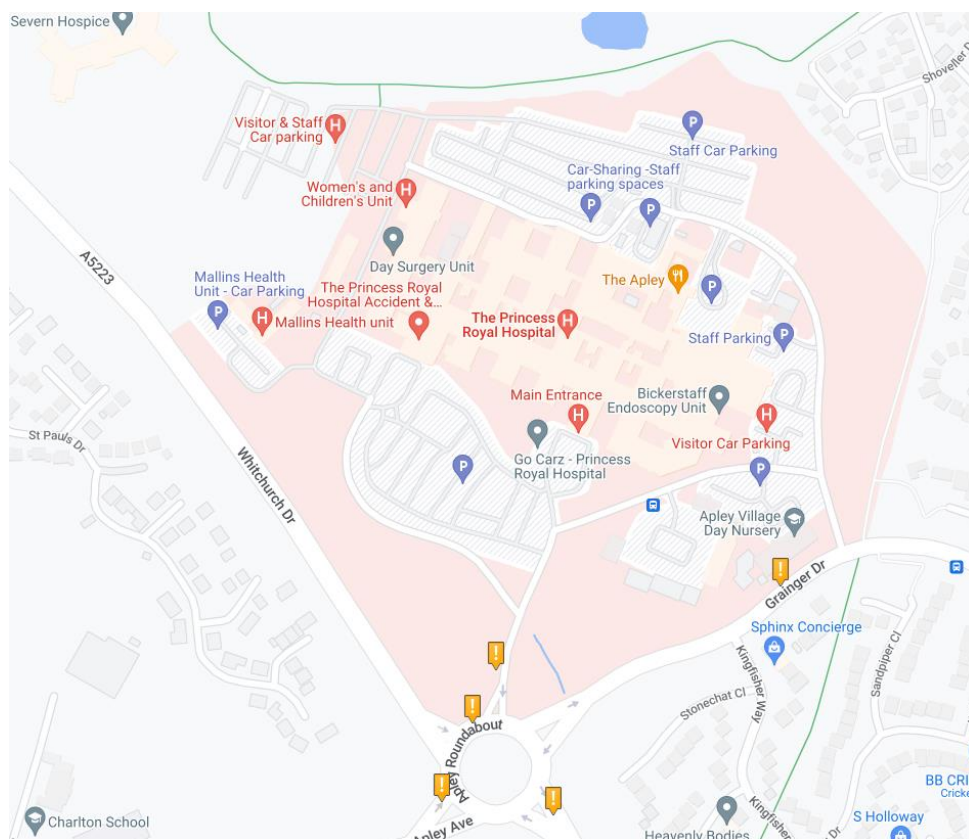
## Whitchurch Drive

- 2.3.6 Whitchurch Drive provides connections south from the site towards M54 Junction 6 and also Telford Town Centre via Lawley Drive, B5072 and West Centre Way. North of the site the road connects with the A442 which provides connections to Sleaford, Crudgington and areas further afield.
- 2.3.7 The section of the road in the vicinity of the site is predominantly rural in nature and subject to a 30 mph speed limit. Footway provision is continuous along one side of the road and is lit throughout.

## Road Safety

- 2.3.8 Collision data for the local highway network has been analysed for the period between 2017 and 2021, to determine if there are any clusters or trends which could potentially be exacerbated by increases in traffic at the site.
- 2.3.9 The Department for Transport (DfT) Crash Map database has been used to analyse the collisions near to the site. The collisions have been categorised as 'slight', 'serious' and 'fatal'. Definitions from the Crash Map website are as follows:
- **Slight injury** - An injury of a minor character such as a sprain (including neck whiplash injury), bruise or cut which are not judged to be severe, or slight shock requiring roadside attention. This definition includes injuries not requiring medical treatment.
  - **Serious injury** - An injury for which a person is detained in hospital as an "in patient", or any of the following injuries whether or not they are detained in hospital: fractures, concussion, internal injuries, crushing, burns (excluding friction burns), severe cuts, severe general shock requiring medical treatment and injuries causing death 30 or more days after the accident. An injured casualty is recorded as seriously or slightly injured by the police on the basis of information available within a short time of the accident. This generally will not reflect the results of a medical examination, but may be influenced according to whether the casualty is hospitalised or not. Hospitalisation procedures will vary regionally.
  - **Fatal injury** - A collision which caused fatality.
- 2.3.10 The figure overleaf identifies the collisions over the most recent five-year period in the vicinity of the site. A total of five collisions occurred within the study area between 2017 and 2021, all consisting of 'slight' collisions.

**Figure 10. PRH – Collision Data**



- 2.3.11 A total of five collisions have occurred in the vicinity of PRH between the period of 2017-2021, in which they are all categorised as 'slight' severity.
- 2.3.12 One of the accidents occurred within the internal road network of the hospital, which involved a collision between a car and pedestrian, resulting in a slight injury to the pedestrian.
- 2.3.13 Additionally, three of these collisions have been identified at Apley Roundabout, which provides access to the site, however, these are not clustered and have occurred at separate arms of the roundabout. Moreover, none of the collisions involve vulnerable road users such as pedestrians or cyclists.
- 2.3.14 Therefore, despite three accidents occurring at Apley Roundabout, it can be concluded that there is no correlation between them and that the highway network operates in a safe manner.

### **Car Parking**

- 2.3.15 Demand for parking at PRH is very high, including at both staff and visitor car parks, with incidences of unallocated parking found across most car parks at the site.
- 2.3.16 As mentioned previously, at RSH, there are more measures to discourage unallocated parking than at PRH, including cones, high kerbs and fences to stop parking on grass verges and footways. However, despite the measures provided, it was observed that more unallocated parking occurs at RSH than at PRH.
- 2.3.17 A breakdown of the main car parks at PRH are provided overleaf.

**Table 5. PRH Main Car Parks**

<b>CAR PARK</b>	<b>USER</b>	<b>NUMBER OF SPACES PROVIDED</b>
Main Entrance	Staff and Visitors	140 Staff 356 Visitors
A&E Entrance	Staff	48
Women & Children's	Staff and Visitors	249 Staff 121 Visitors
Northern Car Park	Staff	320
Eastern Car Park	Staff and Visitors	58
Apley Clinic	Visitors	17

**Main Entrance – Staff and Visitor Parking**

- 2.3.18 The majority of visitor parking on site is located immediately south of the main entrance to the hospital. The car park can accommodate a total of 356 vehicles, with an additional 6 disabled spaces. This includes approximately 140 spaces to the western side of the car park which are allocated for staff only.
- 2.3.19 At this time of visit, a section of to the east of the car park was closed due to redevelopment. In regard to the remaining section of the car park that was open, no free spaces were observed within the car park, in which there were incidences of unallocated parking on grass verges and over marked lines recorded.



**Figure 11. PRH Unallocated Parking Observation 1**



**A&E Department Entrance – Staff Parking**

2.3.20 To the west of the staff and visitor car park, adjacent to the hospital’s emergency entrance, a further 48 spaces are allocated for staff parking. A total of 1 free space was recorded at this location, with instances of parking on grass verges observed.

**Women & Children’s Ward – Visitor Parking**

2.3.21 A second major area of visitor parking is located to the west of the site, adjacent to the Women and Children’s Ward (WCW), which comprises a total of 121 spaces. During the time of visit, 1 free space was recorded at this location, along with incidences of unallocated parking.

**Figure 12. PRH Unallocated Parking Observation 2**



**Women & Children’s Ward – Staff Parking**

2.3.22 To the west of the WCW Visitors Car Park, there is a second major area of staff parking, which comprises approximately 249 spaces. Upon visiting the site, approximately 16 free spaces were observed at this location, with some incidences of unallocated parking.

**Northern Car Park – Staff Parking**

2.3.23 The main element of staff parking is situated to the north of the site, with a total of 320 spaces. At the time of the site visit, approximately 8 free spaces were recorded and incidences of vehicles parked outside of formal parking bays were recorded.

**Eastern Car Parks – Staff and Visitor Parking**

2.3.24 To the east of the site, there are two small car parks. The first being adjacent to the Wrekin Midwifery Unit, which is for staff parking only, and the second being adjacent to the Bickerstaff Endoscopy Unit, which is a visitor’s car park. These two car parks comprise of approximately 58 spaces, all of which were in use at the time of the site visit. At this location, incidences of unallocated parking were also recorded.



**Figure 13. PRH Unallocated Parking Observation 3**



**Apley Clinic – Staff & Visitor Parking**

2.3.25 Located to the southeast of the site, Apley Clinic provides 17 spaces for visitors, all of which were in use at the time of the site visit. There were incidences of unallocated parking at this location, with three vehicles parking on footways.

**Accommodation Parking – Staff Parking**

2.3.26 Accommodation parking, also located to the southeast of the site, recorded two free spaces at the time of the site visit, with around 7 incidences of unallocated parking on grass verges recorded.

**Additional Parking and Comments**

2.3.27 Additional minor car parks situated across the remainder of the site were also busy and unallocated parking was recorded, including outside the Mallins Health Centre and the Eye Clinic, with vehicles parked on footways and verges at these locations.

**Figure 14. PRH Unallocated Parking Observation 4**



### **Charging and Fees**

- 2.3.28 Parking charges at PRH are identical to those at the RSH. The details of these parking charges can be found in sections 2.2.25 and 2.2.26.

### **Non-Motorised Users**

- 2.3.29 The site is relatively poorly connected internally for Non-Motorised Users (NMUs). Whilst the area is generally well lit, footway and cycleway provision is intermittent, making the site feel disjointed. The issue is exacerbated further by the lack of clear onsite signage, which hinders wayfinding for NMUs.

### **Pedestrians**

- 2.3.30 Tactile paving is present on both sides of Grainger Drive near to the main entrance on Whitchurch Drive roundabout, however it is missing at the eastern entrance to the site to allow crossing of the junction. A signalled crossing point is present close to the hospital's eastern entrance, as well as to the north west of the main entrance on Whitchurch Drive roundabout, as depicted by Figure 16.



## Cyclists

- 2.3.31 Local traffic free cycle routes surround the hospital site in all directions. The routes provide good links into the centre of Wellington and also connect to National Cycle Route 81, which offers a wider connection to Telford.
- 2.3.32 Bicycle shelters are provided at the site, located adjacent to the hospitals main entrance, adjacent to the WCW, and adjacent to the Bickerstaff Endoscopy Unit.

**Figure 15. PRH Cycle Parking**



## Public Transport

### Bus

2.3.33 The hospital has a bus station near to the main entrance, which receives a number of services from Telford Town Centre, Shrewsbury, Wellington and Leegomery, which are detailed below.

Table 6. PRH Bus Service Summary

ROUTE	DAYTIME FREQUENCY	EVENING FREQUENCY
4 – Leegomery – Madeley	5 p/h	2 p/h
15 – Telford – Arleston	1 p/h	No evening services
16 – Telford – High Ercall	3 services	No evening services
17 – Shrewsbury – Princess Royal Hospital	5 services	No evening services
17a - Shrewsbury to Newport	4 services	No evening services

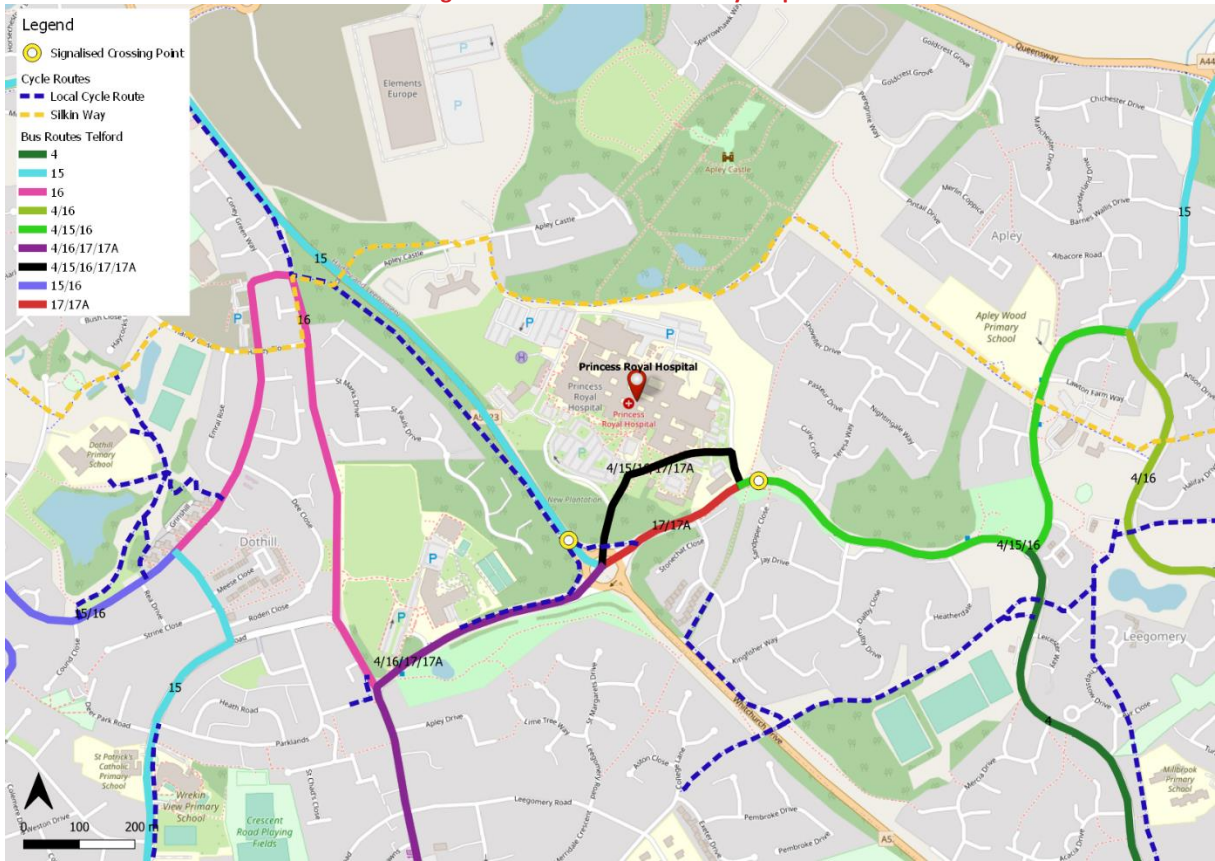
### Rail

2.3.34 The closest train station to the site is Wellington which is approximately a 24 minute walk. Telford Train Station is situated approximately 5.8km southeast of the site. Both stations are located on the Wolverhampton to Shrewsbury line. A summary of services from Wellington Station is outlined below:

Table 7. PRH Rail Service Summary

ROUTE	DAYTIME FREQUENCY	EVENING FREQUENCY
Wellington – Aberystwyth	1 every 2 hours	1 every 2 hours
Wellington – Birmingham New Street	2 p/h	2 p/h
Wellington – Birmingham International	1 p/h	1 p/h
Wellington – Shrewsbury	2 p/h	2 p/h
Wellington – Holyhead	4 services	No evening services

Figure 16. PRH Accessibility Map



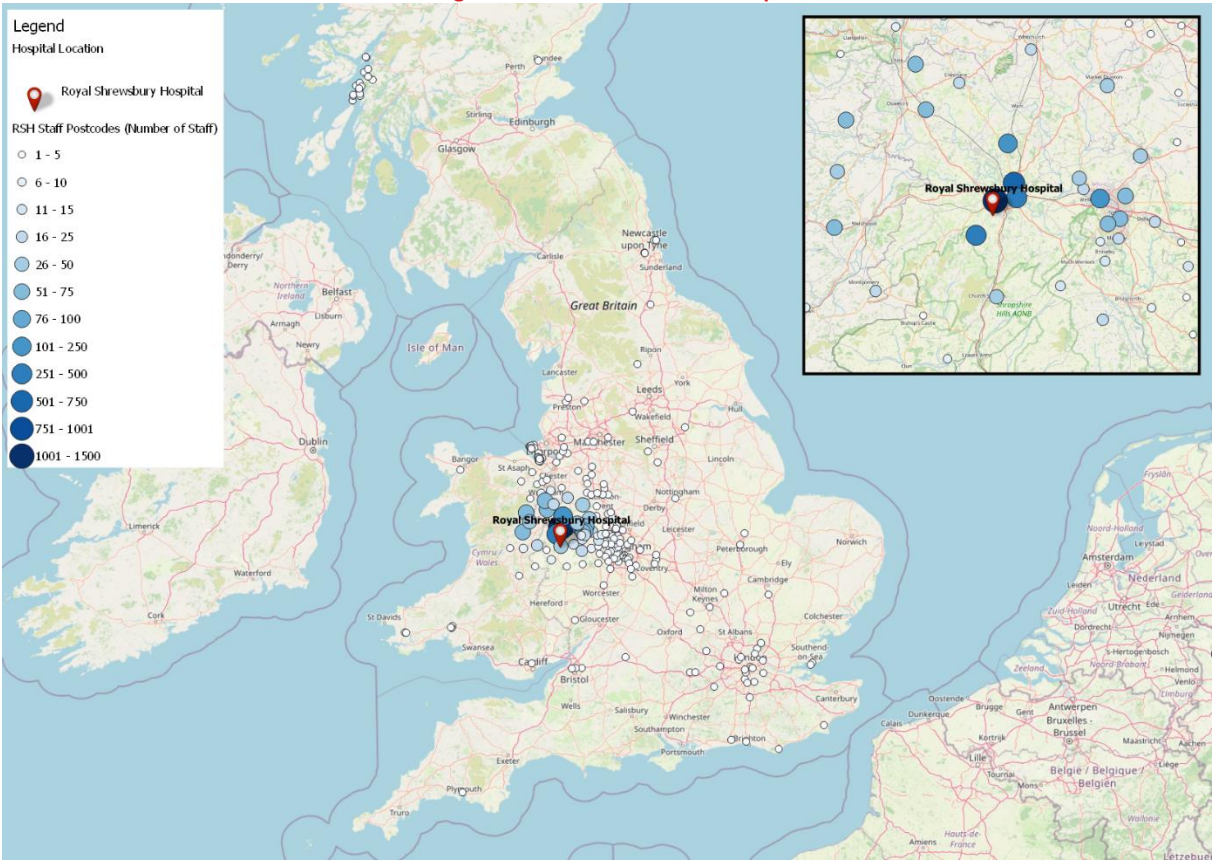


### 3. STAFF POSTCODES

#### 3.1 Royal Shrewsbury Hospital

- 3.1.1 The postcode districts of staff who work at RSH have been mapped to illustrate the areas employees are most likely to travel from. These are illustrated in Figure 17 below.
- 3.1.2 Despite staff living across the UK, the majority of staff working at RSH travel locally, and live within SY (Shrewsbury) and TF (Telford) postcode areas. The district in which most staff live within is SY3, which accounts for 1035 staff. This district incorporates the west of Shrewsbury town centre and is also the district in which RSH is located.
- 3.1.3 Following this, SY1 is the second most common district for RSH staff to live in, which accounts for 598 staff. This district incorporates Shrewsbury town centre and areas to the north-west of the town.

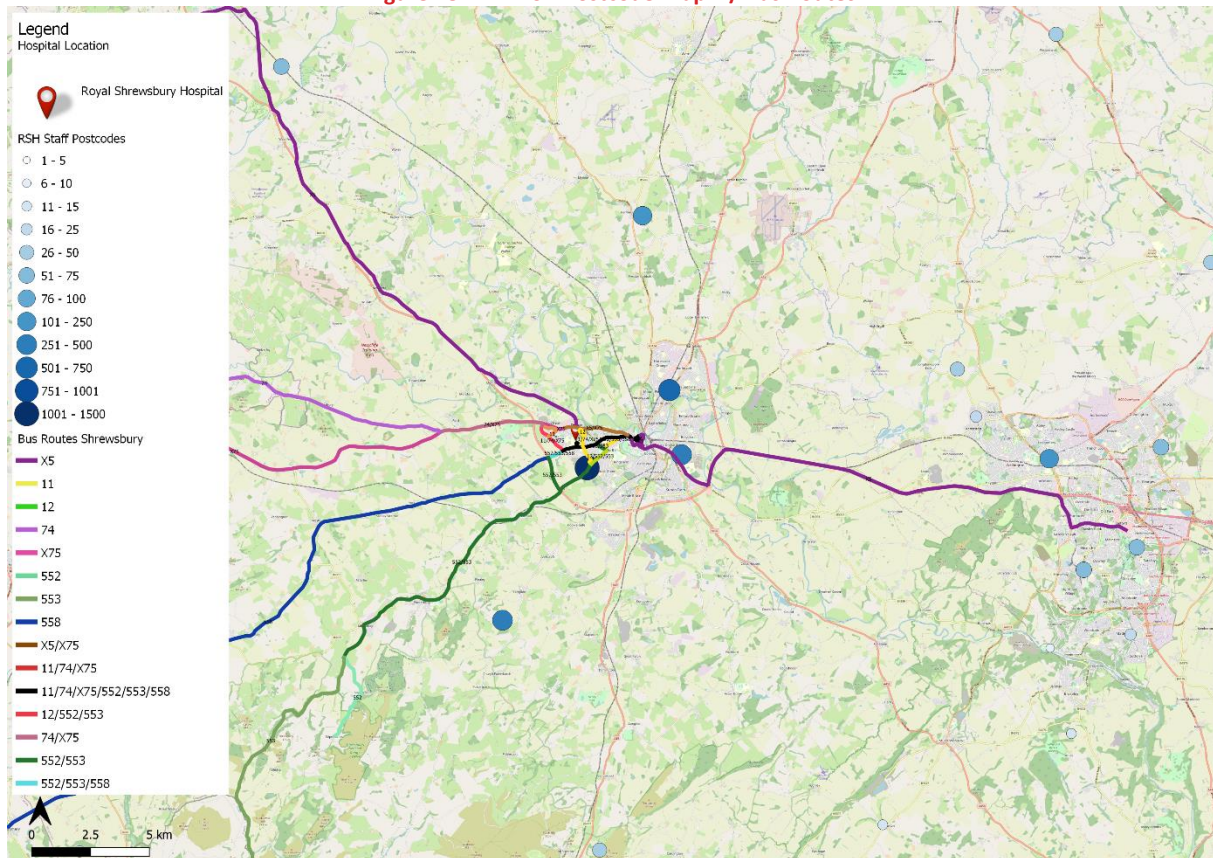
Figure 17. RSH Postcode Map



- 3.1.4 Bus routes which serve RSH have been illustrated alongside staff postcodes to understand if there are any districts with a high density of staff living within them, which are not currently connected to the hospital by public transport. These are shown in Figure 18.
- 3.1.5 The map illustrates that SY1 and SY4 to the north of Shrewsbury town centre and SY5 to the south of Shrewsbury have very poor public transport connections and could be improved.



Figure 18. RSH Postcode Map w/ Bus Routes



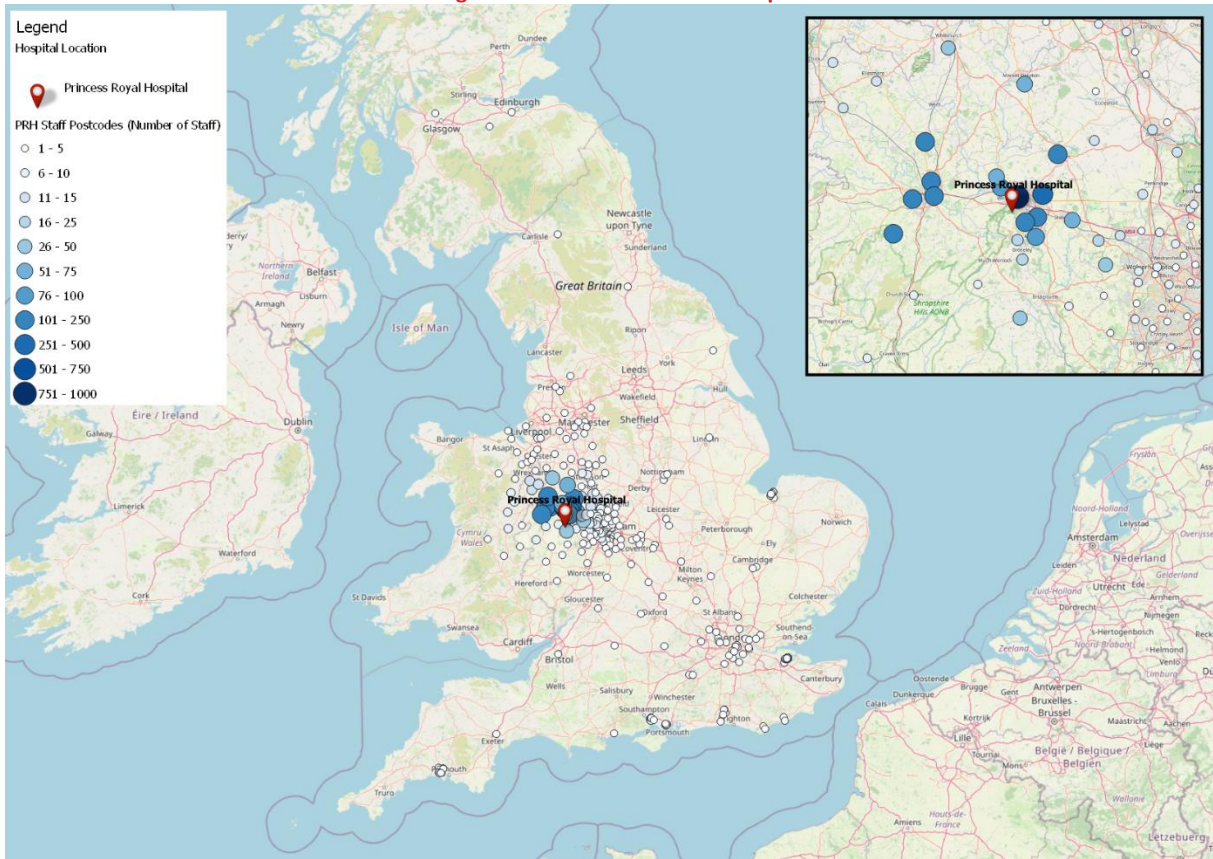
## 3.2 Princess Royal Hospital

3.2.1 The postcode districts of staff who work at PRH have also been mapped to illustrate the areas employees are most likely to travel from. These are illustrated in Figure 19.

3.2.2 Similarly to RSH, whilst there are staff living across the UK, the majority of staff working at PRH travel locally, and live within SY (Shrewsbury) and TF (Telford) postcode areas. The district in which most staff live within is TF1, which accounts for 802 staff. This district incorporates a large area north-west of Telford town centre and the M54, and is also the district in which PRH is located.

3.2.3 Following this, TF2 is the second most common district for PRH staff to live in, which accounts for 361 staff. This district incorporates an area north-east of Telford town centre and the M54.

**Figure 19. PRH Postcode Map**

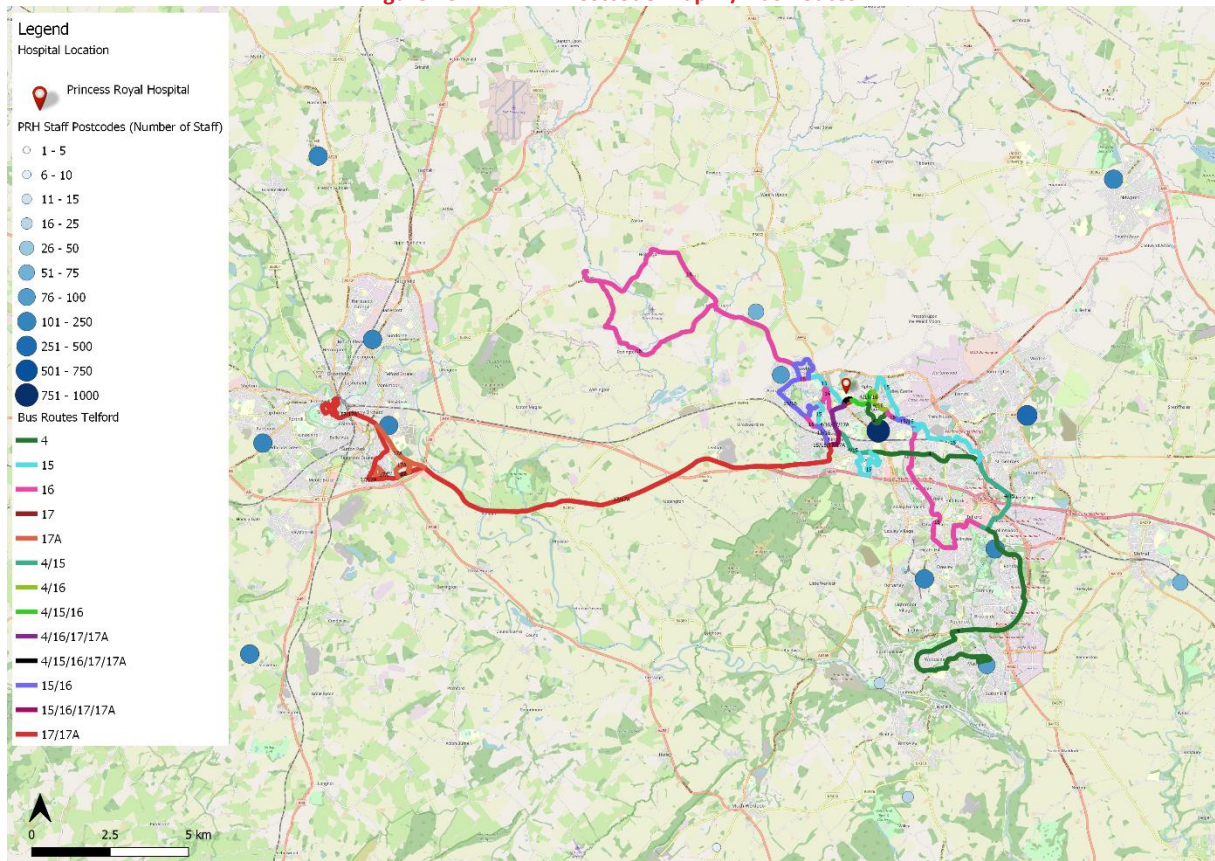


3.2.4 Bus routes which serve PRH have been illustrated alongside staff postcodes to understand if there are any districts with a high density of staff living within them, which are not currently connected to the hospital by public transport. These are shown in Figure 20 Figure 18.

3.2.5 The map illustrates that TF2 and TF10 to the north-east of Telford could be better served by public transport, as well as SY1, SY4 and SY5 district areas in Shrewsbury.



Figure 20. PRH Postcode Map w/ Bus Routes



## 4. SUMMARY AND CONCLUSIONS

### 4.1 Summary

- 4.1.1 This Baseline Report provides a review of the existing conditions at the Royal Shrewsbury Hospital and the Princess Royal Hospital sites.
- 4.1.2 The sites are well situated in terms of sustainable access opportunities and benefit from a range of sustainable transport and travel links within the immediate area. Whilst internal walking and cycling connections could be improved at Princess Royal Hospital, external cycling provisions are good at both sites, with existing nearby low-traffic, arterial routes provided.
- 4.1.3 Additionally, although both sites are served by several bus services, which call directly into the hospital sites, many of the services do not run into the late evening. Furthermore, based on staff home postcodes, there are some districts which are poorly served by public transport and could be improved. Finally, the sites are located close to rail stations, which provide onward connections to key towns and cities.
- 4.1.4 Collision data analysed at Royal Shrewsbury Hospital and Princess Royal Hospital revealed that there has been a minimal amount of incidents in the vicinity of both sites, and additionally, that there is no correlation between the accidents, in which it is concluded that the highway network operates safely.
- 4.1.5 Demand for parking at both hospital sites is incredibly high, with incidences of unallocated parking found across most of the car parks at the two sites. Whilst there were more measures to discourage unallocated parking at RSH, this didn't stop staff and visitors parking unauthorised.
- 4.1.6 Moreover, whilst parking charges have fractionally increased for visitors since the previous study, this hasn't reduced demand for parking at either of the two sites. Furthermore, this is exacerbated as a result of not reintroducing parking permit charges for staff following the COVID-19 pandemic, which encourages single occupancy vehicle travel to the sites.
- 4.1.7 Overall, the report has revealed that three key improvements should be considered by the Shrewsbury and Telford Hospital Trust:
- Reintroduction of staff parking permits/fees;
  - Better management and enforcement of car parking at the sites; and
  - Improvements to bus services which serve the sites in coordination with transport providers, including routes and frequency.



## Appendix A: Site Visit Notes

## Royal Shrewsbury Hospital

Car Park	Demand for parking (Low to High)	Number of free spaces	Unallocated parking	Parking prices	Cycle parking available?	Further Notes	
1 – Mytton Oak Centre	High	3	On verges, footways and yellow lines	Blue Badge Holders: Free  0-20 minutes: Free  20 minutes to 2 hours: £3.50  2 hours to 3 hours: £4.50  3 hours to 4 hours: £5.50  4 hours to 5 hours: £6.50  5 hours up to 24 hours: £8.50		Only disabled spaces free	
2 – Outpatient Parking	High	4	None			Disabled parking area only	
3 – Adj. to A&E Department	High	0	On yellow lines				
4 – Ward Block - Visitor	High	0	None				
4 – Ward Block - Staff	High	1	On yellow lines			Only disabled space free	
5 – Treatment Centre Visitors	High	0	On verges			Car park partly closed – only disabled spaces free	
5/6 – Treatment Centre and Learning Centre – Staff	High	3	On verges				
7 – Western Car Park	High	0	On verges and footways			Y	
8 – Edgecombe Way	High	2	On verges				
Daisy Chain Nursery	Low	10	None				Nursery drop-off only
Maternity & Children’s Unit	High	0	On verges and hatched areas				Mainly drop-offs
Lingen Davies Centre	High	0	Hatched areas/yellow lines				
Shropshire Education & Conference Centre	Medium	5	None			Y	Accessed by barrier
Boiler House	High	2	None				

## Princess Royal Hospital

Car Park	Demand for parking (Low to High)	Number of free spaces	Unallocated parking	Parking prices	Cycle parking available?	Further Notes
Main Entrance	High	0	On verges and yellow lines	Blue Badge Holders: Free  0-20 minutes: Free  20 minutes to 2 hours: £3.50  2 hours to 3 hours: £4.50  3 hours to 4 hours: £5.50  4 hours to 5 hours: £6.50  5 hours up to 24 hours: £8.50	Y	Part of Main Entrance car park closed for redevelopment
A&E Department Entrance	High	1	On verges		Y	
Mallins Health Centre	Medium	5	On verges			
Eye Clinic	High	0	On footways			
Women & Children's Ward – Visitors	High	1	On footways, hatched areas and outside of marked bays			
Women & Children's Ward – Staff	High	16	Outside of marked bays		Y	
Northern Car Park	High	8	Parking outside of marked bays			
Eastern Car Parks	High	0	On verges and footways			
Apley Village Nursery Parking	Low	17	None			Nursery only parking
Resident Accommodation Parking	High	2	On verges			Residents only parking. Only disabled spaces free
Apley Clinic	High	0	On footways			







## NHS Shrewsbury and Telford

### BASELINE TRANSPORT SCOPING STUDY

Report



# NHS Shrewsbury and Telford

## BASELINE TRANSPORT SCOPING STUDY

Report

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# Contents

<b>1</b>	<b>INTRODUCTION</b>	<b>5</b>
	Introduction .....	5
<b>2</b>	<b>CURRENT SITUATION</b>	<b>6</b>
	Princess Royal Hospital .....	6
	Access .....	7
	Local Highway Network .....	7
	Road Safety .....	8
	Car Parking .....	8
	Non-Motorised Users .....	12
	Public Transport.....	13
	Royal Shrewsbury hospital .....	13
	Access .....	14
	Local Highway Network .....	14
	Road Safety .....	14
	Car Parking .....	15
	Non-motorised Users .....	17
	Public Transport.....	18
<b>3</b>	<b>TRAVEL PLAN REVIEW</b>	<b>20</b>
<b>4</b>	<b>FUTURE SCENARIOS &amp; RECOMMENDATIONS</b>	<b>22</b>
	Introduction .....	22
	Site Options .....	22
	Car Parking .....	22
	Cycle Network Connections.....	26
	On Site Road Assessment.....	27
	Blue Light Only ROUTE (BLOR) – RSH .....	27
	Travel Plan Review Reccomendations .....	28
	Summary of Reccomendations.....	30

## Tables and Figures

Figure 2-1 Site Location - PRH .....	6
Figure 2-2 Queueing Outside Main Entrance - PRH.....	7
Figure 2-3 Collision Data - PRH.....	8
Figure 2-4 Overflow Parking Women & Children’s Ward Car Park - PRH.....	9
Table 2-1 Current Staff Parking Charges.....	11
Figure 2-6 Accessibility Map - RSH .....	12
Table 2-2 Bus Service Summary - PRH .....	13
Table 2-3 Telford Train Service Summary - PRH .....	13
Figure 2-7 Site Location - RSH .....	14
Figure 2-8 Collision Data - RSH.....	15
Figure 2-9 Parking Signage - RSH .....	15
Figure 2-10 Staff Parking North - RSH .....	16
Figure 2-11 Accessibility Map - RSH .....	17
Table 2-4 Bus Service Summary - RSH .....	18
Table 2-5 Train Service Summary – RSH.....	19
Table 4-1 FTE Staff Members.....	23
Table 4-2 Parking Space Provision.....	23
Table 4-3 PRH Car Parking Options Summary .....	25
Table 4-4 SRH Car Parking Options Summary .....	26
Table 4-5 Summary of Reccomendations.....	31

## Appendices

- Appendix A Car Park Locations
- Appendix B Swept-Path Analysis (Inlcuding BLOR Routes)



# 1 Introduction

## INTRODUCTION

- 1.1 JMP Consultants Ltd has been commissioned by AHR Architects, on behalf of the Shrewsbury and Telford Hospital NHS Trust (SaTH) to provide a review of baseline conditions and future recommendations for the Royal Shrewsbury Hospital (RSH) and the Princess Royal Hospital (PRH) sites.
- 1.2 The SaTH is reorganising the way the trust will function in the future across the two sites. How the reorganisation is to be implemented across both sites is still to be determined but it will see the concentration of Emergency facilities at one location and at the other, the current Emergency facility will be replaced with a Planned Care Site (PCS).
- 1.3 This document provides Travel and Transport Planning advice to support the project team with the preparation of the Outline Business Case (OBC) for submission in October 2016.

## 2 Current Situation

2.1 This chapter examines the baseline conditions at each site, which have been highlighted both through desk-based analysis, and observations undertaken during site visits to each respective site as set out below:

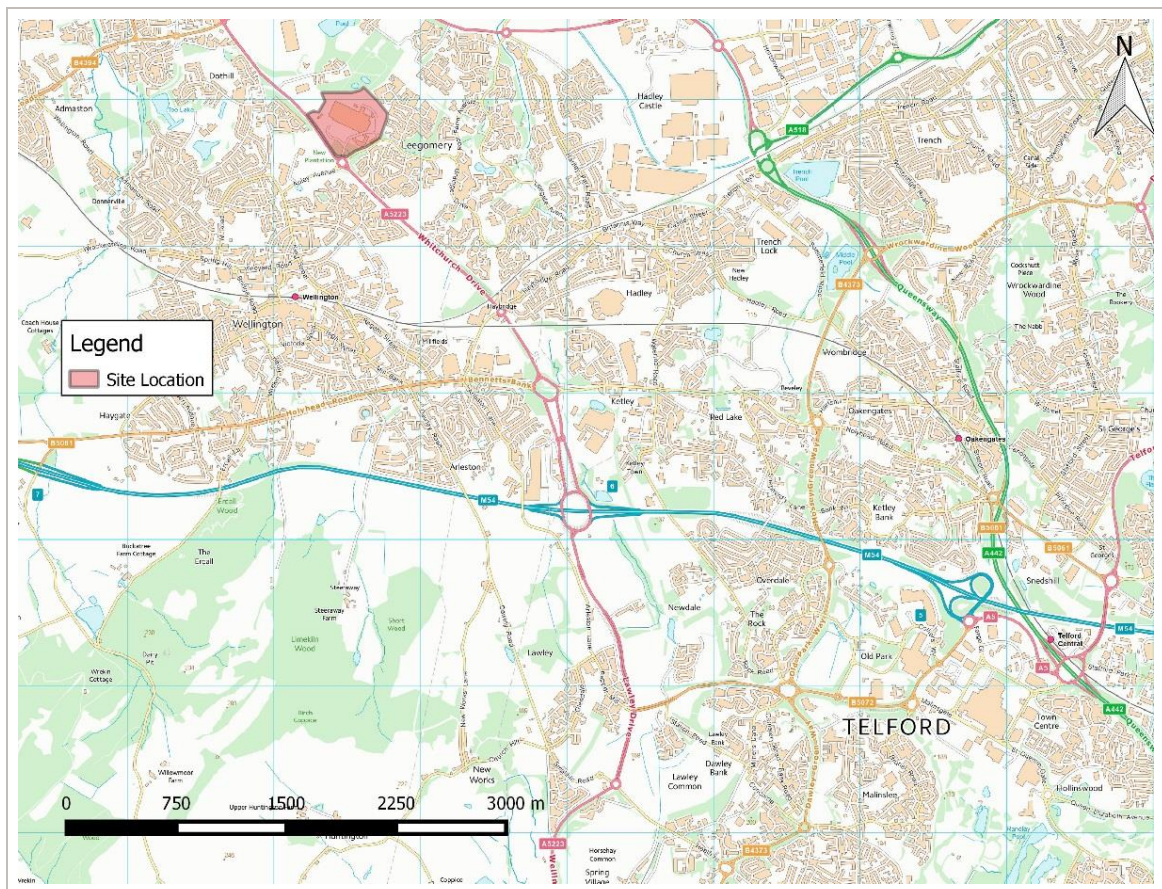
- PRH – Wednesday 24<sup>th</sup> August, 1:00pm
- RSH – Wednesday 24<sup>th</sup> August, 2:30pm
- PRH – Thursday 8<sup>th</sup> September, 3:00pm
- RSH – Thursday 8<sup>th</sup> September, 1:30pm

2.2 During the site visit the travel distance between PRH and SRH was recorded as 25 minutes.

### PRINCESS ROYAL HOSPITAL

2.3 The PRH is located in Apley, approximately 5.5km northwest of Telford Town Centre. It forms the Telford site of the SaTH, providing a range of acute hospital services, mainly for people from Telford, Shropshire, and mid Wales. Apley is a suburban residential area, on the edge of Telford’s rural-urban fringe. Figure 2-1 provides an overview of the site location.

Figure 2-1 Site Location - PRH



GIS

## ACCESS

- 2.4 Access to the site can be achieved via the priority junction with Grainger Drive and the northern arm of the Apley Roundabout which serves Whitchurch Drive, Apley Avenue and Grainger Drive. Upon visiting the site free-flowing traffic conditions were observed at each of the access points to the site.
- 2.5 The site is served internally by an unnamed access road, which encircles the main buildings of the hospital and is accompanied by a substantial provision of allocated parking spaces around the perimeter of the buildings. There is no drop-off zone for taxis onsite, instead taxis were seen queueing outside the main entrance as shown in Figure 2-2.

**Figure 2-2 Queueing Outside Main Entrance - PRH**



## LOCAL HIGHWAY NETWORK

### Grainger Drive

- 2.6 Grainger Drive is a speed-camera safety zone, subject to a 30mph speed limit. The road provides a link through the residential areas of Apley and Leegomery towards Leegate Avenue.
- 2.7 In the vicinity of the hospital site, footway provision is continuous along each side of the road, and is lit throughout.

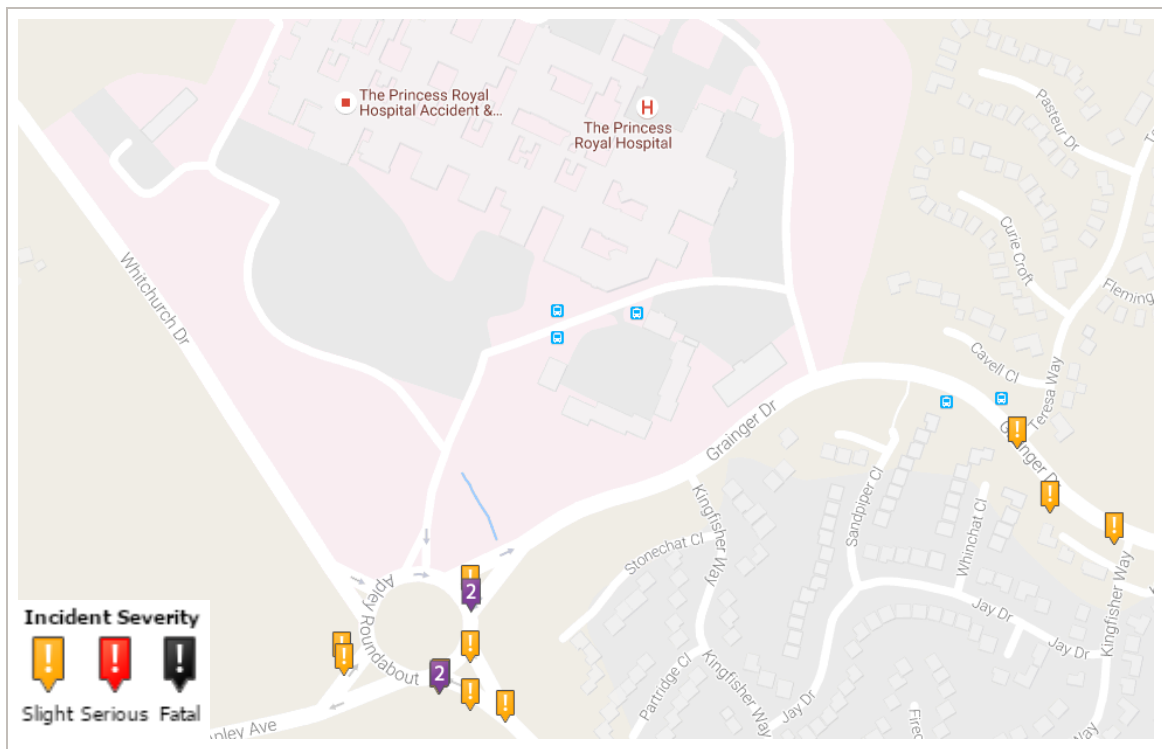
### Whitchurch Drive (A5223)

- 2.8 Whitchurch Drive provides connections south from the site towards M54 Junction 6 towards Telford Town Centre via Lawley Drive, B5072 and West Centre Way. North of the site the road connects with the A442 which provides connections to Sleaford, Crudginton and areas further afield.
- 2.9 The section of the road in the vicinity of the site is predominantly rural in nature and subject to a 40 mph speed limit. Footway provision is continuous along one side of the road and is lit throughout.

## ROAD SAFETY

- 2.10 Collision data has been sourced for the local highway network to determine if there are any clusters or trends which could potentially be exacerbated by any increases in traffic at the site. Crashmap has been used, as the system provides the most recently published Department for Transport (DfT) collision data, from 2011 to 2015.
- 2.11 Figure 2-3 shows that there were no collisions recorded at the site access points off Grainger Drive and Apley Roundabout respectively.
- 2.12 Three 'slight' collisions were recorded on Apley roundabout itself, with a further three recorded on the approach from Grainger Drive and two on each of the approaches from Apley Avenue and Whitchurch Drive. Nonetheless, this is a busy roundabout and the cluster of 'slight' collisions recorded is to be anticipated given the large number of vehicle movements at this location.

Figure 2-3 Collision Data - PRH



Crashmap

- 2.13 After reviewing relevant collision data, no abnormal trends or clusters have been identified on the respective routes and these are unlikely to be exacerbated by potential increases in trips generated by the site.

## CAR PARKING

### Main Entrance – Visitor Parking

- 2.14 The majority of visitor parking on site is located immediately south of the main entrance to the hospital. The car park can accommodate a total of 356 vehicles, with an additional 6 disabled spaces, however after liaising with the on-site attendant for the car park, it is understood that approximately 140 spaces to the western side of the car park have now been allocated for staff.



- 2.15 Visitor parking at the site typically peaks between 2-4pm and 7-9pm, which coincides with peak visiting times at the hospital. As part of the second site visit, undertaken on 8<sup>th</sup> September, parking surveys were conducted between 1:45 and 2:30pm. At this time no free spaces were observed within the car park and 10 incidences of unallocated parking were recorded.
- 2.16 During the first visit to the site, the parking attendant indicated that during peak times drivers often park on the grass verges, as there are not enough spaces to accommodate the level of demand at the car park. At the time of the second site visit, all ten incidences of unallocated parking were recorded on the grass verges of the visitor car park.

### **Main Entrance – Staff Parking**

- 2.17 As stated above, a provision of spaces to the western side of the main entrance car park have now been allocated for staff. Similar to the visitor section of the car park, no free spaces were observed, and 6 incidences of unallocated parking were recorded, all of which were on the grass verges within the car park.
- 2.18 A further 13 incidences of unallocated parking were recorded along the grass embankments of the unnamed internal access road, which runs adjacent to this car park.

### **Emergency Entrance – Staff Parking**

- 2.19 To the west of the visitor car park, adjacent to the hospital’s emergency entrance, a further 48 spaces are allocated for staff parking. A total of 7 free spaces were recorded at this location.

### **Women & Children’s Ward – Visitor Parking**

- 2.20 A second major area of visitor parking is located to the west of the site, adjacent to the Women and Children’s Ward (WCW), which comprises a total of 121 spaces. During peak visiting hours, 2 free spaces were recorded at this location, along with 10 incidences of unallocated parking, predominantly along the access road for the car park, as depicted by Figure 2-4.

**Figure 2-4 Overflow Parking Women & Children’s Ward Car Park - PRH**



### **Women & Children's Ward (WCW) – Staff Parking**

- 2.21 To the west of the WCW Visitors Car Park, there is a second major area of staff parking, which comprises approximately 249 spaces. Upon visiting the site, approximately 85 free spaces were observed at this location, with no recorded incidences of unallocated parking.

### **Northern Car Park – Staff Parking**

- 2.22 The main element of staff parking is situated to the north of the site, with a total of 320 spaces. At the time of the site visit, approximately 42 free spaces and 37 incidences of overflow parking were recorded in the vicinity of this car park; the latter were primarily along the grass verges to the east and the access road to the west, adjacent to the WCW.

**Figure 2-5 Overflow Staff Parking – Eastern Site Perimeter - PRH**



### **Eastern Car Parks – Visitor Parking**

- 2.23 To the east of the site, adjacent to Ward 16, there is a visitor's car park, comprised of approximately 20 spaces, all of which were in use at the time of the site visit. At this location 15 incidences of unallocated parking were also recorded.

### **Eastern Car Parks – Staff Parking**

- 2.24 Adjacent to the above referenced visitor car park, there are two staff car parks, outside the Endoscopy and Wrekin Midwifery Units. In total these car parks provide a total of 39 spaces, all of which were in use at the time of the site visit. Furthermore, a total of 41 incidences of unallocated parking were recorded along the grass verges surrounding these car parks.

### **Apley Clinic – Staff & Visitor Parking**

- 2.25 In contrast to the major parking issues observed across the majority of the hospital site, parking appeared to be relatively well managed outside the Apley Clinic, to the southeast of the site. This car park provided 20 spaces for staff and 19 for visitors, all of which were in use at the time of the site visit. Nonetheless, no incidences of unallocated parking were recorded at this location.

## Accommodation Parking – Staff Parking

- 2.26 Similar to the above, Accommodation Parking, to the southeast of the site, appeared to be relatively well managed. All of the 51 spaces were in use at the time of the site visit, however no incidences of unallocated parking were recorded at this location.

## Additional Comments

- 2.27 In addition to observations made at the main parking areas on site, major issues with regard to unallocated parking were noted on the grass verges immediately east of the site entrance from Grainger Drive. At the time of the site visit a total of 23 vehicles were parked along the grass verges at this location, which has caused major damage to the ground.

## Charging

- 2.28 There is a tiered charging system for visitors on site offering a ranges of rates according to the length of stay:
- 0-30 minutes : Free
  - 30 minutes to 2 hours : £2.50
  - 2 hours to 5 hours: £3
  - 5 hours up to 24 hours: £3.50
- 2.29 Members of staff are able to purchase a staff parking permit through payroll. Table 2-1 below demonstrates the staff parking charges dependent on their employment type.

**Table 2-1 Current Staff Parking Charges**

Level of Employment	£ Per Annum(month)
Full Time (greater than 22.5 hours per week) Band 1-7 and F1, F2 (Foundation Years 1 & 2)	90 (7.50)
Part Time (fewer than 22.5 hours per week) Band 1-7 and F1, F2	45 (3.75)
Full Time (greater than 22.5 hours per week) Bands 8 and above and medical and dental staff (excluding F1,F2)	120 (10)
Full Time (fewer than 22.5 hours per week) Bands 8 and above and medical and dental staff (excluding F1,F2)	60 (5)

- 2.30 One way to improve usage of the staff car park would be through greater parking enforcement. As part of the site visit, parking notices were observed on cars without staff permits. In reference to the SaTH website the following rules apply:
- All vehicles must be parked within the marked bays only.
  - No parking on double yellow lines or yellow cross-hatched boxes.
  - No parking on the grass.
  - Only holders of a blue registered disabled badge are allowed to park in the designated disabled parking spaces. They must display their blue badge and are still required to pay on exit.
  - Any vehicle parked on the Trust's sites that causes an obstruction for emergency vehicles risks being damaged and will be issued with a Parking Charge Notice.

- The owner of any vehicle that causes damage to Trust property will be liable for the full cost of repair/reinstatement of the damaged property.
- Anyone who parks in breach of the rules is liable to be issued, without warning, with a Parking Charge Notice by CP Plus on behalf of the Trust.

## NON-MOTORISED USERS

- 2.31 The site is relatively poorly connected internally for Non-Motorised Users (NMUs). Whilst the area is generally well lit, footway and cycleway provision is intermittent, making the site feel disjointed. The issue is exacerbated further by the lack of clear onsite signage, which hinders wayfinding for NMUs.

### Pedestrians

- 2.32 Tactile paving is present on both sides of Grainger Drive and a signalled crossing point is present close to the hospital's eastern entrance. At the main hospital entrance on the Whitchurch Drive roundabout, only one signalled crossing point exists, situated to the north, as depicted by Figure 2-6.

Figure 2-6 Accessibility Map - RSH



GIS

### Cyclists

- 2.33 Local traffic free cycle routes surround the hospital site to the north, east and west. The routes provide good links into the centre of Wellington and also connect to National Cycle Route 81 which offers a connection to Telford.



- 2.34 There is one bicycle shelter located adjacent to the hospitals main entrance, which can accommodate 27 bikes, however upon visiting the site only two of the spaces were being utilised.
- 2.35 New cycle shelters are situated adjacent to the Helipad and the WCW, however no bicycles were parked here during the site visit.

## PUBLIC TRANSPORT

### Bus

- 2.36 The hospital has a bus station near to the main entrance, which receives a number of services from Telford Town Centre, Wellington and Leegomery, which are detailed below.

**Table 2-2 Bus Service Summary - PRH**

Route Number	Daytime Frequency	Afternoon Frequency	Evening Frequency
4 – Leegomery – Madeley	5 p/h	5 p/h	4 p/h
15 – Telford – Arleston	1 p/h	1 p/h	1 p/h
16 – Telford – High Ercall	1 service	3 services	No evening service
860 – Lydbury North – Telford	Very infrequent, one service per day		

- 2.37 Buses from Shrewsbury Bus Station to Telford Town Centre Bus Station take approximately 50 minutes.

### Train

- 2.38 The closest train station to the site is Wellington which is approximately a 24 minute walk. Telford Train Station is situated approximately 5.8km southeast of the site. Both stations are located on the Wolverhampton to Shrewsbury line. A summary of services from Wellington Station is outlined below:

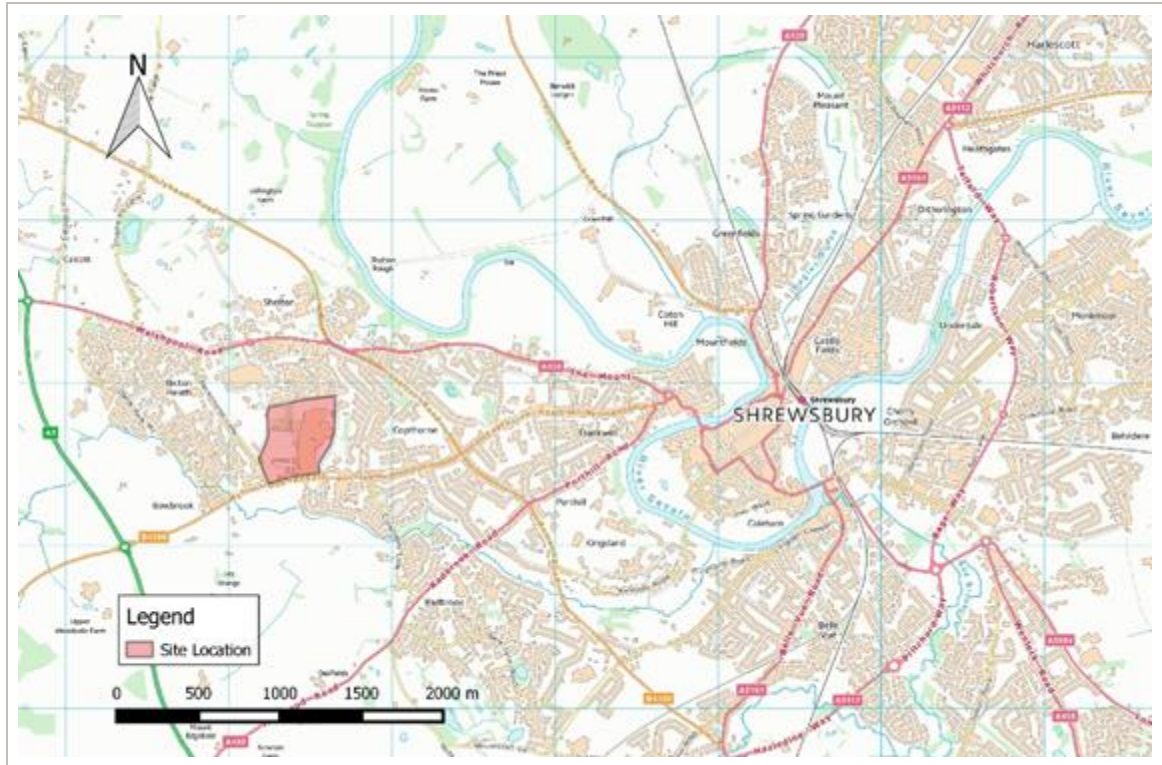
**Table 2-3 Telford Train Service Summary - PRH**

Route	Daytime Frequency	Afternoon Frequency	Evening Frequency
Wellington – B’ham New Street	2 p/h	2 p/h	2 p/h
Wellington – Shrewsbury	2 p/h	2 p/h	2 p/h
Wellington – Holyhead	2 p/h	1 p/h	1 p/h

## ROYAL SHREWSBURY HOSPITAL

- 2.39 The RSH is located approximately 2.5km west of Shrewsbury Town Centre, and forms the Shrewsbury Site of the SaTH. The site is situated within the residential area of Bowbrook, toward the west of Shrewsbury’s urban-rural fringe.

Figure 2-7 Site Location - RSH



GIS

## ACCESS

- 2.40 Access to the site can be achieved via the northern arm of the Mytton Oak Road (B4386) / Seacole Way roundabout and the priority junction of Evolution Road / Mytton Road, both of which are located along the site's southern perimeter.
- 2.41 The site is served internally by Evolution Road and Edgecombe Way to the southwest, and an unnamed access road, which encircles the main buildings of the hospital and is accompanied by a substantial provision of allocated parking spaces around the sites perimeter.

## LOCAL HIGHWAY NETWORK

### Mytton Oak Road (B4386)

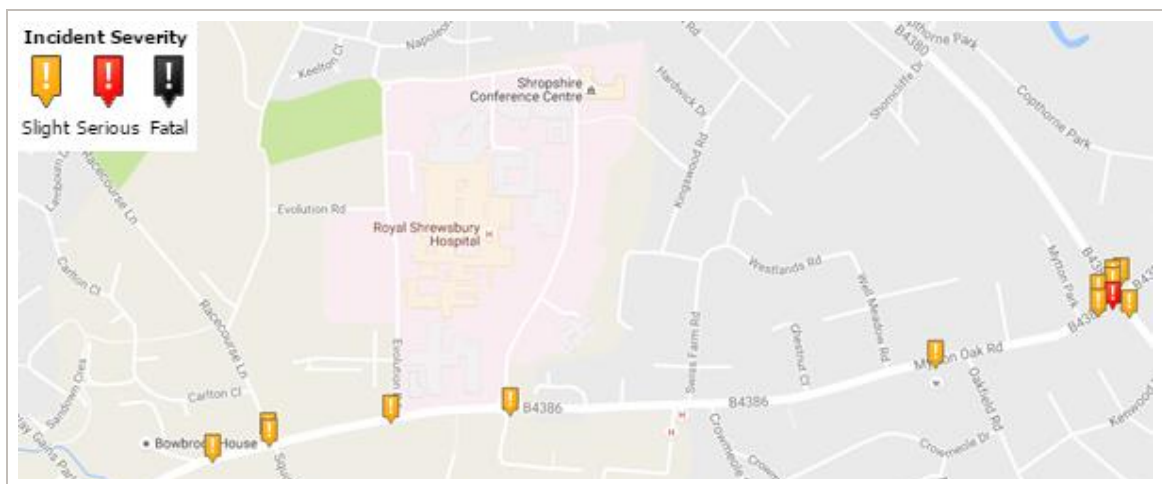
- 2.42 Mytton Oak Road (B4386) provides connections from the site west towards the A5, which in turns provides linkages north towards Oswestry and east towards Telford. West of the site Mytton Oak Road becomes Cophthorne Road which provides a route towards the centre of Shrewsbury. In the vicinity of the hospital site the road is subject to a 30mph speed limit. Footway provision is continuous along each side of the road, and is lit throughout.

## ROAD SAFETY

- 2.43 Collision data for the local highway network has once again been sourced from Crashmap for the period between 2011 and 2015, to determine if there are any clusters or trends which could potentially be exacerbated by increases in traffic at the site.

- 2.44 One 'slight' collision was recorded in the vicinity of the site access point off Evolution Road and another 'slight' collision was recorded at the Mytton Road (B4386) / Seacole Way, the northern arm of which provides the primary point of access to the site.
- 2.45 A cluster of collisions has been identified approximately 0.6miles east of the site, at the B4380 / B4386 roundabout. Six 'slight' collisions were recorded at this location, along with one 'serious' collision. This is a busy roundabout and the cluster of collisions recorded is anticipated to an extent on account of the large number of vehicle movements at this location. Nonetheless, as this cluster is not located in close proximity to RSH it is not anticipated that any developments to the site will have an effect upon these statistics.

Figure 2-8 Collision Data - RSH



Crashmap

### CAR PARKING

- 2.46 At RSH car parking appears to be better managed than at PRH. Double yellow lines along internal access roads were coned to limit overflow parking and grass verges were typically surrounded by fences or high kerbs. Clear signage was also available to discourage parking on grass verges.

Figure 2-9 Parking Signage - RSH





### **Mytton Oak Centre –Visitor Parking**

2.47 The majority of parking for visitors is located to the east of the site, in three separate car parks. The most southern car park, for the Mytton Oak Centre, comprises a total of 101 spaces, 25 of which were free at the time of the site visit.

### **Outpatients – Visitor Parking**

2.48 The second of the three visitor car parks, for outpatients, comprises a total of 190 spaces. At the time of the site visit a total of 21 free spaces were observed in this car park.

### **Ward Block – Visitor Parking**

2.49 The third car park, Ward Block comprises a total of 195 spaces, three of which were free at the time of the site visit.

### **Ward Block – Staff Parking**

2.50 The northern section of the Ward Block Car Park includes a provision for 61 staff vehicles. No free spaces were observed at the time of the site visit.

### **Northern Car Parks – Staff Parking**

2.51 Approximately 356 spaces are provided for staff to north of the main hospital site, formed of the Treatment Centre (218) and Learning Centre Car Parks (138). 3 free spaces were recorded at the former, along with 9 incidences of unallocated parking, predominantly on grass verges as depicted by Figure 2-10.

**Figure 2-10 Staff Parking North - RSH**



### **Northern Car Parks – Visitor Parking**

2.52 Approximately 40 spaces for visitors are provided to the north of the site, in two small car parks adjacent to the Endoscopy Unit and Treatment Centre. At the time of the site visit 1 free space was recorded at this location, along with 2 incidences of unallocated parking.



### Staff Parking – West

- 2.53 The main staff car park is situated to the west of the site, off Evolution Road, and is comprised of 530 spaces. At the time of the site visit 27 free spaces were observed, along with 24 incidences of unallocated parking.
- 2.54 This car park also contains 22 car sharing spaces, which are favourably located closest to the main hospital buildings. 11 of the 22 spaces were in use at the time of the site visit.

### Additional Parking

- 2.55 Additional car parks situated across the remainder of the site were busy, yet typically well managed. However, 15 incidences of unallocated parking were recorded along Evolution Road, in the vicinity of the Estates Centre.

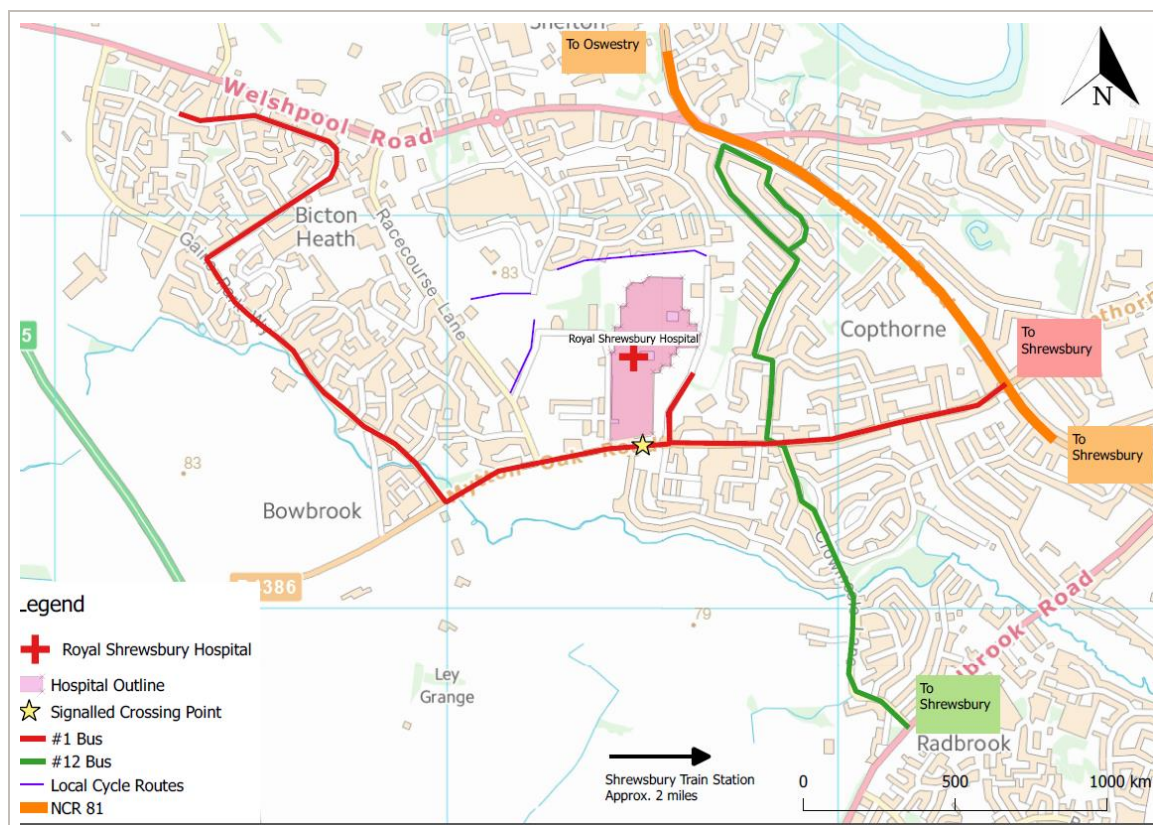
## NON-MOTORISED USERS

- 2.56 The site is reasonably well connected internally for NMUs and is generally well lit. Onsite signage is relatively well placed, providing more convenient access for NMUs than observed at the PRH site.

### Pedestrians

- 2.57 Tactile paving is present on both sides of Mytton Oak Road which runs directly to the south of the site. Pedestrian refuge crossing zones exist along Mytton Oak Road along with a signalled pedestrian crossing point situated to the west of the main entrance of the site as depicted by Figure 2-11 . Pavements and crossing points exist throughout the hospital grounds, providing good access for pedestrians.

Figure 2-11 Accessibility Map - RSH



## Cyclists

- 2.58 Local traffic free cycle routes exist to the north and west of the site. National Cycle Route 81 also runs along the north-east of the site as a traffic free route (a small section of on road cycling also exists). The cycle routes provide strong connections to the centre of Shrewsbury.
- 2.59 Cycle shelters were also available on site, all of which accommodated at least one bicycle at the time of the site visit. The largest and most widely used cycle shelter is situated adjacent to the main staff car park. This contains ‘Sheffield Stands’ with the ability to accommodate 24 bicycles. At the time of the site visit, 7 bicycles were parked in this shelter.

Figure 2-12 Cycle Shelters - RSH



## PUBLIC TRANSPORT

### Bus

- 2.60 There are six bus services within close proximity of the RSH as detailed in the table below. Only one bus service (no. 1) goes directly into the site.

Table 2-4 Bus Service Summary - RSH

Route Number	Daytime Frequency	Afternoon Frequency	Evening Frequency
1 – Gains Park – Telford Estate	4 p/h	4 p/h	2 p/h
12 – Shrewsbury – Kingswood Estate	1 p/h	1 p/h	No evening service
74 – Shrewsbury – Llantyllin	1 service	1 service	No evening service
X75 Shrewsbury – Rhayadar	2 services	2 services	No evening service
553 – Shrewsbury – Bishop’s Castle	2 services	2 services	No evening service
558 Shrewsbury – Montgomery	2 services	1 service	1 service

## Train

2.61 Shrewsbury Train Station is the closest to the RSH, approximately 10 minutes by car and 40 minutes via walking. Table 2-5 provides a summary of rail services from Shrewsbury Train Station.

**Table 2-5 Train Service Summary – RSH**

Route	Daytime Frequency	Afternoon Frequency	Evening Frequency
Shrewsbury – B’ham New Street	2 p/h	2 p/h	2 p/h
Shrewsbury – Manchester	2 p/h	1 p/h	1 p/h
Shrewsbury – Swansea	1-2 p/h	1-2 p/h	2 p/h
Shrewsbury – Cardiff	2 p/h	1 p/h	2 p/h
Shrewsbury - Holyhead	1-2 p/h	1 p/h	1 p/h

## 3 Travel Plan Review

### Green Travel Plan

- 3.1 The SaTH produced a Green Transport Plan (GTP) in order to help minimise the impact of staff, patients and visitors on the local highway network. It recognised the issues surrounding car parking at both the PRH in Telford and the RSH at Shrewsbury. It also acknowledges the fact that both sites were constrained by the lack of public transport services for the site users.
- 3.2 The document outlines:
- What a GTP is;
  - The need for a GTP for the Trust;
  - Key objectives;
  - Measures to be implemented;
  - A brief summary of travel to the site;
  - Modal shift targets; and
  - Implementation and monitoring.
- 3.3 This GTP does not appear to have a date of issue that we can find however, throughout the document objectives are mentioned for 2008/2009 and so this implies the date being early 2008. It therefore is recommended that the GTP is in need of updating to include measures implemented since the date of issue as well as producing further objectives and targets that may now be more suitable for the sites.

### Transport Review and Recommendations

- 3.4 There is also a Transport Review and Recommendations Report dated July 2011.
- 3.5 The general findings confirmed a shortfall in parking provision at peak times and at PRH this is likely to increase post-reconfiguration.
- 3.6 A number of high level measures were identified as being in the following categories:
- Proposals for Change: Strategic Issues such as the development of a 'Parking and Transport Strategy' and establishing and agreeing Parking and Transport Mode Principles; and
  - Proposals for Change: Tactical Issues such as increasing staff parking charges and revising Grey Fleet rates to HMRC rates.

### Travel and Transport Plan (TTP)

- 3.7 A TTP has also been produced for SaTH in 2014. The document was written due to the relocation of staff from the Women's and Children's Centre to the RSH site where car parking was already exceeding capacity. The document sets out plans to be implemented in the long term to reduce single occupancy car journeys by 5% to alleviate the parking issues. Measures on how to do this are outlined in the plan along with the predicted amount of car parking spaces which would be released if the measures are successful. This plan and the targets were written to adhere to planning conditions attached to the planning approval for the new Women and Children's units.
- 3.8 The current failings of the car park management at the sites are acknowledged within the plan as listed below:
- The financial incentives are not large enough to discourage staff from driving to work;



- The pay banding for parking costs means little difference between lower banded staff and senior staff; and
- The penalty system not being adequately enforced to prevent illegal and inappropriate parking.

### **Staff Travel and Transport Updates**

- 3.9 Two updates have been produced in relation to travel planning which are dated January 2016 and March 2016. These updates have been produced for the Executive Directors and the Trust Board to ensure that the Travel Plans are being monitored and implemented. There is no survey information or target information in these updates, and it is therefore difficult to evaluate current modal shift and whether the targets set have been met.
- 3.10 The documents provide an update on the various measures and actions mentioned in the Green Travel Plan, The Travel and Transport Plan and the Transport Review and Recommendations. These measures include:
- Employing a Travel Plan Coordinator (TPC);
  - Improvements to cycling facilities such as cycle parking, showers and lockers;
  - Working with the Trust and Local Authority on improvements to surrounding pedestrian and cycle routes;
  - Discounted public transport tickets;
  - Promotion and incentivising car sharing;
  - Reviewing the car parking permit system;
  - Improving the video conferencing facilities;
  - Introducing an inter-site shuttle bus service; and
  - Reforming the pool car fleet to ensure maximum usage.

## 4 Future Scenarios & Recommendations

### INTRODUCTION

4.1 This chapter provides a series of future scenarios and recommendations which have been formulated in line with observations made as part of the baseline audit of each site. An initial examination of the following key issues is provided:

- Both Sites
  - Rationale for calculating required additional car park and cycle space provision including multi storey provision
  - Assessment of scope of work to connect to surrounding cycle networks
  - Review of the existing on site roads and radius for proposed vehicle types
  - Travel plan review recommendations
- RSH Site Only
  - Viability of providing a 'Blue-Light Only Route' (BLOR)

### SITE OPTIONS

4.2 The SaTH is reorganising the way the trust will function in the future across the two sites. How the reorganisation is to be implemented across both sites is still to be determined but it will see the establishment of an Emergency Site at one location and at the other, the current Emergency facilities will be replaced with a PCS.

4.3 Through discussion of the recommendations outline, reference is made the following options for the two trust:

- Option B – New Emergency Site at PRH
- Option C1 – New Emergency Site at RSH
- Option C2 – New Emergency Site at RSH and W&Cs at PRH

### CAR PARKING

4.4 As highlighted in the baseline review there are major car parking issues across both sites. There have been some steps made by SaTH to address these issues, most notably at the RSH through better enforcement, however further steps are required to improve the overall car park management. The car parks are managed on behalf of the SaTH by CP Plus, Each site's parking provision and associated issues are discussed below.

4.5 In order to provide an indication of traffic associated with the proposed options for each site, the TRICS database (v7.3.2) has been interrogated, using sites from the 'Hospital With Casualty' and 'Hospital Without Casualty' categories. Site surveys have been used to determine, on average, the provision of vehicles travelling to the site as a proportion of total trips. For sites in the 'Hospital With Casualty' category, vehicles accounted for 67% of total trips, where as in the 'Hospital Without Casualty' category, vehicles accounted for 70% of total trips.

4.6 As set out in Table 4-1, the proposed options for PRH and RSH will result in a transition in the number of Full-Time Equivalent (FTE) staff members employed at each site.

**Table 4-1 FTE Staff Members**

Staff	PRH (% Of Current)	RSH (% Of Current)
Current	2075	2432
Option B	2564 (124%)	1943 (80%)
Option C1	1181 (57%)	3393 (140%)
Option C2	1653 (80%)	3022 (124%)

AHR Architects

4.7 In accordance with traffic profiles obtained from the TRICS database, variations in staff numbers are envisaged to result in equivalent increase in the number of trips associated with each site. From the TRICS data the provision of vehicle trips as a percentage of total trips to the site has been calculated. This has then been applied to the percentage increase in staff for each site option, outlined in Table 4-1. The resulting figure has been applied to parking demand figures set out in Table 4-2, in order to forecast future demand.

**Table 4-2 Parking Space Provision**

	Capacity	Free Spaces	Unallocated Parking	Demand
PRH	1336	136	145	1345
SRH	1742	91	50	1701

4.8 For example, currently during peak hours there is a demand for 1345 spaces at PRH, which is 9 more than the 1336 capacity. Option B, which will see a new Emergency Site located at PRH, is predicted to result in 124% of the current FTE staff provision on site. For 'Hospital With Casualty' Sites vehicles are predicted to account for 67% of total trips to the site.

4.9 When taking into account current parking demand, and that 67% of new trips associated with the site are likely to be vehicles, it is envisaged that 225 additional spaces will be required on site to accommodate demand.

<i>Increase in staff * vehicle trips as a proportion of total trips</i>	$24 * 0.67 = 16.08$
<i>Current parking demand * forecast vehicle trips</i>	$1345 * 1.168 = 1561.276$
<i>Forecast parking demand – current capacity</i>	$1561.276 - 1336 = 225.276$
<i>Number of additional spaces required to accommodate demand</i>	<b>225</b>

4.10 This method has been employed in order to provide an estimate of required parking demand for each of the Options proposed at PRH and SRH.

### Princess Royal Hospital

4.11 As outlined within the baseline audit of the PRH, there appears to be a major issue with regard to unallocated, overflow car parking, particularly along the grass verges of the sites internal access roads.

4.12 Upon visiting the site it would appear that staff vehicles (identified through the display of a staff permit in the vehicle) account for a large proportion of this overflow parking, predominantly along the verges of the access road to the east of the site. As part of the baseline site audit, a total of 97 incidences of unallocated

staff parking were recorded on site. At the same time, there were 134 available parking spaces for staff, 85 of which were recorded within the ramped staff car park, to the west of the WCW. Through discussions with the car parking attendant on site, it becomes apparent that this car park has been utilised far less since the allocation of approximately 140 spaces for staff from the main visitor car park on the site. It would appear that staff view the ramped staff park as too remote in relation to their destinations and therefore choose to park inappropriately on grass verges along the internal access road. An element of this may also be down to an unawareness of the availability within the ramped staff car park.

- 4.13 In light of the above, it is recommended that any car park management promotes greater use of the ramped staff car park, as a method of reducing incidences of unallocated staff parking on site. One way to improve usage of the staff car park would be through greater parking enforcement. Upon visiting the site it would appear that enforcement only occurs for vehicles failing to display a staff permit. To ensure that parking at the site is properly managed, it is recommended that enforcement warnings should be served for vehicles parking inappropriately, regardless of whether they belong to staff or visitors. Such efforts should be supported by clear signage and information to direct staff to available spaces at existing spaces.
- 4.14 In addition to the principles outlined above, and to further reduce incidences of unallocated staff parking on site, spaces could be formalised adjacent to the Endoscopy Unit. This would provide formalised parking in a location where numerous incidences of unallocated parking are currently observed and provide additional onsite capacity.
- 4.15 As part of Option B for the PRH site, which involves the construction of a new Emergency Site on the existing Main Visitor Car Park, the possibility of a multi-storey car park has been examined. It is envisaged that this could feasibly be delivered on site, situated on land south of the internal access road. Through preliminary analysis it is suggested that this could provide 150 spaces per storey.
- 4.16 In such a case the topography changes between the existing visitor car park and the adjacent access road will have to be properly considered, in order to provide a pedestrian crossing point between the main hospital buildings and the new multi-storey car park. There is also a potential requirement for the access road to be widened, in order to accommodate increased traffic volumes. This is considered to be feasible given the provision of vacant land adjacent to the road. The potential requirement for a filter lane would also need to be considered, in order to prevent vehicles queueing back along the access road.
- 4.17 For Option B, using the method outlined in Paragraph 4.4 – 4.6, and assuming that no efforts to promote alternative modes of travel are successful, parking demand on site is rise from 1345 to 1557 spaces. At the time of the site visit, demand was observed at 1345 space, 9 more than the total on site capacity of 1336. Current demand rather than capacity has been used as a base figure for these calculations in order to highlight future demand for parking.
- 4.18 In this case any new car park would need to account for 221 new spaces, plus the 216 spaces displaced from the visitor centre car park (356 – 140 staff spaces), amounting to a total of 437 spaces. From preliminary analysis of the land to the south of the access road, it would appear that a multi storey car park of 150 spaces per storey could be established, thus suggesting the requirement for a 3 storey car park. Utilising knowledge drawn from previous experience of working on similar schemes, a multi-storey car park of this size would involve a cost of approximately £12,000 per space, thus equating to a total cost of £5.244 million.
- 4.19 For Option C1 and C2, which involve the situation of a new Emergency Site away from PRH, required parking demand is envisaged to reduce significantly. It is envisaged that Option C1 would result in demand for 397 fewer spaces on site, with Option C2 reducing demand by 182 spaces. In the event of either of these options occurring, it is likely that the requirement for additional parking spaces on site would be eliminated.



- 4.20 Table 4-3 provides a summary of car parking for each of the proposed options in relation to current capacity and demand at PRH.

**Table 4-3 PRH Car Parking Options Summary**

	Current Capacity	Current Demand	Future Demand	Net Change
Option B	1336	1345	1557	+221
Option C1	1336	1345	939	-397
Option C2	1336	1345	1154	-182

### Royal Shrewsbury Hospital

- 4.21 Car parking at RSH appears to be better managed, however there are still a number of issues which require addressing. Numerous incidences of unallocated parking by staff were observed, which could be addressed through an expansion of staff parking areas in order to meet current demand. This could occur through extension of the main staff car park to the west, or the construction of a multi-storey at this location, as outlined in the proposed options for the site. It is likely that a multi-storey would be the most viable option, given the limitations with regard to available land on site. In this case, further work would be required to determine whether Evolution Road, and in particular the T-Junction with Mytton Oak Road would require upgrading in order to accommodate increased traffic levels.
- 4.22 In reference to the plans for the proposed site options, the construction of a new Emergency Site will result in the displacement of 96 spaces from the main staff car park, which must be factored into consideration when calculating the number of additional spaces required on site. In the case of a multi-storey being constructed, the plans indicate that this will provide a total of 155 spaces per storey, however it must be considered that the ground floor of the proposed location of the multi-storey is currently occupied by surface car parking. Any additional parking will therefore need to be provided on the first floor and above (if necessary).
- 4.23 As part of Options C1 and C2, the new Emergency Site would be located at RSH, resulting in an increase in trips to the site. For Option C1, assuming that no efforts to promote alternative modes of travel are successful, parking demand on site is predicted to rise from 1701 to 2151 spaces. In this case any new car park would need to account for 409 new spaces, in addition to 96 displaced by the construction of a new Emergency Site and the 155 which currently occupy the land where the new multi-storey is to be situated. In light of this, the multi-storey would need to provide 660 spaces, at a rate of 155 per storey, which would suggest at a minimum a four storey car park would be necessary. As set out above, utilising knowledge from working on similar schemes, a multi-storey car park of this size would involve a cost of approximately £12,000 per space, equating to an approximate cost of £7.5 million.
- 4.24 With regard to Option C2, again assuming that no efforts to promote alternative modes of travel are successful, parking demand on site is predicted to rise from 1701 to 1977 spaces. In this case any new car park would need to account for 235 new spaces, which again would be in addition to the 96 displaced by the construction of a new Emergency Site and the 155 which currently occupy the proposed location of the new multi-storey. In light of this, the multi-storey would need to provide 486 spaces, at a rate of 155 per storey, which would suggest that a three storey car park would be necessary. The 465 spaces required would suggest an approximate total cost of £5.6 million.
- 4.25 For Option B, which involves the situation of a new Emergency Site away from RSH, required parking demand is envisaged to reduce significantly. It is envisaged that Option B would result in demand for 280 fewer spaces on site. In the event of this option occurring, it is likely that the requirement for additional parking spaces on site would be eliminated.

- 4.26 Table 4-4 provides a summary of car parking for each of the proposed options in relation to current capacity and demand at PRH.

**Table 4-4 SRH Car Parking Options Summary**

	Current Capacity	Current Demand	Future Demand	Net Change
Option B	1742	1701	1462	-280
Option C1	1742	1701	2151	+409
Option C2	1742	1701	1977	+235

## CYCLE NETWORK CONNECTIONS

- 4.27 As outlined above, one of the key recommendations for any Travel Plan Review centres on improving access for cyclists, which in turn could potentially encourage staff to arrive at either site by modes other than the car. As part of this, it is necessary to examine the potential scope of works to connect to surrounding cycle networks at each site.

### Princess Royal Hospital

- 4.28 At PRH, there are several local cycle networks surrounding the site, which permeate through the residential areas of Apley and Leegomery, before connecting with National Cycle Route (NCR) 81, which links with Wellington Train Station and Telford. In spite of this, it appears that cycle parking at the site is largely unused. A number of measures could be considered to encourage increased cycle usage for journeys to work.
- 4.29 In spite of the widespread provision of cycle routes around the site, cycle infrastructure within the site is inadequate. There are no cycle lanes, with cyclists instead using the busy internal access roads, and signage is relatively sparse. Whilst not wishing to overlook the limitations with regard to available space at the site, there is potential space along the grass banks adjacent to the internal access road where a cycle path could be established. These could interlink with external cycle routes to the south of the site, along Whitchurch Drive and Grainger Drive, which benefit from dedicated cycle lanes and signalised crossings.
- 4.30 Any cycle lanes provided within the site could also interlink with the existing route along the northern site boundary, which provides connections from Apley Castle towards residential areas to the west. This would also provide an alternative route for those wishing to avoid the busy main roads of Whitchurch Drive and Grainger Drive.
- 4.31 Any new routes within the site should be accompanied by the provision of frequent, clear signage, as wayfinding was identified as a key impediment to NMU access at PRH.
- 4.32 There are two cycle shelters, located adjacent to the main entrance and the WCW, however at the time of the site visit only two bicycles were parked in these shelters. It is envisaged that use of the shelters could be significantly improved through the measures outlined above.

### Royal Shrewsbury Hospital

- 4.33 At RSH, cycle route provision around the site is relatively sparse. The closest route (NCR 81) is approximately 0.7miles from the site, which provides connections to Shrewsbury Town Centre. In spite of this, cycle use appears to be considerably greater at the site, when compared with PRH. It is envisaged that this may partly be down to the draw from the quiet residential roads surrounding the site.
- 4.34 Similar to the PRH site, it would again be beneficial to investigate the potential for establishing cycle lanes within the site. Preliminary analysis suggests that there would be a lack of available land given the

concentration of development on the site. Nonetheless, there are several potential options which could be explored in order to enhance access for cyclists. For example, there are existing pedestrian routes which connect residential areas to the hospital which could potentially provide a shared space for pedestrians and cyclists thus enhancing permeability for cyclists.

- 4.35 Access into the north of the site from Starcross Close could be enhanced, perhaps through widening the current access point and providing a separate lane for cyclists. This would provide an established access point to the large residential areas to the north of the site. Alternatively the path to the north which links the hospital to Everly Close, Napoleon Drive and Painters Place could also be adapted to make it both more pedestrian, cyclist and disability friendly by widening the path and removing the steps.
- 4.36 Improvements could also be made to the route through to Westhope Avenue, from the east of the site adjacent to the Shropshire Conference Centre. This is currently narrow and overgrown, with little natural surveillance. Enhancing this route would provide greater access to the large residential area to the east of the site, in addition to a shorter linkage with NCR 81.
- 4.37 As with the PRH, a greater provision of clear signage could be help enhance access for NMUs, as wayfinding was valued as a key limitation to NMU access as part of the baseline site audit.

## ON SITE ROAD ASSESSMENT

- 4.38 To ensure that ambulances will be able to approach and enter from the new Emergency Site entrance at each location swept path analyses have been undertaken. These are included in Appendix B.
- 4.39 The scale and layout of the proposed new Emergency Site entrance at PRH is such that ambulances can use the existing access road and follow the circulatory of the new drop off point.
- 4.40 At RSH two potential 'Blue-Light Only Routes' (BLORs) have been examined through swept-path analysis, which confirms that an ambulance would be able to negotiate these routes, and perform a U-turn in front of the Emergency Site entrance.

## BLUE LIGHT ONLY ROUTE (BLOR) – RSH

### New Road Across Land Adjacent to Somerby Drive

- 4.41 Taking into account observations made during the two visits to RSH and preliminary desk-based analysis, the potential establishment of a new blue-light route has been examined. It is envisaged that this will be located to the northwest of the site, crossing a section of green space before joining with Somerby Drive, adjacent to the Redwood Centre, as shown in Appendix A. At this stage is it assumed that this land would be made available.
- 4.42 Currently Somerby Drive is subject to a 20mph speed limit and acts as a major link for residents to the north and west of the site. The road is of sufficient width to facilitate a route for emergency vehicles, however the potential impact on local residents should be considered and it is likely that there would be opposition to a new route for emergency vehicles adjacent to their properties.
- 4.43 The BLOR could be provided toward the southern side of the green space, with an element of screening provided in the form of fencing or a continuous tree line to mitigate the impact of noise pollution and visual intrusion on surrounding properties.
- 4.44 Consideration will need to be made of the future of the play area currently situated within the green space, as this may have to be relocated. The topography of the land will also need to be considered, given that the green space is not at grade with the adjacent internal access road. A cutting into the land will therefore need to be made, in order to maintain a suitable gradient for any adjoining BLOR.

- 4.45 Within the centre of the green space, there are two large trees it is envisaged, therefore, that the input of an ecologist would be required, in order to determine whether or not these are protected species. However it is believed that the route could be provided without the requirement for either tree to be removed. This will require further investigation.
- 4.46 Finally it is likely that some of the smaller trees, in addition to existing signage and lighting along the border between the existing green space and the hospital, may need to be removed, to allow the BLOR to integrate with the existing internal access roads. As outlined above, there are considerations to be made in order to provide a new BLOR at this location, nonetheless, it is envisaged that these could be overcome, providing a new access point adjacent to the Treatment Centre Staff Car Park.

### **Evolution Road**

- 4.47 A second potential option for the BLOR is along the section of Evolution Road to the west of the site, past the Boiler House and Estate, as set out in Appendix A. Evidently this option would not require the same level of intervention as the above option given that much of the BLOR will be along an existing road. This option would, however, be subject to the use of the section of Evolution Road which connects with Racecourse Lane, as outlined below.

### **Additional Considerations – Both Options**

- 4.48 For both options outlined above access via a BLOR could be further enhanced through utilisation of the section of Evolution Road which connects with Racecourse Lane. Should a connection be provided between Somerby Drive and Evolution Road, emergency vehicles will be able to access and enter the site to the north and south.
- 4.49 Restrictions would also need to be in place to prevent stopping along both potential BLORs. Adequate signage would be required to prevent members of the public accessing the routes and interfering with the flow of emergency vehicles. It is also recommended that a lighting system be put in place which prioritises emergency vehicles at the point of access into the site.

### **TRAVEL PLAN REVIEW RECCOMENDATIONS**

- 4.50 Following a review of the documents, and taking into account issues identified as part of the baseline audit of the site, we would advise the following recommendations to be implemented by the Travel and Transport team. The aim would be to provoke a reduction in single occupancy vehicle travel to the site, and to help reduce current car parking issues. Encouraging these changes will have many positive impacts on the sites as they develop, including:
- Improving access for vehicles e.g. deliveries, emergency vehicles,
  - Improving access for pedestrians and cyclists
  - Improving the car parking and access issues for staff and patients
- 4.51 With regards to the staff travel and transport updates it is recommended that these are issued quarterly to the Executive Directors and Trust Board to ensure that progress is being made with regards to the actions and measures produced through the Travel Plan documents and the Transport studies. There is no record of a steering group or of who these updates are sent to.
- 4.52 Although the documents mentioned above are comprehensive and acknowledge many transport issues that have hindered the ability to use sustainable modes of transport to the site, they require updating, especially the GTP and the TTP.
- 4.53 These should be updated to consider all the measures implemented since 2008 and include monitoring of their success. It is recommended that just one document should be produced to encompass both the



GTP and the TTP to avoid repetition, have joined up measures and consistency, and have clear, realistic and achievable measures and targets. More information on this will be given later in this document.

4.54 To ensure their success GTPs and TTPs require the following::

- Travel Plans should conform to the best practice recommended through the National Planning Policy Framework (NPPF) and National Planning Practice Guidance (PPG), especially with regards to the change of use and relocation of staff.
- Travel Plans should ensure and prove that they are in line with National and Local Policy with specific references to these for a joined up consistent approach.
- An analysis of what is currently available to staff, patients and visitors to help them travel sustainably.
- Travel Plans and actions should be based upon site users travel surveys. These need to be tailored to the specific site user needs, for example staff, patient and visitor needs. In order to have an accurate reflection of what specific barriers there are to sustainable travel, surveys must have a statistically accurate response rate. The travel surveys will be reflected in the actions and measures suggested and add justification to the need and success of actions. Travel Plans should include a full analysis of the surveys.
- Develop a marketing strategy to ensure all site users are aware and continuously reminded of sustainable transport options available.
- Investigate the business travel and grey fleet issues to complement the car park management strategy.
- There is mention of other organisations on the site and in the local vicinity. It would be wise to work alongside these organisations, especially with regards to liaising with local public transport operators to improve their services to the sites.
- It is acknowledged that some staff may be relocating. Relocation offers a great opportunity to influence travel behaviour as habits are yet to be formed. A plan should be put in place to assist any relocating staff on their new journeys to work when the new building usages and staff are confirmed.

### **Business Travel and Grey Fleet**

4.55 It has been acknowledged in the documents that grey fleet and business travel is not well managed with significant costs to the NHS, estimated across SaTH at £900,000 per year. It is therefore important to investigate opportunities on how this can be reduced. If there is less need to travel during the working day and therefore less need to drive to work.

4.56 Simple measures could be put in place to ensure that staff can avoid driving during the working day. These include:

- Introduce a business travel hierarchy and process to seek to reduce business travel mileage and deliver cost savings. It will look to promote firstly alternatives to travel such as teleconferencing, followed by active transport, public transport, pool car usage and car sharing, with grey fleet being used as a last resort.
- Ensuring that teleconferencing systems are available and used effectively and all staff are trained in how to use them;
- Ensure that if no sustainable transport modes are available for business travel that staff are able to car share where applicable (conferences etc.);
- Adopt an electronic mileage claim form to monitor business and grey fleet travel; and
- Ensure all staff are aware of the newly contracted lift share scheme through running events and the dedicated car sharing bays.

## SUMMARY OF RECCOMENDATIONS

4.57 Table 4-5 provides a summary of the recommendations set out above.

Table 4-5 Summary of Recommendations

Actions	Delivery	Date to be completed
<b>Car Parking Recommendations</b>		
At PRH promote better utilisation of the Ramped Staff Car Park.	NHS Trust	
At PRH ensure that enforcement warnings are given to cars parked in unallocated spaces.	NHS Trust	
At PRH investigate the use of the land that is currently available to the south of the internal access road and consider its usage as a car park as an alternative to a multi storey.	NHS Trust with the support of JMP Consultants	
At RSH investigate further the need for an extension to the main staff car park to the west of the site or a multi storey.	NHS Trust with the support of JMP Consultants	
At RSH investigate if Evolution Road requires upgrading with emphasis on the junction between Evolution Road and Mytton Oak Road in order to provide capacity for vehicles accessing new multi-storey car park.	NHS Trust with the support of JMP Consultants	
Produce and deliver a Car Park Management Strategy for both sites	JMP Consultants	
<b>Cycle Recommendations</b>		
Conduct site cycle audits to identify key priorities to improve infrastructure and way finding for cyclists on site.	JMP Consultants	
Ensure that existing links to residential areas can be utilised by cyclists to encourage permeability to the sites.	NHS Trust with the support of JMP Consultants	
Work with the local authority and cycling groups (such as Sustrans) to ensure that the local cycle network paths are well maintained, free of vegetation, well-lit and have natural surveillance to ensure that cyclists feel secure throughout the year.	NHS Trust, Local Authorities and Sustrans	

Blue Light Only Route (BLOR)		
Introduce measures to mitigate the impact of noise and visual pollution on local properties.	NHS Trust	
Investigate the future of vegetation and trees surrounding the potential BLOR as well as the children's play area.	NHS Trust with the support of JMP Consultants	
Investigate the use of Evolution Road as a potential alternative BLOR to cutting through the green space.	NHS Trust with the support of JMP Consultants	
Implement Red Route restrictions	NHS Trust and Local Authority	
Implement appropriate signage.	NHS Trust with the support of JMP Consultants	
Travel Plan Review Recommendations		
Produce a Travel Plan to combine the GTP and TTP to take into consideration both staff and visitor travel to the site.	NHS Trust / JMP Consultants	
Set up a Travel Plan Steering Group	NHS Trust	
Conduct a thorough staff and visitor travel survey to feed into the Travel Plan which must reach a statistically accurate response rate. This should be completed annually for monitoring purposes.	NHS Trust with the support of JMP Consultants	
Investigate ways to save time and costs on Business Travel and Grey Fleet issues.	JMP Consultants	
Produce a Car Park Management Strategy.	JMP Consultants	



## 5 Summary

- 5.1 JMP has provided a series of future recommendations to help inform the reorganisation of the PRH and RSH sites. These centre predominantly on car parking, cycle access, the establishment of a BLOR and a review of travel plan principles.
- 5.2 JMP recommend that a car park management strategy is produced for both sites. At PRH focus should be on better utilisation of the ramped staff car park, combined with suitable enforcement measures for cars parked in unallocated space. At PRH, it is also recommended that for Option B, a new 437 space 3 storey car park is provided on land to the south of the internal access road, costing approximately £5.244 million. At RSH in the case of Option C1 being realised, a new multi-storey is deemed necessary, which will provide 660 spaces over 4 storeys at a total cost of £7.5 million. For Option C2, a multi-storey comprising 486 spaces over 3 storeys is considered appropriate, costing approximately £5.6 million. At RSH, given the proposed location of any multi-storey, further investigation will be required to determine whether Evolution Road requires upgrading in order to provide capacity for additional vehicles accessing this location.
- 5.3 With regard to cycle infrastructure, JMP recommend that cycle audits are undertaken in order to identify key priorities to improve infrastructure and way finding for cyclists at both sites. Existing links to residential areas should also be examined further, in order to determine whether these can be utilised by cyclists, enhancing permeability of the two sites. It is also recommended that SaTH work with the local authority and cycling groups (for example Sustrans) to ensure that the local cycle network paths are adequately maintained, free of vegetation, well-lit and benefit from natural surveillance to ensure cyclists feel secure throughout the year.
- 5.4 In the case of an Emergency Site being located at RSH, a new BLOR is proposed for emergency vehicles. In order to support this, JMP recommend that further investigation is undertaken to examine the future of vegetation and the existing play area which are currently situated on the green space to the northwest corner of the site. The use of the exiting section of Evolution Road to the west of Estates may also be considered as a potential alternative route. In the case of a BLOR being brought forward, JMP recommend that appropriate red routes restrictions and subsequent signage are introduced to prevent conflict with public vehicles. In the case of the BLOR being located on green space to the north of the site, JMP would also recommend appropriate screening is provided to mitigate the potential for noise pollution and visual intrusion on existing properties situated adjacent to the green space.
- 5.5 Finally, a number of recommendations are made surrounding a comprehensive review of the travel plans for the two sites. JMP suggest that a travel plan is produced to combine the GTP and TTP to take into consideration both staff and visitor travel to the site, and that a steering group is set up to support this. A thorough staff and visitor travel survey is also required, to feed into the travel plan. This should be completed annually for monitoring purposes. Further investigation is also recommended surrounding potential ways to save time and costs on Business Travel and Grey Fleet Issues.

# Appendix A

## CAR PARK LOCATIONS

# Appendix B

## SWEPT-PATH ANALYSIS (INLCUDING BLOR ROUTES)

**SYSTRA provides advice on transport, to central, regional and local government, agencies, developers, operators and financiers.**

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**WOKING**

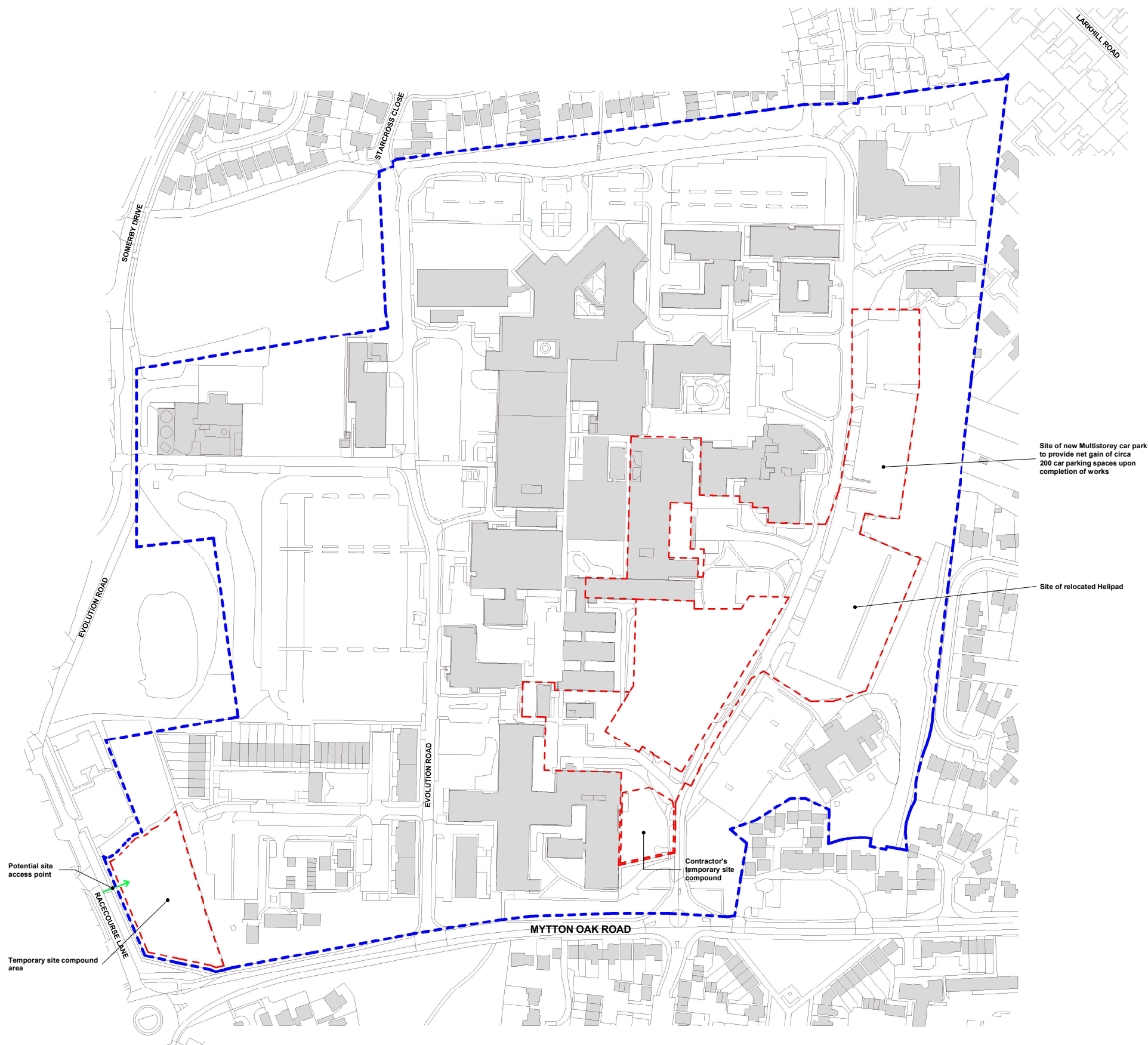
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Key	
<span style="color: blue;">---</span>	Site Boundary
<span style="color: red;">---</span>	Development Boundaries
<span style="background-color: lightgrey; border: 1px solid black; display: inline-block; width: 10px; height: 10px;"></span>	Existing



Site of new Multistorey car park to provide net gain of circa 200 car parking spaces upon completion of works

Site of relocated Helipad

Potential site access point

Temporary site compound area

Contractor's temporary site compound

P03	boundary update	27.03.23	GB	GB
P02	planning issue	14.03.23	GB	GB
P01	Stage 2 issue	08.02.23	WJL	GB
Rev	Description	Date	Dr by	App by
original by		date created		approved by
ETU		02/06/23		CP

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client name	Shrewsbury & Telford Hospitals NHS Trust		
project	Hospital Transformation Programme - Royal Shrewsbury hospital		
drawing	Site Location Plan		
computer file	C:\Users\graham.banks\Documents\RSH-AHR-ZZ-XX-DR-A-08102_graham.banks\33911.rvt		
project number	2019.00606.001	scale	As indicated@A1
drawing number	RSH-AHR-ZZ-XX-DR-A-08102	rev	P03 S3
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**THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST**  
**ROYAL SHREWSBURY HOSPITAL**  
**PATIENT AND VISITOR MULTI-STOREY CAR PARK INITIAL PROPOSAL**



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230303-FATKIN-XX-XX-RP-AX-00001





**PREFERRED OPTION VIEW LOOKING SOUTH**

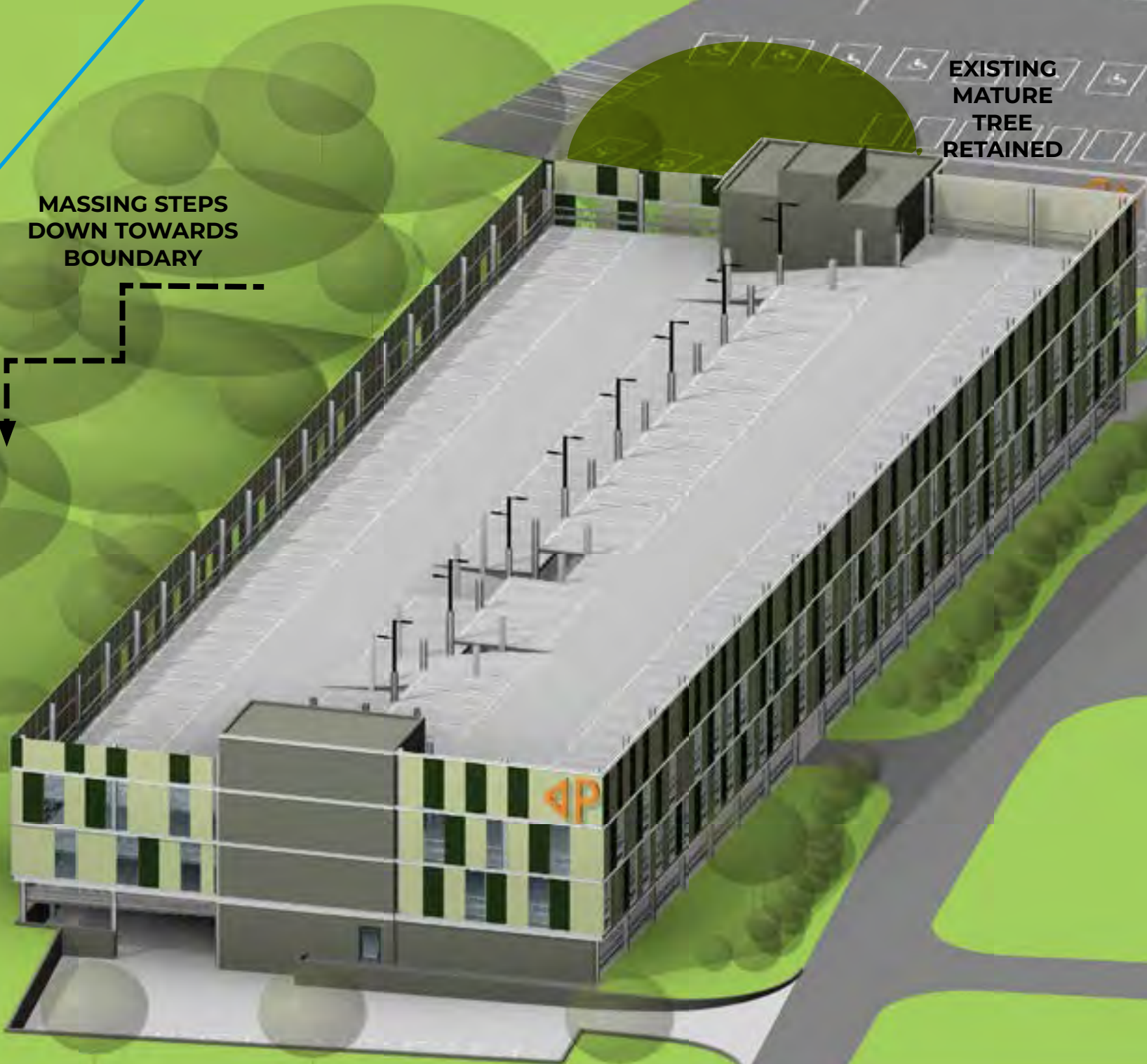
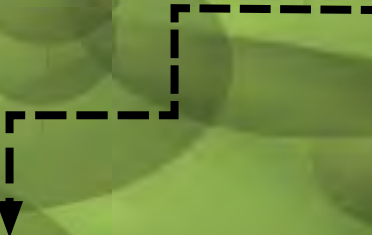
SITE BOUNDARY

**NEW BUILDING**

**NEW HELIPAD**

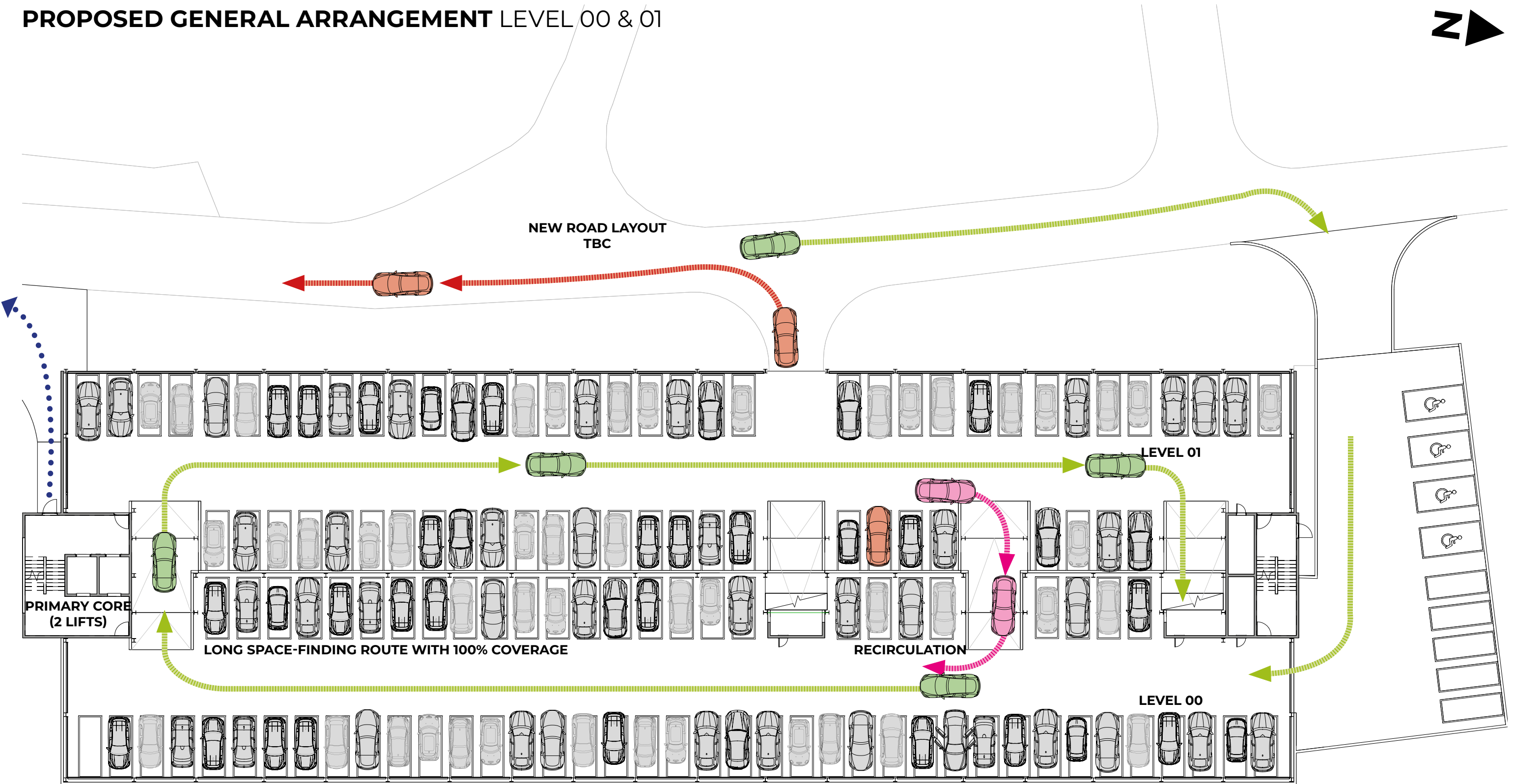
**EXISTING MATURE TREE RETAINED**

**MASSING STEPS DOWN TOWARDS BOUNDARY**

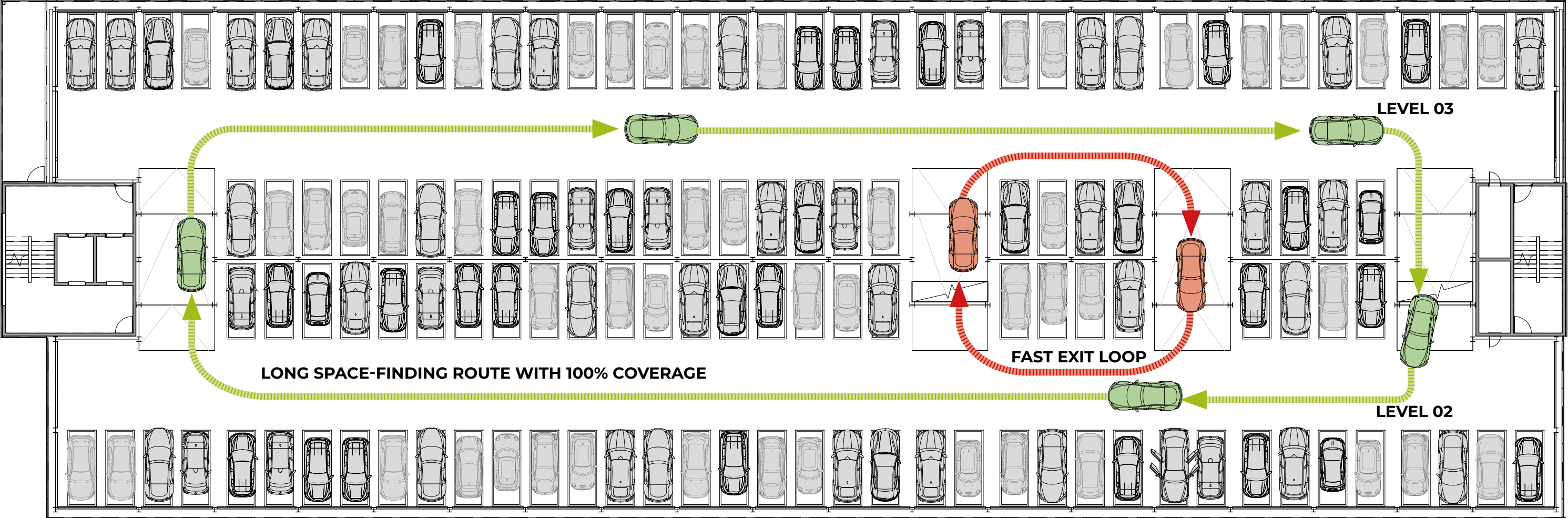




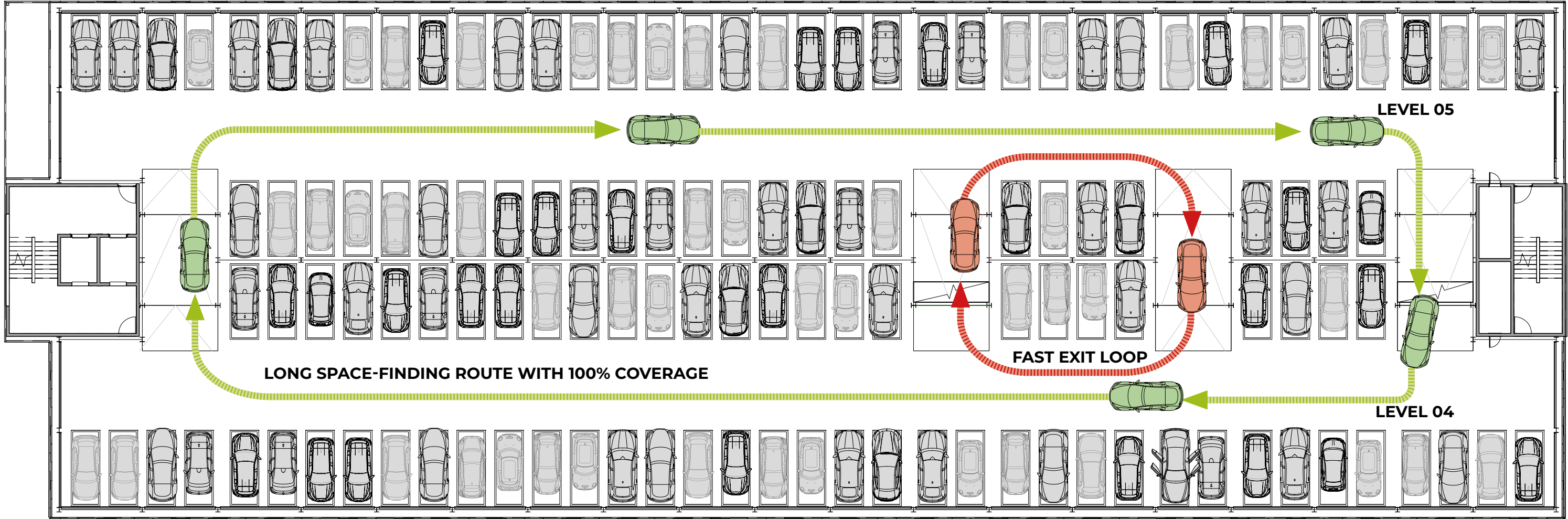
PROPOSED GENERAL ARRANGEMENT LEVEL 00 & 01



PROPOSED GENERAL ARRANGEMENT LEVEL 02 & 03

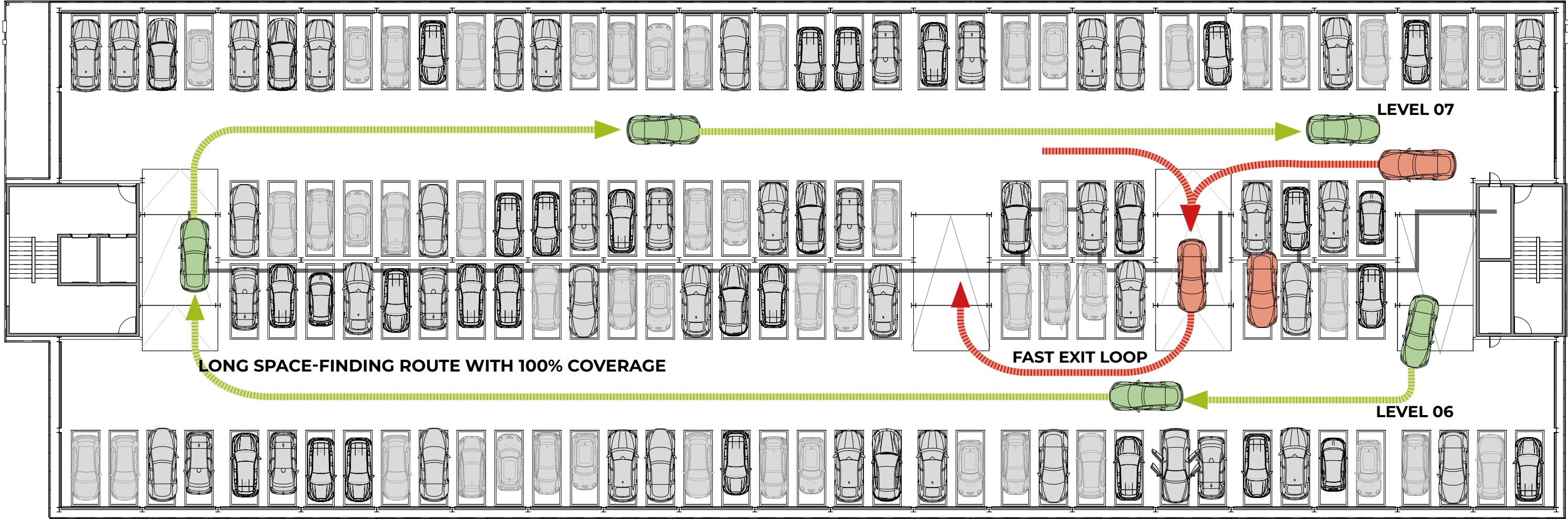


**PROPOSED GENERAL ARRANGEMENT LEVEL 04 & 05**



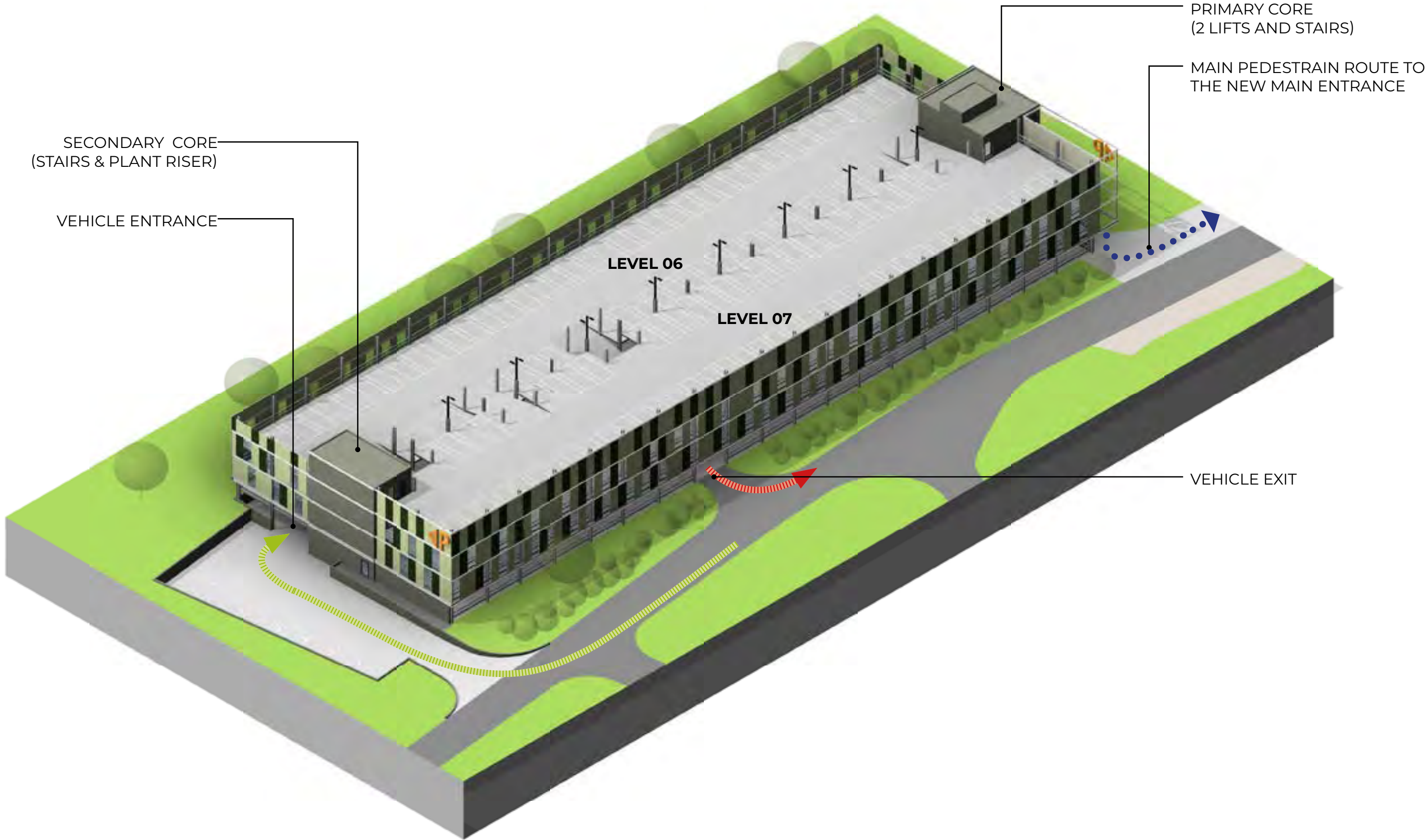


**PROPOSED GENERAL ARRANGEMENT LEVEL 06 & 07**



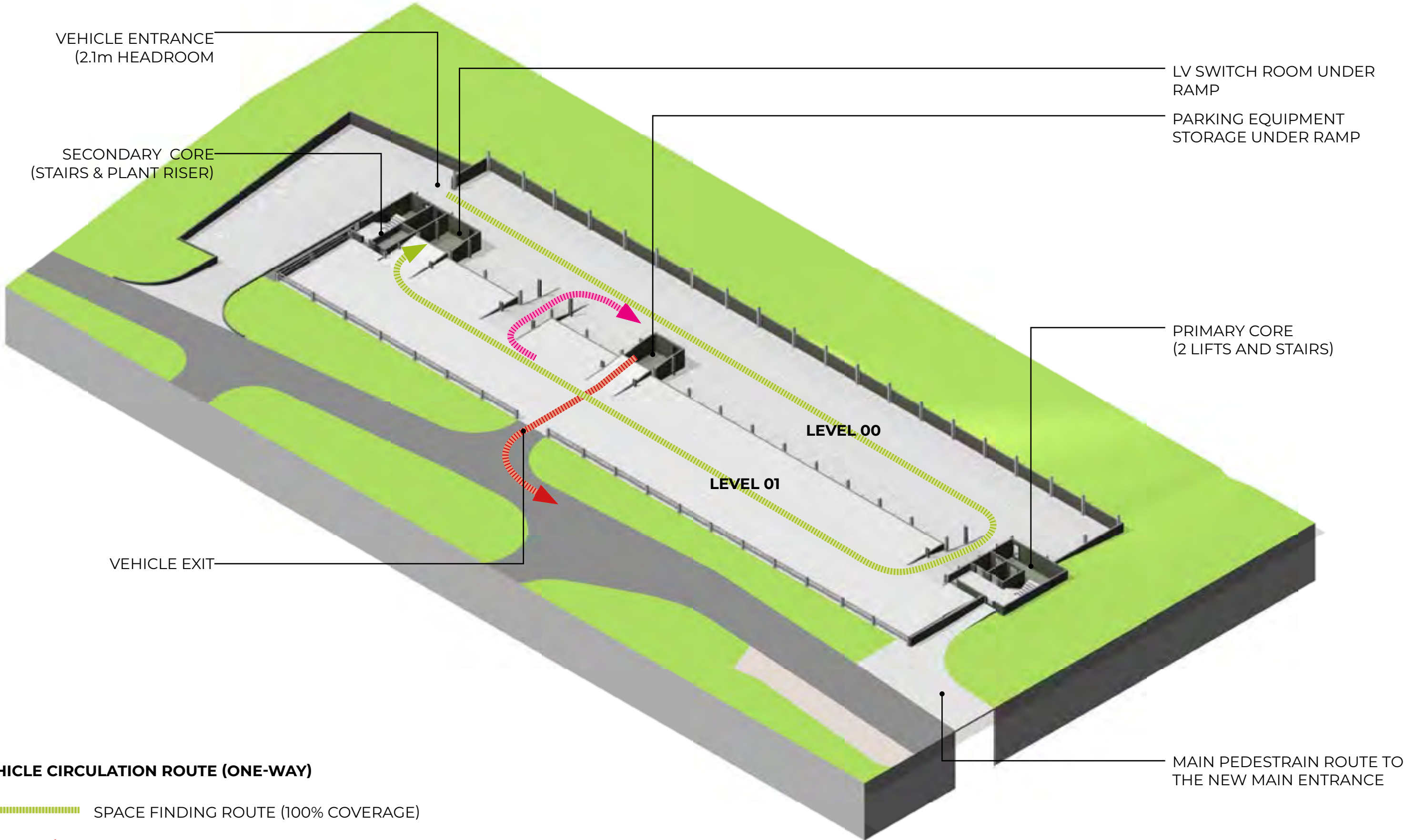
# VIEW FROM THE NORTH WEST

UNIVERSITY OF BRIGHTON MSCP








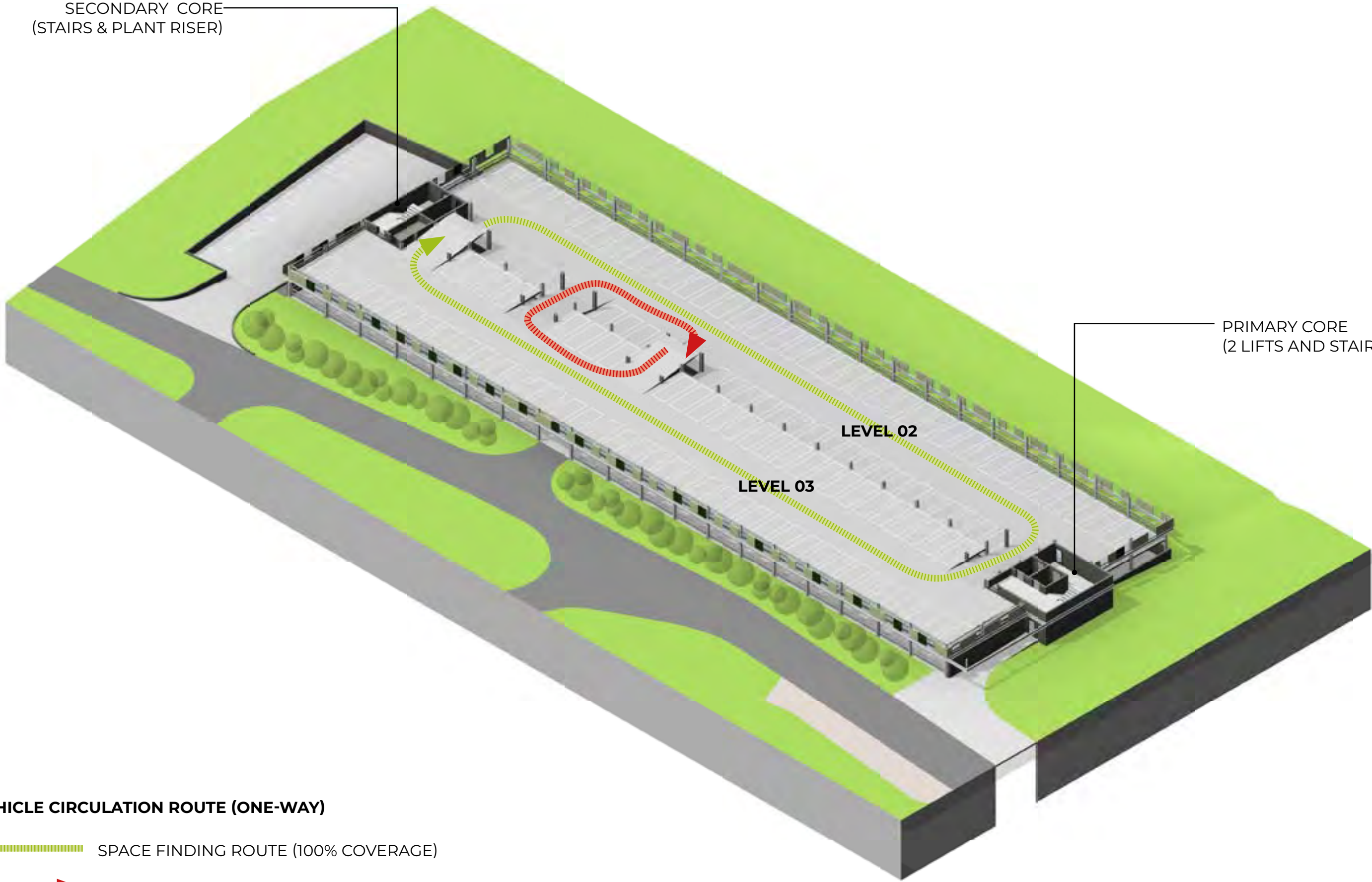
# CUTAWAY VIEW LEVEL 00 & 01



**VEHICLE CIRCULATION ROUTE (ONE-WAY)**

-  SPACE FINDING ROUTE (100% COVERAGE)
-  FAST EXIT LOOP
-  RECIRCULATION

# CUTAWAY VIEW LEVEL 02 & 03






SECONDARY CORE  
(STAIRS & PLANT RISER)

PRIMARY CORE  
(2 LIFTS AND STAIRS)

LEVEL 02

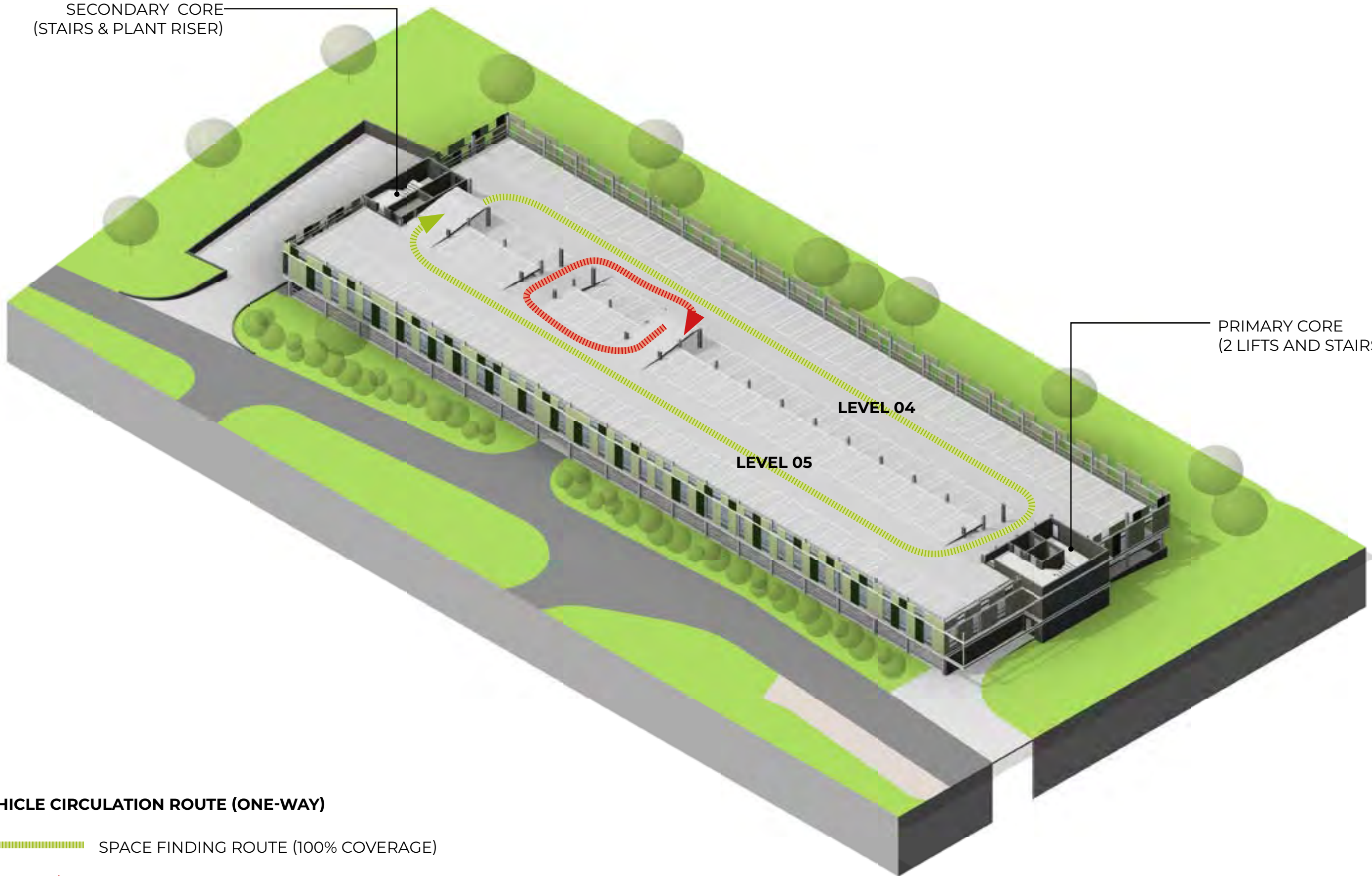
LEVEL 03

### VEHICLE CIRCULATION ROUTE (ONE-WAY)

-  SPACE FINDING ROUTE (100% COVERAGE)
-  FAST EXIT LOOP
-  RECIRCULATION



# CUTAWAY VIEW LEVEL 04 & 05






SECONDARY CORE  
(STAIRS & PLANT RISER)

PRIMARY CORE  
(2 LIFTS AND STAIRS)

LEVEL 04

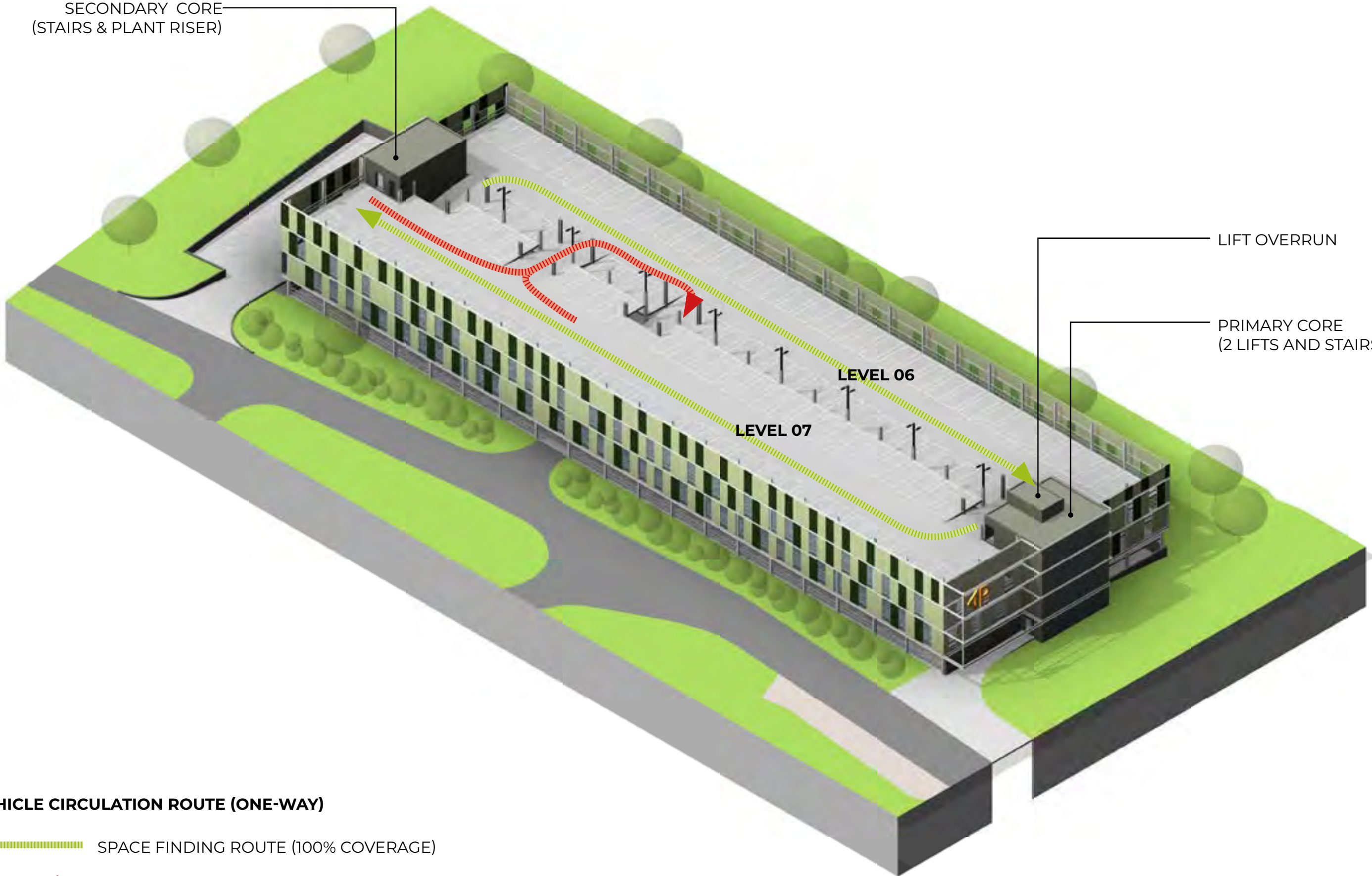
LEVEL 05

## VEHICLE CIRCULATION ROUTE (ONE-WAY)

-  SPACE FINDING ROUTE (100% COVERAGE)
-  FAST EXIT LOOP
-  RECIRCULATION



# CUTAWAY VIEW LEVEL 06 & 07



## VEHICLE CIRCULATION ROUTE (ONE-WAY)

- SPACE FINDING ROUTE (100% COVERAGE)
- FAST EXIT LOOP
- RECIRCULATION



# 3-year SOV Action Plan

	OBJECTIVE	RESPONSIBILITY	MEASURABLE	TIMESCALE			COST/RESOURCES
				YEAR 1 31/12/18	YEAR 2 31/12/19	YEAR 3 31/12/20	
Car Sharing	Reduce the number of Single Occupancy Vehicles accessing the site, as part of WCC planning obligations. Carsharing to work is a Sustainable way of reducing staff demand on limited Car Parking spaces.	<p>Travel Plan coordinator to promote Car-sharing to all that work at the Trust</p> <p>Other partners to be used for sources of input and information;</p> <p>*Local Authorities - T&amp;WC, SCC</p> <p>* Keele Uni &amp; Mid Staff's Uni, Other local NHS organisations</p>	<p>4200 Car parking permits issued</p> <p>Current status</p> <p>* 372 Liftshare members</p> <p>* 25 car sharers</p> <p>* 13 unlisted car sharers</p> <p>* 38 less cars on site</p> <p>* 22 Tonnes of Co2 saved</p> <p>Increase HOV (High Vehicle Occupancy) By 10% per annum *based on the number of current car sharers</p> <p>Police current spaces - with CP plus to encourage car-sharing</p>	Renew licence - 31/10/18	<p>Monthly email communications</p> <p>Quarterly roadshow events</p>	<p>Monthly email communications</p> <p>Quarterly roadshow events</p>	Renew for 3yrs – cost High



Cycling & ebikes	To encourage modal shift from the car to achieve an increase in cycling, as a proportion of sustainable travel for commuting to work.	<p>Travel Plan coordinator to promote cycling to work as an option to all Trust staff</p> <p>*Local Authorities - T&amp;WC, SCC &amp; Powys</p> <p>*Charities - Sustrans, UK Cycling, Brake, etc</p> <p>*NGO's - West Mercia Police, etc.</p> <p>* Others, cycle retailers,</p> <p>Travel user groups, cycle to work provider etc.</p>	<p>Monthly cycle counts on both sites - Average daily count is 66 cyclists</p> <p>Monitor Cycle to Work scheme uptake: YTD 56 cycles purchased.</p> <p>Record number of Dr Bike visits and repairs</p> <p>Record number of bikes security marked by Police</p> <p>Record number of requests for secure cycle parking codes</p>	Continuous promotion	Review onsite cycle infrastructure - 01/08/19	Majority of activities are cost neutral. A Dr Bike exploring possibility of a cost neutral service Nb there is currently no requirement for extra cycle shelters, however with the planned reconfiguration changes this could change and there are outstanding issues with Smokers using the ward block shelter.
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Walking	To encourage modal shift from the car to achieve an increase in walking, as a proportion of sustainable travel for commuting to work.	<p>Travel Plan coordinator to promote Walking to work at the Trust</p> <p>Other partners to be used for sources of input, information and funding;</p> <p>*To Consult with RSH &amp; PRH Estates</p> <p>*Local Authorities - T&amp;WC, SCC</p> <p>* Other parties; Living Streets, Sustrans, Wellington walkers</p>	2018 Travel survey indicated that 7.8% walk to work	Continuous promotion	One Path on RSH requires lighting surface upgrade cost unknown. New path required on PRH site cost estimated at £8k possible part funding through Tesco bags for life and Ownership of path afterwards to be decided. Signage required to Silkin way entrance/exit. To improve online mapped areas of both sites e.g., get Silkin Way marked up.
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Motorcycles & Scooters	Reduce the number of Single Occupancy Vehicles accessing the site, as part of WCC planning obligations. The use of either a Scooter or Motorcycle is a Sustainable way of reducing staff demand on limited Car Parking spaces	<p>Travel Plan coordinator to promote Scooters and Motorcycling to work as an option to all Trust staff</p> <p>*To Consult with RSH &amp; PRH Estates</p> <p>*Local Authorities - T&amp;WC, SCC &amp; Powys</p> <p>*Charities - Wheels to Works, Brake, etc</p> <p>*NGO - West Mercia Police Road safety team, Shropshire Fire Brigade, etc</p>	<p>Monthly Scooter &amp; Motorcycle counts - Average daily count is 6 riders.</p> <p>Ask Wheels to Work for count of NHS participants?</p>	Continuous promotion	<p>Travel Plan Coordinators time</p> <p>**Sometimes opportunities occur when contractors offer a free service because they are onsite, in July one such contractor offered to paint a motorcycle only box on RSH site for free.</p>
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Public Transport	To encourage modal shift from the car to achieve an increase in bus or rail patronage, as a proportion of sustainable travel for commuting to work.	<p>Travel Plan coordinator to promote Bus and Rail (PRH) as a travel option in commuting to work.</p> <p>* Work with Bus Companies – mainly Arriva but also to engage with others ie Tanet Vally, Celtic, etc.</p> <p>*Local Authorities - T&amp;WC, SCC &amp; Powys</p>	<p>Arriva Bus Employer Travel Scheme offering discounted season tickets;</p> <p>* 18 staff signed up - 4 in the last month</p> <p>* Ask ETC scheme if they can provide a carbon saved report based on members</p> <p>* Measure number of Hits of the Travel &amp; transport Website when its live.</p>	<p>Monthly email communications</p> <p>Quarterly roadshow events</p>	<p>Salary sacrifice for public transport season tickets is no longer a valid option as Benefit In Kind, (BIK) is only applicable to Cycle to work, Childcare and ultra-low emission car schemes.</p> <p>Arriva's ETC (Employers Travel Club) scheme is cost neutral to the Trust. They have a marketing team that style posters FOC for use. Currently use Medical Photography to enlarge and laminate A1 size posters.</p>
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	<p>To encourage a modal shift away from SOV to the site, the TPC will offer a personalised travel plan to Staff members showing alternative travel modes to accessing the SaTH sites. This will either increase HOV levels or achieve an increase in Sustainable Travel modes.</p>	<p>Travel Plan Coordinator to promote via all communication avenues.</p> <p>Use current networks to develop the Staff Travel plans.</p> <p>Work with Bus companies to add incentives.</p>	<p>60 staff requested a PTP from the Travel survey.</p> <p>Try to send out 10 a month as detail tends to be generic to member of staffs postcode details.</p> <p>Monitor uptake &amp; response.</p>	<p>Achieve 10 a month</p>	<p>Personalised Travel planning takes a lot of time to collate, especially with Multisite options available.</p>
<p>Other Travel Survey Actions to help reduce SOV levels &amp; Improve Air Quality</p>	<p>Planned reconfiguration of the sites will have a negative impact on parking availability.</p> <p>Offsite parking options should be reviewed e.g.; Oxon P&amp;R.</p>	<p>Travel plan coordinator to look into feasibility with key stakeholders Shropshire County Council Highways Dept and Arriva (or other transport provider).</p>	<p>Trust currently rents space out for offsite pool cars.</p>	<p>31/12/12 - Inquire with council, change of use</p>	<p>High cost</p>
	<p>Pay as you Park systems explore best practice; this system will benefit all those who leave their cars at home for short or long periods of time</p>	<p>Travel plan coordinator to consult with Facilities, IT, HR &amp; Car parking provider.</p>	<p>Benchmark current systems available</p>	<p>2019-2020</p>	<p>High</p>

Provide onsite electric recharging points for e-cars

Travel plan coordinator to consult with Estates on best site locations.

2019-2020

Cost of Chargers is High £8k-£15k each.

How to manage spaces

Waiting on national government grants

Communicate to staff about shower & changing room access for those that walk, cycle or use a motorcycle or scooter for work.

Travel plan coordinator to consult with Estates

Map out areas of current facilities

Apr-19

Cost neutral



# Full Action Plan

## Car Sharing

ACTION	RESPONSIBILITY	TIMESCALE	COST/RESOURCES
Marketing and promoting car sharing website	TPC	Comms and staff engagement campaigns throughout 2019	High, TPC time
Running Events for car sharers, to provide the opportunity for potential car sharers to meet.	TPC	Monthly	TPC-Time – Tea & Coffee
Creation of additional car parking spaces for sharers	TPC / Estates	Complete	24x at RSH 14x at PRH
Issuing of Car-Share permits & policing of areas	TPC/CP-Plus	Quarter1-2, 2019/20	Low TPC & partners
Regular reporting to demonstrate effectiveness of car sharing strategy	TPC	Directorate Report - Monthly KPI	TPC-Time
Investigate opportunities to work with local Partners to reduce car use.	TPC with CCGs/SSSFT/ShropComm/LAs	Ongoing	TPC-Time

## Cycling

ACTION	RESPONSIBILITY	TIMESCALE	COST/RESOURCES
Promote general cycling to work and in local areas	TPC & Cycling partners ie Sustrans, UK Cycling, etc	Comms and staff engagement campaigns throughout 2019	Low/TPC Time
Monthly monitoring of current cycle parking facilities and usage	TPC	Monthly	Low/TPC Time
Improve current cycle infrastructure stock	TPC / Estates	Quarterly	Medium/High Capital/Car parking expenditure
Promote & monitor uptake of Cycle 2 Work scheme	TPC & current provider	Comms and staff engagement campaigns throughout 2019	Low/TPC Time
Improving local cycling environment i.e., signage and lanes	TPC/Estates/TWC/SCC/Sustrans	Ongoing	Small-scale expenditure
Promote Cycle Security	TPC/Security/Estates/Local Police	Developing	TPC-Time
Investigate opportunities to provide discounts at cycling retailers	TPC/Health & Wellbeing	In process	TPC-Time
Promotion of Adult Cycle Training	TPC/outside partners	Comms and staff engagement campaigns throughout 2019	TPC-Time

Arrange cycle maintenance days i.e., Dr Bike either full service or a cost neutral service	TPC	Comms and staff engagement campaigns throughout 2019	Low cost-£300/free
Record condition of changing and storage rooms around the sites on rolling basis and undertake improvements as required, i.e., lockers, etc. Communicate to staff about changing room access and its use by staff	TPC/Estates/HR	Quarterly report to Estates Management team	Medium cost
Develop a cycle map for staff showing all cycle parking at Trust locations	TPC/Comms Team/ Web Dev.	Annual update	N/A
Provide shared cycles & ebikes for staff use	TPC/Estates	Ongoing	Medium cost
Policy on Abandonment of Cycles	TPC/Security/Estates	Jan-20	TPC-time

## Walking

ACTION	RESPONSIBILITY	TIMESCALE	COST/RESOURCES
To promote walking	TPC/Local walking groups (Wellington Walkers)/TWC/SCC	Developing	Low cost
Develop local walks around both sites	TPC /SCC walking coordinator	RSH routes actioned- to publish routes on Travel Website	TPC-Time
To improve access footpaths to the site's ie surfaces, hedge cutting and where possible lighting	TPC/Estates/ Councils	Ongoing	Medium cost
Edit footpath & cycleway source data on OSM "Open Street map" and or Google Maps, so primary data on mobile phone mapping Apps is correct.	TPC	Q3 2019/20	TPC-Time



## Motorcycles

ACTION	RESPONSIBILITY	TIMESCALE	COST/RESOURCES
Investigate opportunities to provide dedicated motorcycle parking facilities in car park.	TPC/Estates	Complete	Low cost
Promotion of Motorcycle/scooter or electric bike training	TPC/Wheels to Work	Comms and staff engagement campaigns throughout 2019	TPC-Time

## Other Active Travel car reduction methods

ACTION	RESPONSIBILITY	TIMESCALE	COST/RESOURCES
Offer personalised travel planning to staff, Students and volunteers; advertised via travel survey and roadshows	TPC	In progress	Low/TPC Time
Promotion at Health & Wellbeing events, induction days, internal conferences	Local Authorities/West Mercia Police/HR/TPC/National Active Travel Challenges	In progress	Low/TPC Time
Develop a Public / Staff Travel & Transport website	TPC/ Web Development team		Low/TPC Time
Investigate opportunities to provide a park and ride scheme for hospital staff at Oxon P&R.	TPC/ Public Transport Operators/Council	Ongoing as part of SSD	High Cost
Action Staff Travel survey for end of year	TPC	Q3 2019/20	Low/TPC Time
Action a Patient Travel survey	TPC/Patient experience lead/Community Engagement Facilitator	Q1-2 2019/20	Low/TPC Time

Investigate opportunity to provide a Shuttle bus between sites.	TPC/Public Transport Operators/Council/Future Fit team	Ongoing as part of SSD	High Cost
Promote Video, Audio & Web conferencing facilities	IT Telecoms	Comms and staff engagement campaigns throughout 2019	TPC/Telecoms Manager
Pay as you Park system explore best practice	TPC/ Facilities/ CP Plus	Unfinished	High Cost
Investigate opportunities to provide discounts at local walking, cycling and leisure shops	TPC/local retailers	Promote on Website	TPC-Time
Continuous development of a Travel User group with regular updates and develop and recognisable identity	TPC	In progress	TPC-Time
Provide an Induction pack leaflet to new starters to the trust	TPC, Communications team/HR	Q1 2019/20	Low Cost
Locate and exploit external funding opportunities	TPC	Ongoing - TCP to report periodically to Good Corporate Citizen Group	TPC-Time

## Air Quality

ACTION	RESPONSIBILITY	TIMESCALE	COST/RESOURCES
To explore government funded grants to improve air quality, ie installation of Electric car charging points at both sites.	TPC/Councils/ National Govt	Ongoing	High – plus TPC time

## Promote Public Transport

ACTION	RESPONSIBILITY	TIMESCALE	COST/RESOURCES
Promote public transport season tickets- bus & rail	TPC/ Public Transport Operators	Comms and staff engagement campaigns throughout 2019	TPC-Time
To develop or change bus routes to benefit staff & patients	TPC/Finance/Public Transport operators	Future Fit Travel Group	TPC-Time
Explore option of Salary sacrifice for public transport season tickets	TPC/HR/Public Transport operators	TPC/HR	TPC-Time
Promotion of Wellington Train Station as Travel asset to PRH.	TPC/HR/Public Transport operators	TPC	TPC-Time



## Patient Travel

ACTION	RESPONSIBILITY	TIMESCALE	COST/RESOURCES
Promotion of Community Transport services	TPC/CTA members	Comms and staff engagement campaigns throughout 2019	TPC-Time
Promotion of Taxi services	TPC/Taxi services	Ongoing	TPC-Time

## Reducing the need to travel

ACTION	RESPONSIBILITY	TIMESCALE	COST/RESOURCES
Reform proposals of Grey and Pool Fleet	Lease Car Manager/Logistics Manager	Q3-4 2019/20	Medium cost
Review a central location for Pool fleet parking	TPC/Estates team	Q2 2019/20	Medium cost
Assess need for a centralised managed pool car fleet	TPC/Lease Vehicle Manager	Ongoing	Medium cost

Integrate electronic expenses system with travel budgets	Lease Car Manager/Assurance team	Complete	Software and running expenses
Solicit bids for centralised fleet system	Procurement team, TPC/Lease Vehicle Manager	TBC	High Cost
Trial fleet system	TPC/Departmental managers	Ongoing	High Cost
Smarter driver training	TPC/Local Authorities/Carbon Trust	TBC	Medium cost
Review site connectivity options	TPC/Local Authorities	TPC periodic/annual report to GCC Group	To be assessed
Introduce & Monitor EV's & hybrids to existing fleet	TPC/Lease Vehicle Manager	Unknown	High Cost – pending National Government incentives
Increase awareness and uptake of Tele-conferencing systems	Telecoms Manager/Comms team/TPC/CCG	Comms and staff engagement campaigns throughout 2019	High/Medium Cost

## Lease Cars

ACTION	RESPONSIBILITY	TIMESCALE	COST/RESOURCES
Review lease car scheme	Workforce/ Lease Car Manager	Complete	-
Introduce a no-diesel policy for SaTH Fleet	Lease Vehicle Manager	Ongoing – policy amended Jan-19	-
Use new policy to evaluate need for leases as they expire	Lease Vehicle Manager	Ongoing	-
Encourage uptake of low emission cars	Lease Vehicle Manager/Salary Sacrifice scheme/TPC	Ongoing	Low or high if Charge points need fitting
Re-evaluate existing leases to find best value	Lease Vehicle Manager/Payroll	Ongoing	-

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**NHS Premises Assurance Model: Patient Experience Domain**

The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.

◀◀ **Back to instructions**

Ref.	SAQ/Prompt Questions	2020-21	2021-22	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	<b>Rate the prompt question by using the drop down menus in the columns below</b>		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
P1	<b>P1: With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff can your organisation evidence the following?</b>	Applicable	Applicable	P1 replicates the CQC Provider handbooks KLOE W4 and assesses your processes for patient involvement, compliments and complaints	
P1	<b>1. Views and Experiences</b> Are people's views and experiences gathered and acted on to shape and improve the services and culture?	Not applicable	Not applicable	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	
P1	<b>2. Engagement</b> Are people who use services, those close to them and their representatives actively engaged and involved in decision making?	Not applicable	Not applicable	1. Engagement process and methodology 2. Friends and Family Test 3. Patient Advice and Liaison Service (PALS)	1. Data Protection Act 1998 2. Freedom of Information Act 2000 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 16: Receiving and acting on complaints (FS) 17(2)(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services; 17(2)(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).
P1	<b>3. Staff Engagement</b> Do staff feel actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture?	Not applicable	Not applicable	1. Surveys and questionnaires 2. Focus Groups 3. Engagement feedback influencing services developments and improvements	4. CQC Provider Handbooks
P1	<b>4. Prioritisation</b> Do leaders prioritise the participation and involvement of people who use services and staff?	Not applicable	Not applicable	1. Governance and process for dealing with feedback	R1.1. Is information about the needs of the local population used to inform how services are planned and delivered? R1.2. How are commissioners, other providers and relevant stakeholders involved in planning services? R1.3. Do the services provided reflect the needs of the population served and do they ensure flexibility, choice and continuity of care? R1.4. Where people's needs are not being met, is this identified and used to inform how services are planned and developed?
P1	<b>5. Value</b> Do both leaders and staff understand the value of staff raising concerns? Is appropriate action taken as a result of concerns raised?	Not applicable	Not applicable	1. Adherence to confidentiality policy 2. Feedback to stakeholders and patients	5. NHS England Transforming Participation in Health and Care – September 2013 6. The Kings Fund Research Paper; Patient Engagement and Involvement 7. The Kings Fund Research Paper; The Quality of Patient Engagement and Involvement in Primary Care 2010
P1	<b>6: Costed Action Plans</b> If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? <b>Costs can be entered below.</b>	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

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Ref.	SAQ/Prompt Questions	2020-21	2021-22	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	<b>Rate the prompt question by using the drop down menus in the columns below</b>		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
P2	<b>P2: With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory can your organisation evidence the following?</b>	Applicable	Applicable	<b>P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues on condition, appearance, maintenance and P&amp;D. Safety aspects are dealt with in the safety domain.</b>	1. Department of Health Mixed-Sex accommodation guidance 2. Patient Led Assessments of the Care Environment (PLACE). 3. Health Ombudsman 'Care and Compassion' report 4. National In-patient survey 5. Commission for dignity in Care for older people 'delivering dignity' report 6. Patient Association 'Patients not numbers, People not statistics' 7. Joint Committee on Human Rights 'The Human Rights of Older People in healthcare' 8. CQC Provider Handbooks C1.5. How do staff make sure that people's privacy and dignity is always respected, including during physical or intimate care?
P2	<b>1. PLACE Assessment</b> The organisation has completed the PLACE assessment relating to the care environment (estate) and estates related privacy and dignity issues, for all relevant sites and published a local improvement plan.	Not applicable	Not applicable	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services developments and improvements 7. Adherence to confidentiality policy 8. Feedback to stakeholders and patients 9. Complaints Procedure 10. Diversity considerations	
P2	<b>2. Other Assessments</b> Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction with the estate and related privacy and dignity issues and is action taken on the results?	Not applicable	Not applicable	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Monthly reporting of breaches of mixed-sex accommodation guidance 6. Meetings and dialogue with CQC identifying improvements	
P2	<b>3: Costed Action Plans</b> If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? <b>Costs can be entered below.</b>	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

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The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.

◀◀ Back to instructions

	SAQ/Prompt Questions	2020-21	2021-22	Evidence (examples listed below)	Relevant guidance and legislation
Ref.	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
P3	<b>P3: With regard to ensuring that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory can your organisation evidence the following?</b>	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues on cleanliness. Safety aspects of cleanliness are covered in the safety domain.	1. Health and Social Care Information Centre: Patient Led Assessments of the Care Environment (PLACE)
P3	<b>1. PLACE Assessment</b> The organisation has completed the PLACE assessment relating to cleanliness for all relevant sites and published a local improvement plan.	Not applicable	Not applicable	<ul style="list-style-type: none"> <li>1. Policy and procedures relevant to E&amp;F services relevant to the trust/site;</li> <li>2. Regular assessment of policies and procedures;</li> <li>3. Engagement process and methodology</li> <li>4. PLACE training and trust results</li> <li>5. Internal structure to consider and action feedback</li> <li>6. Engagement feedback influencing services developments and improvements</li> <li>7. Adherence to confidentiality policy</li> <li>8. Feedback to stakeholders and patients</li> <li>9. Complaints Procedure</li> <li>9. Diversity considerations</li> </ul>	
P3	<b>2. Other Assessments</b> Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the cleanliness and is action taken on the results?	Not applicable	Not applicable	<ul style="list-style-type: none"> <li>1. Surveys and questionnaires</li> <li>2. Focus Groups</li> <li>3. Benchmarking, KPIs and peer comparison process</li> <li>4. Patient, visitor and staff charter</li> <li>5. Monthly reporting of breaches of mixed-sex accommodation guidance</li> <li>6. Meetings and dialogue with CQC identifying improvements</li> </ul>	
P3	<b>3. Cleaning Schedules</b> Are Cleaning Schedules publicly available?	Not applicable	Not applicable	<ul style="list-style-type: none"> <li>1. Reviews of policy stating where schedules are available compared with actual checking of availability.</li> </ul>	

**NHS Premises Assurance Model: Patient Experience Domain**

The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.

◀◀ **Back to instructions**

	SAQ/Prompt Questions	2020-21	2021-22	Evidence (examples listed below)	Relevant guidance and legislation
Ref.	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	<b>Rate the prompt question by using the drop down menus in the columns below</b>		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
P3	<b>4: Costed Action Plans</b> If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? <b>Costs can be entered below.</b>	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		



**NHS Premises Assurance Model: Patient Experience Domain**

The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.

◀◀ Back to instructions

Ref.	SAQ/Prompt Questions	2020-21	2021-22	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	<b>Rate the prompt question by using the drop down menus in the columns below</b>		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
P4	<b>P4: with regard to ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors can your organisation evidence the following?</b>	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues with access and car parking. Safety SAQ SS7 covers car park management and access arrangements	
P4	<b>1. PLACE Assessment</b> The organisation has completed the PLACE assessment relating to access and car parking for all relevant sites and published a local improvement plan.	2. Good	Not applicable	<ul style="list-style-type: none"> <li>1. Policy and procedures relevant to E&amp;F services relevant to the trust/site;</li> <li>2. Regular assessment of policies and procedures;</li> <li>3. Engagement process and methodology</li> <li>4. PLACE training and trust results</li> <li>5. Internal structure to consider and action feedback</li> <li>6. Engagement feedback influencing services developments and improvements</li> <li>7. Adherence to confidentiality policy</li> <li>8. Feedback to stakeholders and patients</li> <li>9. Complaints Procedure</li> <li>10. Diversity considerations</li> </ul>	<ul style="list-style-type: none"> <li>1. Department of Health: NHS patient, visitor and staff car parking principles 29 October 2015</li> <li>2. Car parking charges best practise for implementations, Department of Health (2006)</li> <li>3. Health Technical Memorandum 07-03 (2006): Transport management and car parking, Department of Health</li> </ul>
P4	<b>2. Other Assessments</b> Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the service provided and is action taken on the results?	2. Good	Not applicable	<ul style="list-style-type: none"> <li>1. Surveys and questionnaires</li> <li>2. Focus Groups</li> <li>3. Benchmarking, KPIs and peer comparison process</li> <li>4. Patient, visitor and staff charter</li> <li>5. Monthly reporting of breaches of mixed-sex accommodation guidance</li> <li>6. Meetings and dialogue with CQC identifying improvements</li> </ul>	
P4	<b>3: Costed Action Plans</b> If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? <b>Costs can be entered below.</b>	Not applicable	Not applicable	<ul style="list-style-type: none"> <li>1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments;</li> <li>2. Evidence of escalation to Trust Board and relevant committees;</li> <li>3. Inclusion of investment to deliver Actions in future budgets as appropriate;</li> <li>4. Assessment of effect of prior identified investment;</li> </ul>	
	Capital cost to achieve compliance	£0	£0		
	Revenue consequences of achieving compliance	£0	£0		

**NHS Premises Assurance Model: Patient Experience Domain**

[◀◀ Back to instructions](#)

Ref.	SAQ/Prompt Questions	Comments
P1	<p><b>P1: With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff can your organisation evidence the following?</b></p>	
P1	<p><b>1. Views and Experiences</b> Are people's views and experiences gathered and acted on to shape and improve the services and culture?</p>	
P1	<p><b>2. Engagement</b> Are people who use services, those close to them and their representatives actively engaged and involved in decision making?</p>	
P1	<p><b>3. Staff Engagement</b> Do staff feel actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture?</p>	
P1	<p><b>4. Prioritisation</b> Do leaders prioritise the participation and involvement of people who use services and staff?</p>	Facilities/PALS/Clinical ops
P1	<p><b>5. Value</b> Do both leaders and staff understand the value of staff raising concerns? Is appropriate action taken as a result of concerns raised?</p>	
P1	<p><b>6: Costed Action Plans</b> If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? <b>Costs can be entered below.</b></p> <p style="text-align: right;">Capital cost to achieve compliance</p> <p>Revenue consequences of achieving compliance</p>	

**NHS Premises Assurance Model: Patient Experience Domain**

◀◀ **Back to instructions**

	SAQ/Prompt Questions	Comments
Ref.	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
P2	<p><b>P2: With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory can your organisation evidence the following?</b></p>	
P2	<p><b>1. PLACE Assessment</b> The organisation has completed the PLACE assessment relating to the care environment (estate) and estates related privacy and dignity issues, for all relevant sites and published a local improvement plan.</p>	
P2	<p><b>2. Other Assessments</b> Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction with the estate and related privacy and dignity issues and is action taken on the results?</p>	Facilities responsibility
P2	<p><b>3: Costed Action Plans</b> If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? <b>Costs can be entered below.</b></p> <p style="text-align: right;">Capital cost to achieve compliance Revenue consequences of achieving compliance</p>	

NHS Premises Assurance Model: Patient Experience Domain

◀◀ Back to instructions

Ref.	SAQ/Prompt Questions	Comments
P3	<p><b>P3: With regard to ensuring that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory can your organisation evidence the following?</b></p>	
P3	<p><b>1. PLACE Assessment</b> The organisation has completed the PLACE assessment relating to cleanliness for all relevant sites and published a local improvement plan.</p>	
P3	<p><b>2. Other Assessments</b> Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the cleanliness and is action taken on the results?</p>	Facilities responsibility
P3	<p><b>3. Cleaning Schedules</b> Are Cleaning Schedules publicly available?</p>	



**NHS Premises Assurance Model: Patient Experience Domain**

**◀◀ Back to instructions**

	SAQ/Prompt Questions	Comments
Ref.	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
P3	<p><b>4: Costed Action Plans</b>                      If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? <b>Costs can be entered below.</b></p> <p>Capital cost to achieve compliance                      Revenue consequences of achieving compliance</p>	

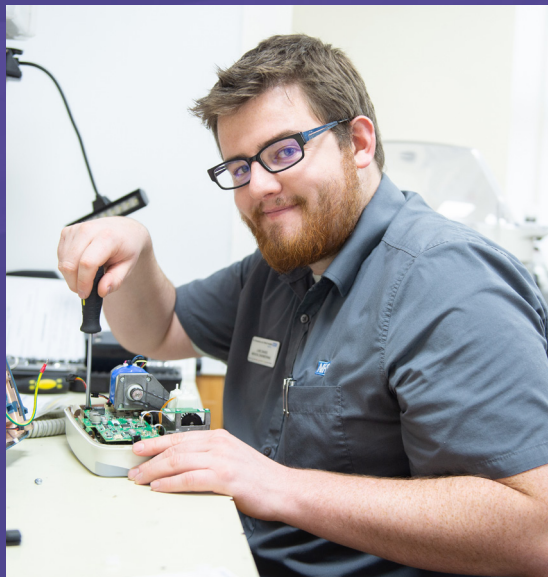
NHS Premises Assurance Model: Patient Experience Domain

◀◀ Back to instructions

SAQ/Prompt Questions		Comments
Ref.	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	
P4	<b>P4: with regard to ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors can your organisation evidence the following?</b>	
P4	<p><b>1. PLACE Assessment</b> The organisation has completed the PLACE assessment relating to access and car parking for all relevant sites and published a local improvement plan.</p>	<p>1. All relevant policies in place. Assessments carried out as part of PLACE Assessments. Action plans produced and issues addressed. Parksmart audits also carried out annually. Changes made if possible when complaints received. 2. Parksmart. Survey monkey carried out annually for travel plan.</p>
P4	<p><b>2. Other Assessments</b> Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the service provided and is action taken on the results?</p>	
P4	<p><b>3: Costed Action Plans</b> If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? <b>Costs can be entered below.</b></p>	
	<p>Capital cost to achieve compliance Revenue consequences of achieving compliance</p>	



**Integrated  
Care System**  
Shropshire, Telford and Wrekin



# MANAGEMENT APPENDICES



**The Shrewsbury and  
Telford Hospital**  
NHS Trust

## **Stakeholder engagement meeting arrangements and outcomes: Communications and Involvement activity and feedback November 2022 to March 2023**

### **Introduction**

This document sets out how the communications and engagement teams from the Shropshire, Telford and Wrekin Integrated Care System (ICS) and The Shrewsbury and Telford Hospital Trust (SaTH) have supported the Hospital Transformation Programme (HTP) to meet its objectives through effective communications and involvement activity with our stakeholders and communities in the development of the Outline Business Case (April 2023).

Since the approval of the Strategic Outline Case in August 2022, we have worked to raise awareness of HTP, the benefits and rationale for change, how the programme will progress and be delivered and importantly, highlight opportunities for our stakeholders and wider communities – patients, their families and the public – to be involved in the development of the Outline Business Case and continued conversations.

The Communications and Engagement team from Shrewsbury and Telford Hospital NHS Trust lead on the Communications and Involvement activity, working closely with Trust colleagues from the Public Participation, People and OD Directorate (OD), HTP teams, as well as wider colleagues across health and care in Shropshire, Telford and Wrekin and Powys.

### **Communication and Involvement Objectives**

As part of the Hospitals Transformation Programme Communications and Involvement Strategy, the following objectives were agreed:

- To build public and internal awareness of HTP, encouraging key stakeholders and staff to become ambassadors for change.
- To build support/ understanding for the case for change and Outline Business Case, working together to deliver the best care possible for patients.
- To communicate the clinical voice and clinical need for change and how this will improve the safety and sustainability of our services across Shropshire, Telford and Wrekin and Powys.
- To deliver our statutory duties and continue to engage service users and carers, interested groups, partners and staff in optimising the design of future services to inform the Outline Business Case.
- To ensure the lived experience of patients and staff are used to inform the programme by using inclusive, representative, and accessible involvement approaches.



- To work across the local health and care system to support the development of relationships and to support partners in communicating the changes that are happening and the benefits this will bring to all communities.
- To provide regular toolkits and resources to support partners to inform, engage and align communications messaging and outputs.
- To ensure communications are consistent, timely, responsive, accessible, and proactive.

## **Communications and engagement approach**

During 2022-23 there are a number of critical phases that we have been and will be supporting from a communications and involvement perspective:

- **Phase one: Listening and awareness** – December 2022 to March 2023 we will develop specific focus groups with service users and interested groups to help inform the development of the Outline Business Case. We will work with SaTH's Public Assurance Forum whose members belong to organisations that have key roles in health and social care, including the voluntary sector. This will also be a period of ensuring wider awareness as we will use a range of activities to promote the work that is happening and raise the level of understanding about what is happening.
- **Phase two: Development of the Outline Business Case** – Current – June 2023. The development of the detailed Outline Business Case has been informed by the engagement activity with key stakeholders ahead of the draft of the Outline Business Case being reviewed by April 2023. The final OBC is required by June 2023 for formal assurance. It is expected to be formally published in Summer 2023.
- **Phase three: Development of the Full Business Case** – Summer- Autumn 2023. Continued awareness raising of the programme, clinical benefits and what this means for staff and communities accessing and providing care.
- **Phase four: Implementation phase** – Autumn 2023- 2025. Informing and involving people as detailed plans are developed and put in place to reconfigure services, including building works and service movements. Regular communications to staff, service users and partners on progress towards implementing change.
- **Phase five: Launch of new service configuration** – 2025. Formal informing and communicating the changes and how patients will access services. Supporting ongoing communications to demonstrate the difference the new services are making.

## **Communications and involvement approach to phases one and two**

### **Key messages**

All communications and involvement activity centred around the following core messages to highlight the importance and benefits of the programme.

1. The investment will improve care for everyone/the services that we provide to all of our communities will be improved.
2. Our plans will deliver two thriving hospital sites.
3. We cannot continue as we are.
4. We must put the available funding to good use.

The core messages provided a consistency of approach throughout our activity and will be built upon in the next phases to ensure we are continuing to highlight the key benefits whilst taking our audience(s) on the journey, offering opportunities to shape and tailor key points as we progress.

### **Awareness raising**

Throughout November 2022 to March 2023, we amplified the clinical voice, using a range of resources, to support people to understand the clinical reasons for change and how this will improve care for everyone.

The following news articles were released and published across our internal and external channels, as well as having received local media reporting:

3 November 2022: [£24m boost to improve planned care facilities for local population](#)

10 November 2022: [Transformation of hospital services will improve care for everyone](#)

14 December 2022: [Improving care for everyone – faster access to better cancer services](#)

19 January 2023: [Crucial year for hospital services](#)

26 January 2023: [HTP About Health Event: live-stream roundup](#)

9 February 2023: [Can you help us improve hospital services?](#) (Open invitation to attend focus groups)

14 February 2023: [Significant investment for the future of the Princess Royal Hospital in Telford](#) (complementary piece)

27 February 2023: [Improving care for everyone – local GP welcomes developments for hospital services](#)

27 February 2023: [Open letter on the Hospital Transformation Programme from The Shrewsbury and Telford Hospital NHS Trust](#)

17 March 2023: Changing hospital services is the right thing to do for patient safety, says West Midlands Ambulance Service

Our press releases were all published internally for staff first, before being issued to wider stakeholders (eg, MPs) and the media. Follow up coverage on local radio stations was also gained with the Clinical Director for HTP taking the lead for interviews and responses.

Information has also been shared via existing communications channels across the Trust and wider system, circulating messages every month to our 3600 community members (which includes all Town and Parish Councils and all Town and Borough Councillors in Shropshire, Telford & Wrekin and Mid-Wales as well as over 300 organisations with thousands of members. Last month's edition included the open letter on the HTP. Information has also been shared with the ICB and constituent partners. Website

information has been updated with stories and updates about HTP gaining 1,500 page views between November 2022 and March 2023.

Booklets describing HTP have been produced and shared with key groups, as well as translated into Welsh for our partners and patient population in North Powys. Further collateral has also been developed and is on display across our two hospital sites (posters, screensavers and roller banners with a more permanent display for each site in development as the programme progresses).

### **Stakeholder involvement**

We have worked with partners within the NHS, local authorities, voluntary sector colleagues, politicians and interested groups to understand their needs, any concerns and to support them in promoting the benefits these changes will bring.

Communications and engagement support has been provided to ensure consistent messaging and increased awareness across our stakeholders at both routine and standalone HTP briefings attended by the Executive and Clinical Directors for HTP.

This includes standalone briefings with:

- Shropshire Telford & Wrekin GP Forum (23.11.22, 01.03.23)
- MPs – routine and individual briefings where requested.
- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (08.02.23)
- Midlands Partnership Foundation Trust (private board 15.02.23)
- North Powys Wellbeing Programme (31.01.23 and 16.02.23)
- Community Health Council (CHC) – Powys (17.01.23)
- Local Planning Committee – Montgomeryshire (19.01.23)

Updates on HTP have also been provided to the Shrewsbury and Telford Hospital NHS Trust Board members and the Shropshire, Telford and Wrekin Integrated Care Board every month since the approval of the Strategic Outline Case, offering assurance as key decision makers. The programme has also been a key topic in the development of the ICB's joint forward plan which includes all strategic partners and their interdependencies.

### **Involving staff and clinicians**

A dual approach has been taken to involving staff and clinicians in the development of the Outline Business Case: directly via the programme team in modelling and pathway design discussions as well as through the communications and engagement route of briefings and information dissemination.

There have been a number of opportunities for staff to participate, share their feedback and to get involved ahead of implementation. This includes:

- Ongoing clinical workshops to co-design the detailed clinical modelling that will inform the designs and OBC.
- Attendance at existing internal meetings, for example COO huddles (weekly), Joint Negotiating Consultative Committee (JNCC) x 2 between November 2022 and March 2023, Divisional committees and senior team meetings (seven sessions across the Divisions and teams have taken place).

- A webinar for staff (particularly those working virtually) took place in December to find out more about the programme and to answer questions. The session was recorded and made available to all staff. Recognising operation pressures during the winter period, further sessions will take place and be made available.
- Working with HR, we have developed a series of staff FAQs and in time, will provide more targeted communications for any individuals/ teams that may be affected by change.

Members of the programme team have also worked to become embedded into the clinical divisions to share updates, disseminate information and answer questions on a routine and ongoing basis.

We recognise there is still more to do in bringing teams on the journey and are committed to supporting staff to be champions for the programme, taking ownership of messaging and will continue to plan roadshows, drop-in session and ward walks to reach as many frontline and corporate teams as possible, whilst ensuring we have a central repository for information and the ability for staff to ask questions and get involved.

#### **For systemwide staff**

- System-wide communications channels have also been used to raise awareness of HTP and the benefits and distributed to all partners across the ICS. Offers of attendance at existing briefings for more detailed discussions were made with members of the programme team attending where requested (eg, North Powys Wellbeing Programme 31 January 2023).

#### **Involving patients and the public (including seldom heard groups)**

Over the last five months, we have used both existing mechanisms for communications and involvement, including existing patient, carer and public forums across Shropshire, Telford & Wrekin as well as developing bespoke focus groups directly linked to each of our workstreams.

This activity started with an “About Health” Event digital meeting on 24 January 2023, with key clinicians and programme leads giving an overview of the programme’s latest position and developments. Those interested in attending were asked to submit their questions in advance of the session, which helped to inform the content and all questions were responded to post the event as well as being made [publicly available for review](#). In total, 389 people have [viewed the session](#) (either on the night or post publication).

Deliberative focus groups have been established by the Public Participation team, supported by Communications and clinical and programme leads to support open dialogue about HTP and inform pathway design, aesthetics of services and buildings and overarching patient experience. The first round of focus groups have taken place, with over 80 people having joined, received the update and participated in discussions.

Presentations, actions and Q&As from all four focus groups are published in the public domain and can be found here:

- [Urgent and emergency care and medicine](#)



- [Clinical support services](#)
- [Surgery, anaesthetics and cancer \(“Planned care”\)](#)
- [Women’s and children’s](#)

Each focus group, aligned to the four clinical workstreams, will be tailored to individual developments within the service area and work to the timeframes within the wider programme. Ongoing discussions will cover:

- What questions do people have?
- What will work well under the clinical models?
- How do we improve/optimize the patient experience?
- Is there any potential positive or negative impact we need to consider?

Over the coming months we will seek to enhance our focus groups by recruiting further people to provide balanced and relevant feedback. This includes the following:

- Patients (recent experience and future).
- Carers and partners (for example maternity).
- Health and care professionals.
- Seldom heard groups/inequality groups or their representatives.
- Representatives from SaTH’s Public Assurance Forum (who represent many voluntary/patient groups).
- Interested parties and individuals.

Over the last five months we have involved the following groups in the development of the OBC by providing updates and opportunities for feedback, both on our communications and involvement approach and that of the wider programme:

- The Public Assurance Forum at SaTH (09.01.23, further updated scheduled for 03.04.23)
- Shawbirch Patient Participation Group (09.01.23)
- Community Health Councils for Montgomeryshire and Powys (17.01.23, 19.01.23)
- Integrated Care Board Equality and Involvement Committee (18.01.23)
- Monthly Community Cascade
- Community Connectors Powys (09.02.23)
- AF Veterans Drop-Ins
- Joint Health Overview and Scrutiny Committee (13.02.23)
- Shropshire, Telford and Wrekin Involvement and Insight Group (16.02.23)
- Shropshire Patient Group (21.02.23)
- Community Connectors Shrewsbury (26.02.23)
- Telford Patients First (01.03.23)
- Maternity Voice Partnership (involved in focus groups and information shared via MVPs and the SaTH maternity social media account)
- Shropshire Voluntary and Community Sector Assembly (09.03.23)
- Shropshire, Telford and Wrekin Big Health and Wellbeing Conversation

Working with our social inclusion officer, and partners we will seek to further involve seldom heard groups and groups representing health inequalities. As well as actively promoting our events to these community networks, we will continue with our offer to attend local groups to support a representative and inclusive voice. We will continually tailor our methods and

approach based on the insights of our Health Equality and Quality Impact Assessments (in development, to be signed off by the Clinical Assurance Group).

We are committed to the continued involvement of patients, families and our communities in the development of our future services and will work closely with the Health Overview and Scrutiny Committees to continually refine and inform our approach as we work towards implementation and beyond.

### Feedback and key themes

Key themes and mitigating actions are highlighted below.

Key feedback from staff	How has this been addressed?
Ensuring the appropriate representation at key internal and external meetings relating to the clinical workstreams and ensuring the 'passing on' of messages to the wider teams.	HTP team to ensure appropriate representation through clinical workshops and embedding into workstreams. Developing a 'champion' model to share and disseminate messages and updates and pass on questions.
Impact on work-base/location.	Addressed on a workstream-by-workstream basis and the involvement of HR and the JNCC.  Further updates to be shared as programme progresses and relevant TUPE processes to be followed.
Workforce mapping and challenges to support the delivery of the new model.	Picked up in demand and capacity modelling.
Bed base.	Picked up in demand and capacity modelling.
Staff receiving messages from the media.	We have adopted a 'staff-first' approach in that all updates are sent to our staff and published internally before being published in the public domain, sent to wider stakeholders or to the media.
Travel and transport, including reimbursements for a change in work-location.	Travel and Transport group to be re-established (initial group informed the Future Fit consultation).

Key feedback from communities	How has this been addressed?
<p>Opportunities to help name the enhanced urgent care service in Telford and the level of commitment to the term, "A&amp;E Local."</p>	<p>Whilst we are committed to developing an "A&amp;E Local model" of care, opportunities to develop the name of the service will be identified closer to implementation.</p> <p>Advice has been sought from the Royal College of Emergency Medicine and we will work with NHS England to agree the scope of naming options/whether these can be locally decided.</p>
<p>Public perception isn't necessarily represented accurately in the media and is currently based on misinformation.</p>	<p>Increased involvement activity to ensure we are hearing a representative view and are raising awareness across all communities, including seldom heard groups and those identified in the Equalities and Health Inequalities Impact Assessments.</p>
<p>Clarity over messaging for the Midwifery-led Units and how a fully functioning unit on each site will be supported by HTP.</p>	<p>Through the Hospitals Transformation Programme, we remain committed to supporting the delivery of a standalone MLU at the Princess Royal Hospital site and a consultant-led maternity unit at the Royal Shrewsbury Hospital site with an onsite MLU.</p> <p>There is a commitment to involving service users and special interest groups, e.g., our dedicated Maternity Voice Partnerships, to inform the design of the maternity environments to ensure the best possible patient and family experience.</p>
<p>Positive feedback about the introduction of day-case chemotherapy in Telford and the need for more publicity around this.</p>	<p>Proactive media release to be issued.</p> <p>Plans for a Chemotherapy Day Centre development at the Princess Royal Hospital site with charitable partner involvement will help expand the capacity of Cancer Services and provide local provision for patients undergoing treatment. The timeframes of this development will be dictated by the availability of future vacated space at PRH. The clinical team believe that the current Day Surgery area would be suitable for conversion into a treatment area, and we envisage that this will be at the later stages of the programme.</p> <p>In conjunction with the clinical team, charitable partner and the architect this will be a great opportunity for patients, carers and</p>

	families to work alongside to optimise the design.
Opportunities to help shape physical space within the hospitals eg, for families, carers and visitors, eg, children’s outdoor play area.	<p>Paediatric Ward design will include, alongside the Children’s Assessment Unit and Inpatient area, an adolescent zone, oncology department, day surgery zone and indoor/outdoor play areas.</p> <p>Conversations are ongoing with the architect and clinical teams to work alongside patients, carers and families on optimising the design as well as with the already established Women’s and Children’s focus group.</p> <p>Bespoke engagement work will also take place to ensure we are taking people’s mental health needs and diagnoses into account.</p>
Travel and transport, including reimbursements for a change in work-location.	A Travel and Transport group will be re-established (initial group informed the Future Fit consultation).

All feedback received during our focus groups can be found here: Appendix M-04b: Summary of User Groups.

### Next steps

The first and second phases of our communications and involvement strategy have focused on raising awareness, ‘re-launching’ HTP and how we are progressing the outcomes of the Future Fit consultation and setting up our forums and processes as the programme develops.

We have continued to provide input and assurance into the Management Case for the Outline Business Case and are committed to ensuring the ongoing involvement of all our stakeholders and will continue to support the Hospitals Transformation Programme as we work to develop the Full Business Case, throughout implementation and in the launch of new services.

Via the Communications, Engagement and OD forum we have established, we will continue to provide regular updates to all partners, working through the HTP, SaTH and wider ICB governance processes.

There is also a commitment to identifying key areas for influence within the programme which will be communicated across our stakeholders, offering opportunities to shape real and tangible developments as the programme and subsequent services are implemented.

We will continually review our messaging and methods to ensure we are reaching and involving our stakeholders in the best possible way.



# **DRAFT: Hospitals Transformation Programme Communications and Involvement Plan**

**Version: 14.0**

**Updated: 26 June 2023**

**PLEASE NOTE: THIS IS A WORKING DOCUMENT THAT IS REGULARLY BEING  
UPDATED.**

## **Introduction**

This document sets out how the communications and engagement teams from the Shropshire, Telford and Wrekin Integrated Care System (ICS) including The Shrewsbury and Telford Hospital Trust (SaTH) will support the Hospitals Transformation Programme (HTP) to meet its objectives through effective communications and involvement activity with our stakeholders and communities. This recognises that not one single partner can deliver the proposed benefits in isolation and the HTP is part of a wider system programme that delivers change for the local population.

We will work together to raise awareness of HTP, the benefits and rationale for change, how the programme will progress and be delivered and importantly, highlight opportunities for our stakeholders and wider communities – patients, their families and the public – to be involved in the development of the new model of care and the Outline Business Case. The Communications and Engagement team from The Shrewsbury and Telford Hospital NHS Trust will lead on the Communications and Involvement activity, working closely with Trust colleagues from the Public Participation, People and OD Directorate (OD), HTP teams, as well as wider colleagues across health and care in Shropshire, Telford and Wrekin and Powys.

## **Background**

A Strategic Outline Case (SOC) for the Hospitals Transformation Programme was approved at the end of August 2022 by the Department of Health and Social Care (DHSC) and NHS England's (NHSE) Joint Investment Committee.

The SOC sets out plans to progress the implementation of the reconfiguration of acute services agreed upon as part of the Future Fit public consultation. This will see the Princess Royal Hospital in Telford specialise in planned care and the Royal Shrewsbury Hospital specialise in Emergency Care.

The Hospitals Transformation Programme is a key part of the overarching plan to transform health and care services across Shropshire, Telford and Wrekin and Powys.

Our current clinical model is not fit for purpose because an outdated service configuration significantly impacts on our ability to address quality and operational issues. The workforce situation is not sustainable if we continue to duplicate services across both sites.

Our population needs are increasing and changing. Shropshire's over-65 population is set to grow from 25% to 33% by 2043 of the total population. Telford & Wrekin is growing from 18% to 23%.

Our buildings do not give us the capacity, space, or layout we need for modern healthcare.

Our local health system has one of the largest financial recovery challenges in the NHS.

By having a site specialising in planned care, patients will wait less time for their appointments and beds would be protected for planned operations, meaning that it is highly unlikely operations will be cancelled due to emergency admissions.

Residents across Shropshire, Telford & Wrekin and mid Wales will benefit from a state of the art, modern Emergency Department that will have access to 24/7 specialist consultants, emergency surgery and be co-located with specialist, acute in-patient services. The new Emergency Department will have dedicated space for paediatric emergencies, providing an

attractive offer to paediatric emergency medicine consultants to live and work in the region, as well as dedicated space for those presenting with mental health needs.

Most people who currently attend our A&E departments need urgent care for non-life-or-limb-threatening conditions and don't need a comprehensive emergency department or hospital admission.

Approximately two-thirds (65%) of patients will access urgent care in the same place they do now, either through the A&E Local model in Telford or enhanced urgent care service in Shrewsbury.

This will result in better care for our communities with the development of two vibrant, state-of-the-art facilities that offer excellent care, in the right place at the right time.

### **Communications and Engagement Context**

We are entering a critical phase for the programme as more detail, including building designs are developed to inform the Outline Business Case (OBC) and then subsequent Full Business Case. This detail sets the foundations for the future of local services. Subject to national approval, this will then lead to an implementation phase, which will require a separate C&E plan.

This is an opportunity to:

- Re-energise our local communities and staff about the benefits this programme will bring
- Support our continuous involvement programme to help inform the pathway design and the Outline Business Case
- Reduce any confusion and myths circulating about the programme, by communicating the clinical voice and clinical-need for change and importantly using storytelling to explain what this will mean for local people and staff.

Throughout our activities we will demonstrate we are listening and addressing ongoing feedback.

### **Communication and Engagement Objectives**

- To build public and internal awareness of HTP, encouraging key stakeholders and staff to become ambassadors for these changes
- To build support/ understanding for the case for change and Outline Business Case, working together to deliver the best care possible for patients
- To communicate the clinical voice and clinical need for change and emphasising how they will improve the safety and sustainability of our services across Shropshire, Telford and Wrekin and Powys
- To deliver our statutory duties and continue to engage service users and carers, interested groups, partners and staff in the design of future services to inform the Outline Business Case
- To ensure the lived experience of patients and staff are used to inform the programme by using inclusive, representative, and accessible involvement approaches
- To work across the local health and care system to support the development of relationships and to support partners in communicating the changes that are happening and the benefits this will bring to all communities

- To provide regular toolkits and resources to support partners to inform, engage and align communications messaging and outputs
- To ensure communications are consistent, timely, responsive, accessible, and proactive

### **Communications and engagement approach**

During 2022 and 2023 there are a number of critical phases that we will support from a communications and involvement perspective:

- **Phase one: Listening and awareness** – December 2022 to March 2023 we will develop specific focus groups with service users and interested groups to help inform the development of the Outline Business Case. We will work with SaTH's Public Assurance Forum whose members belong to organisations that have key roles in health and social care, including the voluntary sector. This will also be a period of ensuring wider awareness as we will use a range of activities to promote the work that is happening and raise the level of understanding about what is happening.
- **Phase two: Development of the Outline Business Case** – December to June 2023. The development of the detailed Outline Business Case will need to be informed by the engagement activity with key stakeholders ahead of the draft of the Outline Business Case being reviewed by Summer 2023. The final OBC is required by June 2023 for formal assurance.
- **Phase three: Planning permission for Royal Shrewsbury Hospital – Summer 2023.** Listening to the views of our communities as we seek planning permission for the Royal Shrewsbury Hospital build.
- **Phase four: Development of the Full Business Case** – Summer- Autumn 2023 The development of the Full Business Case will need to be informed by the continuous engagement activity with key stakeholders ahead of the submission in Autumn 2023.
- **Phase five: Implementation phase** – December 2023- 2026. Informing and involving people as detailed plans are developed and put in place to reconfigure services, including building works and service movements. Regular communications to staff, service users and partners on progress towards implementing change.
- **Phase six: Implementation of new service configuration** – 2026. Formal informing and communicating the changes and how patients will access services. Supporting ongoing communications to demonstrate the difference the new services are making.

This C&E plan covers the activity in phases one and two and is an iterative document and further information will be added as it becomes available. Further C&E plans will be developed in the future for the following phases.

### **Key messages**

- We need to work differently to deliver better care for patients
- We are committed to maintaining two thriving hospitals that best serve the people of Shropshire, Telford and Wrekin and Powys



- We have been allocated substantial funding of £312million and we need to utilise this funding to deliver the best care possible.
- Our services are under extreme pressure and we need to invest in better urgent and emergency care services for everyone. This includes new 24/7 urgent care services at both hospital sites, which the majority of our patients will use, as well as a state-of-the-art emergency centre for the people who need these services
- We are investing £24m in planned care services at Princess Royal Hospital. By having a dedicated centre for planned care (operations and treatment) we can reduce the number of cancelled operations and appointments due to a busy emergency care system
- Ultimately, by creating the two centres of excellence we will attract and retain more staff and clinicians. We know that the current pressures are impacting on their wellbeing, and this transformational change is bringing hope to our staff.

## **Communications and involvement approach**

### **Awareness raising**

We will amplify the clinical voice, using a range of resources, to support people to understand the clinical reasons for change and how this will improve care for everyone. We will deliver a sustained campaign of awareness, using both traditional and digital resources, as the Outline Business Case is developed.

We will also offer to attend existing community meetings, as part of our continuous involvement, to update on progress with the programme, dispel any myths and listen to any suggestions.

### **Stakeholder involvement**

We will work with partners within the NHS, local authorities, voluntary sector, politicians and interested groups to understand their needs and support them in promoting the benefits these changes will bring. We will offer regular meetings both with individuals and by attending existing forums, including community groups to grow confidence in the new models and to show united commitment to delivering the best care possible for local people within the resources available.

We will work closely with partners to build awareness and support for the Outline Business Case and Full Business Case. This includes providing assurance to the Trust's Board and ICB Board as key decision makers.

### **Involving staff and clinicians**

We recognise that we need two approaches to this audience, supporting a proactive dialogue both internally within the Trust and within wider organisations. Through the programme team we will offer core resources and narrative and an offer to attend existing meetings with staff and clinicians to listen to their suggestions for the OBC and also to support them to be part of this change.

In the Trust, our action plan will detail a range of opportunities to take staff on this journey and to build momentum ahead of implementation. This includes:

- Ongoing clinical workshops and ward walks to co-design the detailed clinical modelling that will inform the designs and OBC

- Attendance at existing internal meetings, for example COO huddles, JNCC and Divisional committees and meetings
- General awareness roadshows within the Trust in high footfall areas
- Webinar for staff (particularly those working virtually) to find out more about the programme and to answer questions. This will include videos from our key clinicians
- Dedicated HR advice and support for any individuals/ teams that may be affected by the changes.

#### **For systemwide staff**

- Working with partners, offering to attend existing meetings or provide webinars to give staff from across the system the chance to ask questions and share their ideas on the emerging designs
- Primary care – we will attend existing meetings, provide regular copy for use in the ICB existing channels and offer for a specific webinar for primary care clinicians
- We will provide resources, for example videos and presentations that system partners can use to engage their staff in the discussion. Wherever possible the programme team will try and attend any meetings that are requested to answer more detailed questions.

#### **Involving patients and the public (including seldom heard groups)**

We will utilise existing mechanisms for communications and involvement, including existing patient, carer and public forums across Shropshire, Telford & Wrekin as well as developing bespoke focus groups directly linked to each of our workstreams to inform the OBC.

This activity will start with an "About Health" Event digital meeting in January, with key clinicians and programme leads giving an overview of the programme's perspective and a series of focus groups to inform the OBC.

These deliberative focus groups (with both digital and face to face options - COVID-19 allowing) will be supported by clinicians and programme leads. They will support open dialogue about the pathway design and aesthetics of the services and buildings, including patient experience. We recognise each workshop will be tailored to the specific service, but will include:

- What questions do people have?
- What will work well under the clinical models?
- How do we improve/optimize the patient experience?
- Is there any potential positive or negative impact we need to consider?

We will seek to recruit people to form balanced focus groups, including:

- Patients (recent experience and future)
- Carers and partners (for example maternity)
- Health and care professionals
- Seldom heard groups/inequality groups or their representatives
- Representatives from SaTH's Public Assurance Forum (who represent many voluntary/patient groups)
- Interested groups

We will work closely with the Public Assurance Forum at SaTH and Patient Assembly in the ICB to inform our approach to continuous involvement as part of the development of the OBC. We will manage expectations about the different phases of the programme and what can be influenced by our clinicians, staff and patients.

Working with our social inclusion officer, and partners we will seek to involve seldom heard groups and groups representing health inequalities. As well as actively promoting our events to these community networks, we will also offer to attend local groups to support a representative and inclusive voice. We will tailor this C&I plan based on the insight of our Health Equality and Quality Impact Assessments.

We recognise a need to reach our general population and we will aim to visit high footfall areas and understand people's questions and ideas.

Our communications will complement our involvement activities through bespoke stakeholder briefings, media and social media campaigns, internal briefings and regular two-way updates.

We will continue to work closely with the Health Overview and Scrutiny Committees to inform our approach to continuous involvement as we develop the Outline Business Case.

### **Methods and resources**

We will use a variety of methods to communicate and involve our various stakeholders. These are detailed in our action plan, but in summary include:

- Internal communications and involvement channels (Trust and systemwide partners)
- Media relations
- External channels via stakeholder bulletins and briefings
- Collateral development for dissemination across partners and the public
- Dedicated involvement sessions to help the development of the OBC
- Wider community outreach with members of the Voluntary and Community Sector.

We will develop a range of resources that can be used by the programme team, HTP champions and system partners to promote across a wide variety of community networks as well as the planned involvement activities. These will be developed as appropriate during the lifetime of the programme and could include:

- Visual representations of initial architect visuals, and if budgets allow VR tools could be used (or considered at the implementation phase)
- Animations that show the patients journey, subject to funding including urgent care, emergency care, planned care
- Clinical videos with a range of system partners, including hospital consultants/nurses, GPs, community care, paramedics
- Core narrative resources, including: core presentation, flyers on each of the benefits (tailored to local areas), digital posters to be used on partner digital screens and libraries/community venues
- Visuals, including timelines to show the "stepping stones" to 2025
- Podcasts and talks from key clinicians talking about their support for change
- Accessible tools – BSL, easy read and resources in Welsh and alternative formats as appropriate
- Paid for advertising to explain the changes and opportunities to get involved, including social media to key audiences
- Visual resources at both hospitals, including using digital screens and information zones within the hospitals for the latest information on the programme

- Monthly stakeholder update and resource pack to support promotion across a range of community partners. This content can be used by partners, including the Trust's own Community Cascade monthly meetings and monthly news updates.

### **Building support and enthusiasm for the programme**

Throughout this journey we will capture through digital and written tools people's experiences and hopes for the future. We will launch a campaign in January that will look to the future and encourages people to be part of the change and make a difference. This will include local clinicians, partners and patients sharing their hopes for the future.

### **Key spokespeople**

The below core spokespeople will be media trained and represent the programme. A range of specialist clinicians will also be trained, for bespoke news stories.

<b>Role</b>
Clinical Director for HTP and emergency care
Clinical Lead Planned Care
Medical Director
Director of Nursing SaTH
Chief Medical Officer ICB
Director of the HTP programme
CEO SaTH
CEO ICB

These spokespeople will be kept under regular review.

### **Communication & engagement activities and plan**

The communications and engagement plans will remain flexible enough to adapt to meeting the programme's needs as it develops, and in line with the feedback, at each stage of the process.

We have divided our stakeholders into three groups for communication and involvement purposes:

1. Patients and public
2. Staff
3. Wider stakeholders (such as MPs, GPs, Healthwatch etc)



### Communications and involvement activities

The below table provides a summary of core activity and milestones a more detailed action plan is in place and monitored by the C&I working group.

Audience	Activity	Description / Purpose	Timing
<b>Patients and Public</b>	Expanded social media presence on Twitter, Facebook and Instagram driving people to our dedicated webpage for more information, social media assets will include: clinician videos, infographics	Social media campaign designed to drive people to our dedicated web presence for more information on what HTP is and generate more understanding of what the programme aims to achieve.	Ongoing
	A schedule of regular proactive media releases and interviews reinforcing the aims and ambitions of the programme.	To keep public and patients informed about HTP.  The plan is to issue one press release a fortnight, including pieces from our clinicians.	Ongoing
<b>Patients and Public and Staff</b>	Staff and visitor information at our two acute hospital sites to support engagement activities and capture feedback	Posters, banners, infographics to generate interest and awareness. Purpose of these zones is to bring the planned changes to life. For that purpose we will schedule drop in briefing sessions. This will also help us to gain comments/feedback on the proposed changes as well as informing people about how they can get involved, as appropriate to the timeline.	Phased approach – posters on site/ drop in sessions  Interactive zones – Autumn 2023
<b>Patients and Public</b>	Virtual / face-to-face focus groups and face to face events for our communities (Public Assurance Forum (PAF) & other stakeholders' events (as HealthWatch, Telford Patient First, Shropshire Patient Group Focus group meeting)	Focus groups, including PAF members and community representatives, for each of the work streams to inform the OBC. PAF members will be able to identify and help us to link with other key groups across Shropshire, Telford & Wrekin and Mid Wales.	January, June, July

Audience	Activity	Description / Purpose	Timing
<b>Patients and Public, Staff and Stakeholders</b>	About Health Event	Online event for communities and public to inform the programme.	January, May, July
<b>Patients and Public, Staff and Stakeholders</b>	Websites – SaTH and ICS HTP webpage	We will publish the latest information on the website, highlighting the key messages, current activity and signpost to all assets developed as well as latest news.	December
<b>Patients and Public, Staff and Stakeholders</b>	Communications and engagement asset development	<p>A suite of assets will complement all activity and could include:</p> <ul style="list-style-type: none"> <li>• Case studies and infographics of patient journeys</li> <li>• Clinician videos highlighting the changes per Division and overarching programme plan</li> <li>• Posters to be displayed across both hospital sites and across the ICS and for use in the interactive zones, on social media and digital screens</li> </ul>	Ongoing
<b>Staff</b>	Updates across all internal SaTH and ICS channels	Signposting to the related materials and informing on wider public engagement and opportunities for involvement (asking staff to be our ambassadors).	Ongoing
<b>Staff</b>	Update SaTH Intranet - intranet HTP pages focused on the planned changes, what this investment means for staff, opportunities to get involved etc and provide content for ICS internal channels as appropriate	Giving a single, central place for all information, updates, news, opportunities to get involved and Q&As.	Ongoing
<b>Staff</b>	Staff briefings across Divisions. HTP team to support at any relevant ICS staff briefings/comms briefings and offer opportunity for partner briefings eg, WMAS, GPs etc	To receive updates and galvanise support for the HTP plans and also to receive staff feedback/questions	December- March June- August

Audience	Activity	Description / Purpose	Timing
<b>Staff</b>	Identify ambassadors	<p>In all communications and engagement activity we will seek staff ambassadors for the programme who can act as key messengers across the organisation.</p> <p>Embedded programme leads within Divisions to support ongoing engagement.</p>	Ongoing
<b>Stakeholders</b> (MPs, Primary and Community Care, ICS Colleagues and Executives)	Monthly updates from SaTH	A monthly e-shot will be circulated to all stakeholders which will include updates on HTP. Cascade and Impact newsletters may be the tool	Ongoing (through stakeholder emails)
<b>Patients and the Public</b>	Monthly community update from SaTH. Monthly Community Cascade meeting plus other meetings in the community attended by the Public Participation team	An email update to our Community Members (3000) and organisations (300) to keep them informed of HTP. We will continue to promote the community membership as a method for partners to be kept informed and involved.	Ongoing (through stakeholder emails)
<b>Patients and the Public</b>	Community Cascade	Regular monthly updates on the HTP to be included in community cascade meetings	Monthly
<b>Stakeholders</b>	Issue to ICS colleagues for circulation via ICS channels and stakeholder bulletins	Use existing content for onward circulation to wider partners and identify opportunities to attend partner briefings, eg, WMAS, GPs	Monthly (except through pre-election period).
<b>Stakeholders</b>	JHOSC meetings	Identify when the meetings are taking place and whether written or face to face updates can be taken	December
<b>Stakeholders</b>	<p>Shrewsbury and Telford Hospital NHS Trust Board</p> <p>NHS Shropshire, Telford and Wrekin Board Meeting</p>	Provide update in required format	<p>Monthly</p> <p>30 November/ 29 March/ 30 May</p>

Audience	Activity	Description / Purpose	Timing
<b>Patients and Public</b>	Virtual/face to face/online feedback sought on opportunities to shape estates and clinical pathway design.	Opportunities to help shape the Outline Business Case will be identified with the programme team and awareness raised amongst patients and the public with virtual/face to face focus groups and attendance at community meetings.	As appropriate to programme development
<b>Patients and Public, Stakeholders</b>	Public Assurance Forum	HTP to provide an update on the programme and gain assurance from the group around patient/public engagement, which will be reported back to Trust Board in line with ToR of PAF	January, April, July, October
<b>Patients and Public, Staff, Stakeholders</b>	Online "About Health" Event on HTP	An online event open to re-energise and build public awareness and understanding of HTP	January, May, July
<b>The key focus between May and September will be on the Outline Business Case, where are in the process and what happens next</b>			
<b>Patients and Public</b>	Press release, radio interview, website and social media updates on the programme to acknowledge the process, people's input and outline the next steps.	Clinical spokesperson to update on the next steps and acknowledge the work to date, including the input from patients and public, staff and all stakeholders.	May - September
<b>Staff</b>	Updates across all internal channels.	Signposting to the related materials and informing on the latest updates, proposed clinical pathways, estates design and opportunities to get involved.	April- September
<b>Stakeholders</b>	Update and briefings from the HTP team	Update on the work taken to get to this point and next steps. The OBC will be shared as relevant to those necessary.	April - September
<b>Stakeholders</b>	JHOSC update	Offer to provide update on progress and OBC as appropriate and in preferred format	June – July
<b>Stakeholders</b>	NHS Shropshire, Telford and Wrekin Board Meeting	Provide update in required format	30 May



Audience	Activity	Description / Purpose	Timing
<b>Expected NHS E/I response in Summer 2023</b>			
All	Planning permission involvement for RSH build	Dedicated website area Stakeholder updates Drop-in roadshows for staff and communities Survey for correspondence Targeted focus group Online webinar	July – September
Patients and Public	Announcement press release and media interviews	All to be prepared in advance and issued in a co-ordinated way so that all partners and stakeholders are updated as soon as we receive feedback and can discuss next steps.	Summer 2023
Staff	Announcement message from CEO		
Stakeholders	Announcement notice		
All	Summary of Outline Business Case to be produced	Public facing Outline Business Case to be produced and website updated	Summer 2023
Stakeholders	NHS Shropshire, Telford and Wrekin Board Meeting	Provide update in required format	Summer 2023

**\*To note: Telford and Wrekin Council Local elections to take place in May 2023 with a pre-election period from the end of March until early May 2023. During this time there will be a pause on public communications and engagement activity and updates.**

### **Governance and accountabilities**

A C&E working group has been established to drive forward the activity for the HTP programme, this will meet minimum fortnightly. It will include representation from the core members including SaTH communications, SaTH engagement, SaTH People and OD Directorate. It will also provide regular updates and seek involvement from the monthly ICS C&E group, including representation from NHS, local authorities and Healthwatch partners.

We will provide regular updates to the PAF to seek assurance on our approach to involvement activity to inform the Outline Business Case, Full Business Case and subsequent implementation phases.

This group will formally report into the HTP Programme Board and as required the SaTH and ICB Board meetings as the decision makers.

## **Delivery, evaluation and measurement of success**

By working together across the Hospitals Transformation Programme, we will outline individual responsibilities and actions in a detailed action plan that will underpin the strategy and that is signed off by relevant executive leads from across the programme and ICS.

We will continuously measure the effectiveness of communications and engagement activities. A monthly review of all communications and engagement activity will be produced to include but not limited to:

- Sentiment analysis of that coverage to measure whether it is positive, negative, or neutral
- Anecdotal feedback from face-to-face meetings
- Attendance at staff and stakeholder briefings
- Opening rates of the stakeholder briefings (subject to an appropriate software tool being identified)
- Reach and sentiment of media and social media coverage
- Social media sentiment (subject to the availability of social media listening software).

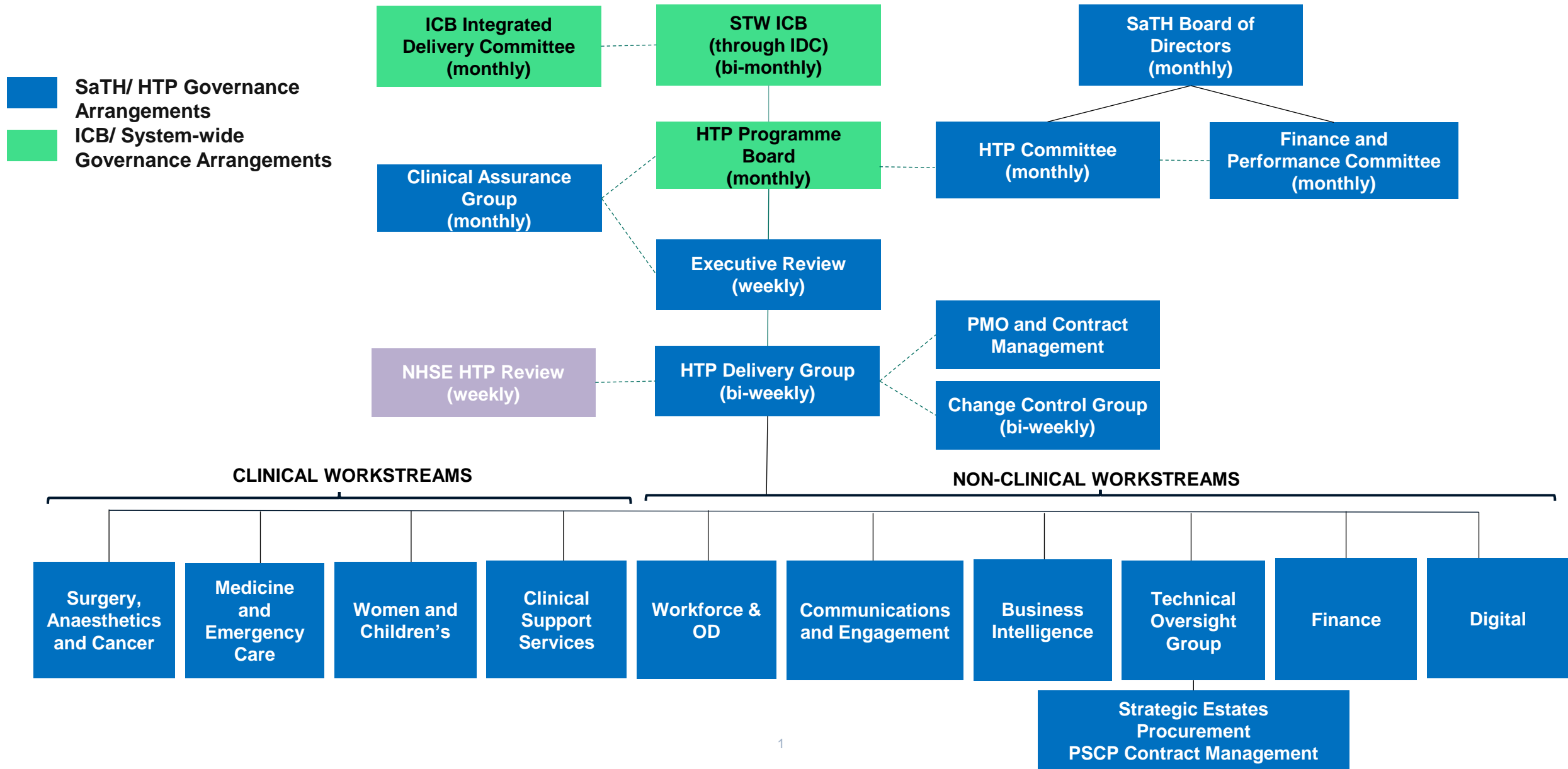
The success criteria of our communications and engagement activities is described below:

### *Communications*

- Staff able to articulate strategic objectives and transformation priorities and act as champions for the programme
- Stakeholders understand, get involved and support the need to move forward and deliver better care for patients
- Patients and public aware of HTP objectives and transformation programme and contribute through engagement opportunities.

### *Engagement*

- Ongoing involvement from key stakeholders
- Positivity and interest evident in involvement events and activities
- Demonstrable wide participation in involvement activities and events. Feedback from attendees at events
- Improved feedback from independent stakeholders.
- The number of staff/teams engaged within the Trust and an improved level of staff engagement and satisfaction
- The number of Community Groups/seldom-heard groups attended, the number of attendees, the number of people directly engaged.



**HOSPITALS TRANSFORMATION PROGRAMME  
CLINICAL ASSURANCE GROUP  
TERMS OF REFERENCE**

**Constitution**

As a Committee of the Trust, the Standing Orders of the Trust shall apply to the conduct of the working of the HTP Clinical Assurance Group. The Clinical Assurance Group is authorised by the Programme Board to;

- Act as a clinical advisory forum for the clinical programme that informs the business cases
- Formally oversee and approve the functional briefs, staffing and activity assumptions, and design elements relevant to the delivery of the clinical model developed by the clinical specialties, architectural specialists and Health Care Planners.
- Drive forward the operationalising of the Hospitals Transformation Programme and support delivery of the future clinical model including new ways of working and development of the sustainable workforce
- Provide leadership and involvement in the delivery and implementation of the HTP clinical model
- Ensure the quality and safety impact of the proposed service changes are assessed and that mitigating actions are identified and delivered
- Ensure delivery of the clinical model has evidence of multi-disciplinary involvement and, when necessary cross divisional and ICS involvement
- Ensure our future service descriptions align with the clinical model
- Provide assurance that the service delivery within the clinical model is effective and safe

**Membership**

**Role**

Medical Director (Chair)  
Clinical Lead of Hospitals Transformation Programme (*Deputy for Medical Director*)  
Interim Director of Hospitals Transformation Programme  
Medical Director for Medicine and Emergency Care  
Medical Director for Surgery, Anaesthetics and Cancer  
Medical Directors for Clinical Support Services  
Medical Director for Women and Children's  
Divisional Operational Director for Medicine and Emergency Care  
Divisional Operational Director for Surgery, Anaesthetics and Cancer  
Divisional Operational Director for Clinical Support Services  
Divisional Operational Director for Women and Children's  
Divisional Director of Nursing for Medicine and Emergency Care  
Divisional Director of Nursing for Surgery, Anaesthetics and Cancer  
Divisional Director of Nursing for Women and Children's  
Director of Midwifery  
Director of Nursing  
Acting Chief Operating Officer

**Attendance when required**



The Committee has the power to co-opt, or to require to attend, any member of the Integrated Care System staff as necessary, and to commission input from external advisors as agreed by the Chair.

Nominated/agreed deputies to attend as long as they are mandated to make a decision. Other members will be co-opted as and when required i.e. Deputy Divisional Directors.

The Committee will be chaired by the Medical Director. In the absence of the nominated Chair the HTP Lead Clinician to Chair the Meeting.

### **Responsibilities of Members**

- If unable to attend, send their apologies to the Chair and Committee Administrator prior to the meeting and, if appropriate, seek the approval of the Chair to send a deputy to attend on their behalf.
- When matters are discussed in confidence at the meeting, maintain such confidences.
- At the start of the meeting, declare any conflicts of interest/potential conflicts of interest in respect of specific agenda items (even if such a declaration has previously been made in accordance with the Trust's policies and procedures).

### **Attendance**

It is expected that a member or their nominated deputy will normally attend for a minimum of 75% of meetings in a year.

### **Quorum**

The Committee will be deemed quorate to the extent that the following members are present:

- Medical Director or Clinical Lead of Hospitals Transformation Programme.
- Medical Director / Divisional Operational Director from each Division.
- Divisional Director of Nursing/Midwifery or nominated deputy from each Division.

### **Frequency of meetings**

The Committee will normally meet monthly. The Chair may convene additional meetings of the Committee to consider business that requires urgent attention.

The agenda will be circulated with papers at least 5 working days before the meeting. The agenda will be approved by the Chair prior to circulation. Requests for non-routine agenda items are to be forwarded to the Chair normally at least 5 working days prior to the meeting.

Additional meetings may be held at the discretion of the Chair.

### **Authority**

- The Clinical Assurance Group is authorised by the Programme Board to act within its Terms of Reference. The Clinical Assurance Group is authorised to investigate any Trust activity within its Terms of Reference and is expected to make recommendations to the Programme Board. All members of staff are directed to co-operate with any request made by the Programme Board.
- The Clinical Assurance Group is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its terms of reference.
- The Clinical Assurance Group has no executive powers other than those specifically delegated in these Terms of Reference.
- The Clinical Assurance Group approves the work and decisions made by the Task and Finish Groups, makes recommendations and reports into the HTP Executive Group and HTP Programme Board.

## Duties and Accountability

The duties of the Clinical Assurance Group can be categorised as follows:

1. To oversee the clinical input into the development of the Outline Business Case and Full Business Case.
2. To provide assurance that operating plans are aligned with the Clinical Model described in the SOC and provide a description of safe and effective clinical services at Divisional level.
3. To capture and oversee the management of risk in relation to the Quality Impact Assessment and the Hospitals Transformation Programme, ensuring alignment with the Corporate Risk Management process.
4. To formally report into the HTP Executive Group and HTP Programme Board on the Clinical element of the programme in relation to progress and issues for escalation and proposed solutions.

## Reporting

The Clinical Assurance Group shall report to the HTP and HTP Programme Board on how it discharges its responsibilities by monthly summary.

A summary of its meetings is formally recorded and submitted to the HTP Executive Group and HTP Programme Board, by exception. This shall be presented by the Chair who will bring any significant matters under consideration and make recommendations on any area within its remit to Committees.

## Administrative arrangements

The Administrator has responsibility for:

- Keeping a record of matters arising and issues to be carried forward.
- Producing an action list following each meeting and ensuring any outstanding action is carried forward on the action list until complete.
- Producing a schedule of meetings to be agreed for each calendar year and making the necessary arrangements for confirming these are dates and booking appropriate rooms and facilities.
- Producing appropriate support to the Chair and meeting members.
- Providing notice of each meeting and requesting agenda items no later than 7 days before a meeting.
- Agreeing the agenda with the Chair prior to sending the agenda and papers to members no later than 5 days before the meeting.

## Review

The Terms of Reference will normally be reviewed annually, with recommendation on changes submitted to the Trust Board for ratification.

**Approved:**

*Under review due to change in Chairperson  
– will be approved in May 2023*

**To be reviewed:**

*May 2024*

**HTP Technical Oversight Group  
TERMS OF REFERENCE**

**Constitution**

The HTP Delivery Group resolves to establish a group known as the HTP Technical Oversight Group. As a subgroup of the HTP Delivery Group, the Standing Orders of the Trust shall apply to the conduct of the working of the Technical Oversight Group.

**Membership**

The membership of the HTP Technical Oversight group will be:

**Members:**

- Associate Director Estates Strategic Capital (Chair)
- HTP Technical Director (Deputy Chair)
- HTP Strategic Estates Workstream Lead
- HTP Programme Manager
- Interim Director of Estates
- HTP Procurement Workstream Lead
- Lead Cost Consultant - Edmond Shipway
- Lead Consultant Design – AHR
- Lead Architect – AHR
- Lead Design Engineer – DSSR
- Healthcare Planners – SHP
- Digital Workstream Lead
- Master Programme Co-ordinator
- HTP Programme Officer (meeting secretary)

**Attendance when required:**

Other managers/staff may be required to attend meetings depending upon issues under discussion with the prior approval of the group Chair. The group has the power to co-opt, or to require to attend, any member of Trust staff as necessary, and to commission input from external advisors as agreed by the Chairman.

**Responsibilities of Members**

- Identify agenda items for consideration by the Chair and the group administrator at least 7 days before the meeting.
- Prepare and submit papers for a meeting at least 7 days before the meeting.
- If unable to attend, send their apologies to the Chair and Group Administrator prior to the meeting and, if appropriate, seek the approval of the Chair to send a deputy to attend on their behalf.
- When matters are discussed in confidence at the meeting, maintain such confidences.
- At the start of the meeting, declare any conflicts of interest/potential conflicts of interest in respect of specific agenda items (even if such a declaration has previously been made in accordance with the Trust's policies and procedures).

<p><b>Attendance</b></p> <p>If unable to attend a meeting, the members may be represented by a nominated deputy, but this must be agreed before the meeting with the Group Chair. It is expected that a member or their nominated deputy will normally attend for a minimum of 75 % of meetings in a year.</p>
<p><b>Quorum and Invitees</b></p> <p>The Group will be deemed quorate to the extent that the following members are present: The presence of the following roles and functions:</p> <p>Associate Director Estates Strategic Capital (Chair) HTP Strategic Estates Workstream Lead Lead Cost Consultant - Edmond Shipway Lead Consultant Design – AHR Lead Architect - AHR Lead Design Engineer - DSSR Healthcare Planners – SHP</p> <p>Invitees: Interim Director of Estates HTP Technical Director HTP Programme Manager HTP Programme Officer Master Programme Coordinator HTP Procurement Lead</p>
<p><b>Frequency of meetings</b></p> <ul style="list-style-type: none"> <li>• The Group will normally meet fortnightly. The Chair may convene additional meetings of the Group to consider business that requires urgent attention</li> <li>• The Agenda will be circulated with papers at least 7 working days before the meeting. The Agenda will be approved by the Group Chair prior to circulation. Requests for non-routine agenda items are to be forwarded to the Group Chair normally at least 9 working days prior to the meeting.</li> </ul>
<p><b>Authority</b></p> <ul style="list-style-type: none"> <li>• The HTP Technical Oversight Group is authorised by the HTP Delivery Group to act within its terms of reference.</li> <li>• The Group is authorised to investigate any Trust activity within its Terms of Reference and is expected to make recommendations to HTP Delivery Group. All members of staff are directed to co-operate with any request made by HTP Technical Oversight Group.</li> <li>• The HTP Technical Oversight Group is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its terms of reference.</li> <li>• The Group has no executive powers other than those specifically delegated in these Terms of Reference</li> </ul>
<p><b>Duties</b></p> <p>Manage the design and construction workstream of the HTP programme Monitor and put forward changes in technical design scope Manage the budget for the workstream Manage the timeline for the workstream Produce a risks and issues register for the workstream Monitor quality of deliverables and outputs Monitor compliance with all guidance and identify derogations required Confirm and challenge change requests Confirm RFI information requirement from clinical teams</p>



### Reporting

- The Technical Oversight Group will have the following reporting responsibilities:  
The Group will be directly accountable to the HTP Delivery Group and will prepare a summary of the main actions/points at each meeting for presentation to the HTP Delivery Group.
- The Technical Oversight Group will have decision making remit within the scope of its functions mainly as identified in the SOC / OBC / FBC in addition to agreed SOAs. And deviation will be subject to change management process.

### Administrative arrangements

The meeting secretary has responsibility for:

- Production of a AAA report to the HTP Delivery Group
- Keeping a record of matters arising and issues to be carried forward.
- Producing an action list following each meeting and ensuring any outstanding action is carried forward on the action list until complete.
- Producing a schedule of meetings to be agreed for each calendar year and making the necessary arrangements for confirming these are dates and booking appropriate rooms and facilities.
- Producing appropriate support to the Chair and members.
- Providing notice of each meeting and requesting agenda items no later than 10 days before a meeting.
- Agreeing the agenda with the Chair prior to sending the agenda and papers to members no later than 7 days before the meeting.

### Review


The terms of reference will normally be reviewed annually, with recommendation on changes submitted to the HTP Delivery Group for ratification.

<b>Approved:</b>	<i>Under review – will be approved in May 2023</i>
<b>To be reviewed:</b>	<i>May 2024</i>

**Part 1:**

- 1- Welcome and Apologies
- 2- Minutes and action log
- 3- Lead Design Update
  - a. Healthcare Planning
  - b. Lead Design
    - i. Derogations Tracking and Quality Specifications
    - ii. Scope Changes
    - iii. RFI Information
  - c. Architect
  - d. MEP
  - e. Structural
  - f. Cost Consultant
- 4- Costed Risk Register
- 5- Programme Update and Review of Key Milestones
- 6- Procurement Update
- 7- Change Control
- 8- AOB
  - a. Common Data Environment
  - b. Enabling Works
- 9- Group Output Report / AAA
- 10- Date of next meeting

**Part 2:**

- 1- Welcome and Apologies
  - 2- Minutes and action log
  - 3- Interdependent projects aligned to HTP
    - a. Digital
    - b. Power
    - c. Parking
    - d. Helipad
    - e. MLU
    - f. Void space
    - g. Relocation of Execs
  - 4- Corporate / Critical Dependency Risk Register
  - 5- Programme Update and Review of Key Milestones
  - 6- AOB
  - 7- Group Output Report / AAA
  - 8- Date of next meeting
- 

**HOSPITALS TRANSFORMATION PROGRAMME  
DELIVERY GROUP  
TERMS OF REFERENCE**

**Constitution**

The Shrewsbury and Telford Hospital NHS Trust (SaTH) has taken on a 'prime provider' responsibility to lead all aspects of the delivery of the Hospitals Transformation Programme (HTP) (on behalf of system partners).

The HTP Delivery Group reports directly to the Hospitals Transformation Programme Board and its constitution and terms of reference shall be as described below.

The HTP Delivery Group is authorised by the Hospitals Transformation Programme Board to;

- Coordinate and deliver the Trust's actions and deliverables in progressing the Hospitals Transformation Programme
- Ensure the quality and safety impact of the emerging service changes are assessed and all necessary actions delivered
- Oversee and ensure the implementation of the Hospitals Transformation Programme, ensuring alignment with Trust objectives and the wider ICS transformational change plans
- Monitor the delivery of key deliverables and achievement of milestones across work streams and activities
- Oversee the management of risk and issues within the Hospitals Transformation Programme and support its mitigation.

**Membership**

Role	Name:
Co-Medical Director, SaTH	
Interim Director of Hospitals Transformation (Chair)	
HTP Medical Director	
HTP Implementation Leads	
HTP Programme Manager	
HTP Project Support Manager	
HTP Communications and Engagement Lead	
Associate Director of Estates and Hospital Site Transformation (Deputy)	
HTP Estates Lead	
HTP Procurement Lead	
HTP Finance Lead	
HTP Workforce Lead	
HTP Digital Lead	

Other managers/staff may be required to attend meetings depending upon issues under discussion with the prior approval of the Chair. The Chair has the power to co-opt, or to require attendance, any member of Trust staff as necessary, and to commission input from external advisors as agreed by the Chair.

Nominated/agreed deputies to attend as long as they are mandated to make a decision. Other

members will be co-opted as and when required i.e. Divisional Leads / Department Managers.

This Delivery Group will be chaired by the Director of Hospitals Transformation. In the absence of the nominated Chair, a senior leader will be nominated by the Director of Hospitals Transformation to Chair the Meeting.

### **Responsibilities of Members**

- To oversee and drive forward the implementation of the Hospitals Transformation Programme in line with agreed plans, ensuring ongoing alignment with system objectives and change plans.
- To monitor the delivery of key objectives and the achievement of milestones/outcomes across all work streams and activities, ensuring that risks and/or issues are managed proactively and escalated in a timely fashion (if required).
- Identify agenda items for consideration by the Chair and the Administrator.
- Workstream leads will be required to produce a brief one page highlight report addressing;
  - Progress on key milestones
  - Amendments to existing assumptions
  - Arising risks and issues
  - Plans for the coming week and support required.
- If unable to attend, send their apologies to the Chair and Administrator prior to the meeting and, if appropriate, seek the approval of the Chair to send a deputy to attend on their behalf.
- When matters are discussed in confidence at the meeting, maintain such confidences.
- At the start of the meeting, declare any conflicts of interest/potential conflicts of interest in respect of specific agenda items (even if such a declaration has previously been made in accordance with relevant policies and procedures).

### **Attendance**

If unable to attend a meeting, the members may be represented by a nominated deputy, but this must be agreed before the meeting with the Chair. The nominated deputy would be expected to be sufficiently well briefed to fully participate. It is expected that a member will normally attend for a minimum of 75% of meetings in a year.

### **Quorum**

For decision making and authority, the Group will be deemed quorate to the extent that the following members are present:

- Operations Director
- Director of Hospitals Transformation
- HTP Estates Lead / Associate Director of Estates and Hospital Site Transformation (Deputy)
- HTP Medical Director / HTP Implementation Lead
- Programme Manager

A meeting of the Group will be considered quorate with at least three of the members being present, including the Chair. Nominated/agreed deputies to attend as long as they are mandated to make a decision. Attendance of other leads may be required if a particular issue is raised.

### **Frequency of meetings**

The Group will normally meet weekly. The Chair may convene additional meetings of the Group to consider business that requires urgent attention.



## **Authority**

The HTP Delivery Group is authorised by the Programme Board to act within its Terms of Reference. This Group is authorised to investigate any Trust activity within its Terms of Reference and is expected to make recommendations to the Programme Board. All members of staff are directed to co-operate with any request made by the HTP Delivery Group.

The HTP Delivery Group is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its terms of reference.

The HTP Delivery Group has no executive powers other than those specifically delegated in these Terms of Reference.

## **Duties**

The duties of the HTP Delivery Group can be categorised as follows:

- To coordinate and deliver the Trust's actions and deliverables in progressing the Hospitals Transformation Programme
- To ensure the quality and safety impact of the emerging service changes are assessed and all necessary actions delivered
- To oversee and ensure the implementation of the Hospitals Transformation Programme, ensuring alignment with Trust objectives and the wider ICS transformational change plans
- To monitor the delivery of key deliverables and achievement of milestones across work streams and activities
- To oversee the management of risk and issues within the Hospitals Transformation Programme and support its mitigation.

## **Reporting**

The HTP Delivery Group shall report to the Programme Board on how it discharges its responsibilities by monthly summary.

A summary of its meetings is formally recorded and submitted to the Programme Board. This shall be presented by the Chair who will bring to the Programme Board specific attention any significant matters under consideration and make recommendations on any area within its remit.

Workstream leads will be required to produce a brief one page highlight report addressing;

- Progress on key milestones
- Arising risks and issues
- Plans for the coming week and support required

## **Administrative arrangements**

The Administrator has responsibility for:

- Keeping a record of matters arising and issues to be carried forward.
- Producing an action list following each meeting and ensuring any outstanding action is carried forward on the action list until complete.
- Producing a schedule of meetings to be agreed for each calendar year and making the necessary arrangements for confirming these dates and booking appropriate rooms and facilities.
- Producing appropriate support to the Chair and Group members.
- Providing notice of each meeting and requesting agenda items prior to each meeting.
- Agreeing the agenda with the Chair prior to sending the agenda and papers to members.

- Minutes will be circulated to members within 48 hours of the meeting.
- Actions from the meeting will be collated by the Administrator prior to the next scheduled meeting.
- Highlight reports will be collated by the Administrator within 48 hours prior to the next meeting.

**Review**

The terms of reference will normally be reviewed annually, with recommendation on changes submitted to the Programme Board for ratification.

<b>Approved:</b>	11/08/2022
<b>To be reviewed:</b>	11/08/2023

## Hospitals Transformation Programme Committee TERMS OF REFERENCE

### Constitution

Its constitution and terms of reference shall be as set out below. As a committee of the Trust, the Standing Orders of the Trust shall apply to the conduct of the working of the Hospitals Transformation Programme (HTP) Committee.

The HTP Committee supports the Trust's governance framework in ensuring risk assessment and risk mitigation plans are in place across the Trust.

### Membership

The membership of the HTP Committee will be:

Core Committee Members:	Deputies:
Interim Director of Strategy & Partnership (Chair)	Director of Finance (Deputy Chair)
Director of Finance	
Co-Medical Director	
Non-Executive Director	
Non-Executive Director	

- The HTP Programme Director and HTP Medical Director will also be required to attend the HTP Committee and will be expected to comply with the attendance requirements described below (if unavailable, a nominated deputy should attend in their place).
- Other managers/staff may be required to attend meetings depending upon issues under discussion with the prior approval of the Committee Chair. The Committee has the power to co-opt, or to require to attend, any member of Trust staff as necessary.
- The Committee will be chaired by the Interim Director of Strategy and Partnerships. In the absence of the nominated Chair, The Director of Finance will chair the meeting.

### Responsibilities of Members

- To oversee all aspects of the implementation of the Hospitals Transformation Programme (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 SaTH's performance as the 'prime' provider for the Hospitals Transformation Programme (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.
- When matters are discussed in confidence at the meeting, maintain such confidences.
- At the start of the meeting, declare any conflicts of interest/potential conflicts of interest in respect of specific agenda items (even if such a declaration has previously been made in accordance with relevant policies and procedures).

<b>Attendance</b>
<p>If unable to attend a meeting, a member may be represented by their nominated deputy, but this must be agreed before the meeting with the Committee Chair. The nominated deputy would be expected to be sufficiently well briefed to fully participate as a full member. It is expected that a member will normally attend for a minimum of 80% of meetings in a year.</p>
<b>Quorum</b>
<p>The Committee will be deemed quorate to the extent that the following members are present:</p> <ul style="list-style-type: none"> <li>• Chair (or Chair's delegate) and two other members of the committee.</li> </ul>
<b>Frequency of meetings</b>
<ul style="list-style-type: none"> <li>• The Committee will normally meet every two months. The Chair may convene additional meetings of the Committee to consider business that requires urgent attention.</li> </ul>
<b>Authority</b>
<ul style="list-style-type: none"> <li>• The HTP Committee is authorised by the Trust Board to act within its terms of reference. The Committee is authorised to investigate any Trust activity within its Terms of Reference and is expected to make recommendations to the Board. All members of staff are directed to co-operate with any request made by the HTP Committee.</li> <li>• The HTP Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its terms of reference.</li> <li>• The Committee has no executive powers other than those specifically delegated in these Terms of Reference.</li> </ul>
<b>Duties</b>
<ul style="list-style-type: none"> <li>• Constructively challenge and seek assurance in relation to the ongoing alignment of the programme with both Trust and health system strategy and plans.</li> <li>• Constructively challenge and seek assurance in relation to the achievement of milestones/outcomes across all activities (including the acceleration of HTP pathways), ensuring that risks and/or issues are managed proactively and escalated in a timely fashion.</li> <li>• Constructively challenge and seek assurance in relation to SaTH's performance as the 'prime' provider for the Hospitals Transformation Programme (on behalf of the health system).</li> <li>• Recommend to the Board any key actions that need to be taken to support the successful implementation of the programme.</li> </ul>
<b>Reporting</b>
<ul style="list-style-type: none"> <li>• The minutes from each meeting will be circulated for information to the Trust Board.</li> </ul>



**Administrative arrangements**

The Committee Administrator has responsibility for:

- Producing minutes of the meeting, keeping a record of matters arising and issues to be carried forward.
- Producing an action list following each meeting and ensuring any outstanding action is carried forward on the action list until complete.
- Agreeing a schedule of meetings for each calendar year, booking appropriate rooms and facilities.
- Providing appropriate support to the Chair and Committee members.
- Providing notice of each meeting and requesting agenda items no later than 10 working days before a meeting.
- Agreeing the agenda with the Chair prior to sending the agenda to members no later than 8 working days before the meeting. The papers will be circulated at least 5 working days before the meeting. Requests for non-routine agenda items are to be forwarded to the Committee Chair at least 10 working days prior to the meeting.

**Review**

- The terms of reference will be reviewed annually, with recommended changes submitted to the Trust Board for ratification.
- The Chair will undertake a review the effectiveness of the committee on an annual basis through a formal self-assessment process which should take account of the views of all committee members.

<b>Approved:</b>	7 September 2022
<b>To be reviewed:</b>	September 2023

## Hospitals Transformation Programme Board

### TERMS OF REFERENCE

#### Constitution

The Shrewsbury and Telford Hospital NHS Trust (SaTH) has taken on a 'prime provider' responsibility to lead all aspects of the delivery of the Hospitals Transformation Programme (on behalf of system partners).

The Hospitals Transformation Programme Board's constitution and terms of reference shall be as set out below and it reports directly to the STW ICS Chief Executives' Group and indirectly to the ICS Shadow Board.

SaTH has also established an HTP Committee to provide the SaTH board with an independent assessment of delivery progress and the fulfillment of its duties as prime provider.

#### Membership

The membership of the Hospitals Transformation Programme Board is:

Core member	Name of core member	Delegate	Name of delegate
SaTH Chair and HTP SRO		SaTH Director of Finance	
SaTH Director of Finance		SaTH Deputy Director of Finance Strategy	
NHSE/I finance lead		NHSEI Finance Lead	
NHSEI Strategic Estates lead		NHSEI Strategic Estates lead	
ICS Clinical Lead, Chief Medical Officer			
ICB Director of Delivery and Transformation (ICS portfolio lead)			
Chief Operating Officer, Shropshire Community Trust (Local Models of Care Exec Lead)		Local Models of Care Programme Lead	
Primary Care Clinical Lead			
ICB Chief Finance Officer (CCG Lead)			
SaTH Clinical Lead			
Chief Medical Officer, Robert Jones Agnes Hunt Hospital		Head of Planning, Robert Jones Agnes Hunt Hospital	
Clinical and Care Director MPPFT		Managing Director, MPFT	

- Other managers/staff may be required to attend meetings depending upon issues under discussion with the prior approval of the Committee Chair. The Committee has the power to co-opt, or to require to attend, relevant members of staff from system partners.
- The Committee will be chaired by the SaTH HTP Senior Responsible Officer. In the absence of the nominated Chair, the SaTH Director of Finance will deputise.

### Responsibilities of Members

- To oversee and drive forward the implementation of the Hospitals Transformation Programme (HTP) in line with agreed plans, ensuring ongoing alignment with system objectives and change plans.
- 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).
- Identify agenda items for consideration by the Chair and the Committee Administrator at least 10 working days before the meeting.
- Prepare and submit papers for the agenda at least 8 working days before the meeting.
- If unable to attend, send their apologies to the Chair and Committee Administrator prior to the meeting and, if appropriate, seek the approval of the Chair to send a deputy to attend on their behalf.
- When matters are discussed in confidence at the meeting, maintain such confidences.
- At the start of the meeting, declare any conflicts of interest/potential conflicts of interest in respect of specific agenda items (even if such a declaration has previously been made in accordance with relevant policies and procedures).

### Attendance

If unable to attend a meeting, the members may be represented by a nominated delegate, but this must be confirmed with the secretariat before the meeting. The nominated delegate would be expected to be sufficiently well briefed to fully participate as a member of the board. It is expected that a member will normally attend for a minimum of 80% of meetings in a year.

### Quorum

The Committee will be deemed quorate to the extent that the at least three members of the Board are present (including the Chair / nominated delegate).

### Frequency of meetings

- The Committee will normally meet monthly. The Chair may convene additional meetings of the Committee to consider business that requires urgent attention
- Additional meetings may be held at the discretion of the Chair of the Committee.

### Authority

- The Hospitals Transformation Programme Board is authorised by the Integrated Care Board to act within its terms of reference. The Committee is authorised to investigate any activity within its Terms of Reference and is expected to make recommendations to the Integrated Delivery Board, STW ICS Chief Executives' Group, STW ICS Integrated Care Board. All members of staff in partner organisations are directed to actively support any request made by the Hospitals Transformation Programme Board.
- The Hospitals Transformation Programme Board is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its terms of reference.
- The Committee has no formal executive powers.

### Duties

- To ensure ongoing alignment of the programme with system strategy and plans.
- To drive forward the implementation of the Hospitals Transformation Programme (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 the Hospitals Transformation Programme (HTP) and support their mitigation.

### Reporting

The Hospitals Transformation Programme Board will have the following reporting responsibilities:

- The Hospitals Transformation Programme Board Chair shall report monthly to the Integrated Delivery Board, STW ICS Chief Executives' Group and the ICS Shadow Board on how it discharges its responsibilities.



### Administrative arrangements

The Executive Assistant to the Chair has responsibility for:

- Producing minutes of the meeting, keeping a record of matters arising and issues to be carried forward.
- Producing an action list following each meeting and ensuring any outstanding action is carried forward on the action list until complete.
- Producing a schedule of meetings to be agreed for each calendar year and making the necessary arrangements for confirming these are dates and booking appropriate rooms and facilities.
- Producing appropriate support to the Chair and Committee members.
- Providing notice of each meeting and requesting agenda items no later than 10 working days before a meeting.
- Agreeing the agenda with the Chair prior to sending the agenda to members no later than 8 working days before the meeting. The papers will be circulated at least 3 working days before the meeting. Requests for non-routine agenda items are to be forwarded to the Committee Chair at least 8 working days prior to the meeting.

### Review

- The terms of reference will normally be reviewed annually, with recommendation on changes submitted to the HTP Committee for ratification.
- The Chair will undertake a review the effectiveness of the committee on an annual basis through a formal self-assessment process which should take account of the views of all committee members.

<b>Approved:</b>	17 May 2022
<b>To be reviewed:</b>	17 May 2023

# HOSPITALS TRANSFORMATION PROGRAMME (HTP) RISK MANAGEMENT STRATEGY 2023/24

## Purpose of this Document:

The purpose of this Strategy is to:

- Define and set out the benefits of risk management and what drives risk management
- Help to understand risk appetite and tolerances, and make the most out of risk opportunities
- Set out our ambition to continuously improve our risk management arrangements
- Outline how the strategy relates to the Trust's wider strategic aims and objectives
- Assess the current status of risk management within the Trust
- Identify a series of risk management objectives
- Outline the approach to implementation and monitoring
- Describe the relevant compliance and assurance arrangements regarding risk management within the Trust.

## VERSION CONTROL:

Version	Date Issued	Summary of Change
V0.1	20.03.23	
V0.2	25.03.23	Addition of issues and dependent risks.
V0.3	06.04.23	Update to appendix

## Contents

<b>SaTH's Risk Management Strategy</b> .....	<b>4</b>
1. Introduction and Scope of the Strategy .....	7
2. The purpose of the Strategy .....	8
3. What is Risk Management? .....	8
4. Risk Appetite & Tolerances .....	9
5. Risk Opportunities .....	12
6. How does the Risk Management Strategy support the Trust's Plans? .....	12
7. What are the objectives of the strategy? .....	14
8. Implementation and Monitoring .....	16
9. Compliance and Assurance .....	16
10. Horizon Scanning .....	17
<b>HTP</b> .....	<b>19</b>
11. Scoring .....	19
12. HTP Governance .....	20
13. Issues .....	21
14. Risk Ownership .....	21
15. Board Assurance Framework (BAF) .....	22
16. Interdependent risks from other projects or programmes .....	22
Appendix 1 – Identifying and Reporting HTP Risks .....	24

# RISK MANAGEMENT STRATEGY 2021/23

RM01

To be read in conjunction with: Risk Management Policy (RM02)

Version:	15.4
Originally issued	February 1994
Approved by:	Trust Board of Directors
Approval date:	10 June 2021
Ratified by:	-
Date ratified:	-
Name of originator/author:	Chief Risk Officer
Lead Director	Director of Governance & Communications
Date issued:	June 2021
Review date:	June 2023
Target:	Overarching Strategy for specific Trust Risk Management Policies



## Document Control Sheet

<b>Author/Contact:</b>	Anna Milanec, Director of Governance & Communications
Document ID	RM01
Version	15.4
Status	Draft
Date Equality Impact Assessment	1/10/20 This document has been subject to an Equality Impact Assessment and is not anticipated to have an adverse impact on any group
Issue Date	10/
Review Date	June 2023
Distribution	Please refer to the SATH intranet for the latest version. <b>Any printed copies may not necessarily be the most up to date</b>
Key words	RM01 risk, risk management, risk register, risk matrix, assurance, risk assessment, risk appetite

### Version history

Version	Date	Author	Status	Comment
V1	Feb 94	JB	Original	
V2	Jan 01	TL	Final	
V3	Oct 02	TL	Final	
V4	Apr 03	TL	Final	
V5	Sept 05	TL	Final	
V6	Dec 06	CJ	Final	
V7	Jan 08	CJ	Final	
V8	Feb 09	CJ	Final	
V9	Feb 10	CJ	Final	
V10	Oct 11	CJ	Final	
V12.2	Aug 14	CJ	Final	
V13	July 15	CJ	Final	
V13.1	Aug 16	CJ	Draft	Updated to reflect changes to Committee Structure All appendices updated with current versions
V14	Mar 17	CJ	Draft	Sections reordered Updated all appendices Addition to Statement of Intent to reference Duty of Candour Incorporating the Women and Children's Care Group Risk Management Strategy - integrated with Corporate Risk Management Strategy

V14.1	Jun-17	CJ	FINAL	Updated appendices
V14.2	Mar-18	CJ	FINAL	Change of Sustainability Committee to Finance and Performance Committee
V14.3	May-18	CJ	FINAL	Change of committee names, updated appendices
V15	Oct-20	KS	Draft	Root and branch rework to reflect updated approach and alignment to ISO31000
V15.1	Oct-20	KS	Draft	Formatting and minor administrative amendments. Addition of Appendix A
V15.2	Nov-20	KS	Draft	Formatting and minor administrative amendments. Addition of references
V15.3	Feb-21	AM	Draft	Further amendments following Executive Team feedback
V15.4	May-21	AM	Draft	Deletion of previous Appendix A and replacement with new Appendix A
V15.5	June-21	AM	Final	Minor amendments further to ARAC and Board of Directors on 10 June 2021

## 1. Introduction and Scope of the Strategy

The Shrewsbury and Telford Hospital NHS Trust provides services to a diverse range of people across a wide footprint in an ever-changing environment. As such the potential for disruption to services, the impact on patient experience and the loss or damage to assets from a range of risks is inherent. Therefore, it is essential that the Trust takes appropriate action through active risk management to minimise the potential for this disruption, loss or damage.

This Strategy aims to create and protect value in the Trust by facilitating the management of risk, making decisions, setting and achieving objectives and improving performance.

- Managing risk is part of governance and leadership, and is fundamental to how the Trust is managed at all levels. It contributes to the improvement of management systems.
- Managing risk is part of all activities associated with and includes interaction with stakeholders.
- Managing risk considers the external and internal context of the Trust, including human behaviour and cultural factors.
- Managing risk is based on the principles, framework and process outlined in this Strategy. These components might already exist in full or in part within the Trust, however, they might need to be adapted or improved so that managing risk is efficient, effective and consistent.

This Strategy applies to all Trust staff, contractors and other third parties, including honorary contract holders, working in all areas of the Trust. Risk Management is the responsibility of all staff and managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

Managers at all levels are expected to make risk management a fundamental part of their approach to governance.

This Strategy sets out the Trust's objectives for further improving the management of risk at a strategic level; it describes the risk management assurance framework that is in place and aims to ensure that associated thinking and practice is embedded in everyday processes, policies and activity.

This Strategy will further develop the Trust's governance framework within which the Trust leads, directs and controls the risks to its key functions in order to:

- Comply with relevant legislation
- Monitor Strategic and Operational Risk, providing Assurance and Performance data
- Help the Trust to achieve its strategic objectives

The Risk Management Strategy is fully endorsed by the Trust Board to underpin:

- The Trust's ability to achieve strategic objectives
- Meet performance and the values of the Trust
- Protect its reputation

## 2. The purpose of the Strategy

The purpose of this Strategy is to:

- Define and set out the benefits of risk management and what drives risk management within the Trust
- Help the Trust to understand risk appetite and tolerances, and make the most out of risk opportunities
- Set out our ambition to continuously improve our risk management arrangements
- Outline how the strategy relates to the Trust's wider strategic aims and objectives
- Assess the current status of risk management within the Trust
- Identify a series of risk management objectives
- Outline the approach to implementation and monitoring
- Describe the relevant compliance and assurance arrangements regarding risk management within the Trust.

The Risk Management Strategy does not aim to identify or manage specific risks, other than to use those for illustrative purposes. Risk Management is a dynamic process and risks will readily change to respond to internal, external and cultural influences. Risk Management is not a performance tool. All operational risks that can potentially affect the Trust can be found in relevant Risk Registers, with strategic risks being found in the Board Assurance Framework (BAF).

## 3. What is Risk Management?

Risk Management is the process of identifying significant risks to the achievement of the



organisation's strategic and operational objectives, evaluating their potential likelihood and consequences implementing the most effective way of controlling them.

When the management of risk goes well it often remains unnoticed. However, when it fails, the consequences can be significant and high profile. Effective risk management is fundamental to prevent such failures.

#### 4. Risk Appetite & Tolerances

This strategy provides an approach to risk appetite that is practical and pragmatic, and that makes a difference to the quality of decision-making, so that decision-makers understand the risks in any proposal and the degree of risk to which they are permitted to expose the organisation while encouraging enterprise and innovation.

The risk appetite of the Trust is the decision regarding the appropriate exposure to risk that it will accept in order to deliver its strategy over a given time frame. In practice, an organisation's risk appetite should address several dimensions:

- The nature of the risks to be assumed;
- The amount of risk to be taken on;
- The desired balance of risk versus reward.

The Board will set boundaries to guide staff on the limits of risk they are able to in pursuit of achieving its strategic objectives. The Board will set these limits annually and review them as appropriate.

#### **Risk Appetite Statement 2021/2022:**

The Shrewsbury and Telford Hospital NHS Trust is committed to improving the health and wellbeing of the people of Shropshire, Telford & Wrekin and providing the best possible healthcare now and in the future. It has set itself a challenging transformation agenda that will deliver its vision of providing excellent care for the communities it serves and is committed to transforming care and strengthening its services by encouraging improvement, innovation, and a collaborative approach.

This statement sets out the Trust's strategic approach to risk-taking by defining its risk appetite thresholds. It is an iterative document that will be reviewed at least annually and

modified, so that any changes to the organisation's strategies, objectives or its capacity to manage risk are properly reflected. The risk appetite will also be reviewed if there are actual or proposed significant changes to the local healthcare environment.

It will be communicated throughout the organisation in order to drive sound risk management and to ensure risks are properly identified and actively managed.

The Board is responsible for determining the nature and extent of the risks it is willing to accept to enable the Trust's objectives to be successfully achieved. Risk in day-to-day activity is unavoidable and the Board will seek to manage risks to a tolerable level. The risk appetite of The Shrewsbury and Telford Hospital NHS Trust is the amount of risk it is willing to accept, tolerate or justify. The Trust's risk appetite has been assessed in accordance with its Risk Management Framework / Strategy.

The Shrewsbury and Telford Hospital NHS Trust recognises that its long term sustainability depends upon the delivery of its strategic ambitions and its relationships with its service users, carers, staff, public and partners. As such, the Trust has a low risk appetite to any risks that materially provide a negative impact on quality.

However, The Shrewsbury and Telford Hospital NHS Trust has a greater appetite to take considered risks in terms of transformation and their impact on organisational issues.

The Trust has a higher appetite to partnerships and collaboration, digital transformation and innovation and Financial/Value for Money risks where positive gains can be anticipated for the local population, within the constraints of the regulatory environment and delivering on the goals and targets agreed.

The table on the following page provides more details as to how the Trust's agreed risk appetite translates into 'business as usual' arrangements for the organisation.

Organisational Goals	Risk Appetite	Risk appetite Statement
SG1: We deliver safe and excellent care, first time, every time	LOW	SATH has a LOW risk appetite for risks that may compromise safety and the achievement of better outcomes for patients.
SG2: We work closely with our patients and communities to develop new models of care that will transform our services	SIGNIFICANT	SATH is eager to seek original/creative/pioneering delivery options and to accept the associated SIGNIFICANT risk levels in order to secure successful outcomes and transformation reward/return.
SG3: Our staff are highly skilled, motivated, engaged and live our values. SATH is recognised as a great place to work.	MODERATE	SATH has a MODERATE risk appetite to explore innovative solutions to future staffing requirements, our ability to retain staff and to ensure we are an employer of choice.
SG4: Our high performing and continuously improving teams work together to support and enable the delivery of high quality patient care.	MODERATE	SATH has a MODERATE risk appetite for Clinical Innovation and improvement that does not compromise the quality of care
SG5: Our services are efficient, effective, sustainable and deliver value for money.	HIGH	SATH has a HIGH risk appetite and is eager to pursue options which will benefit the efficiency and effectiveness of services whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.
SG6: We deliver our services utilising safe, high quality estate and up to date digital systems and infrastructure.	HIGH	SATH is open to the HIGH risk appetite required to transform its digital systems and infrastructure to support better outcomes and experience for our patients and public.
SG7: We have outstanding relationships with our partners and collectively strive to improve the quality and integration of health and care services.	SIGNIFICANT	SATH has a SIGNIFICANT risk appetite for collaboration and partnerships which will ultimately provide a clear benefit and improved outcomes for the people we serve.
SG8: We are a learning organisation that sets ambitious goals and targets, operates in an open and transparent way and delivers what is promised.	HIGH	SATH has a HIGH risk appetite for innovation and ideas which may affect the reputation of the organisation but are taken in the interest of ensuring we deliver our goals and targets.

## SaTH Risk Management Strategy RM01

### 5. Risk Opportunities

Risk should include both threat and opportunity, and mature risk management should also address both types of uncertainty, seeking to minimise threats and maximise opportunities.

This perspective is being reflected increasingly in risk management standards and professional guidelines, as well as in the practice of leading organisations.

Opportunity is not the absence of threat; some opportunities are created when threats are removed, and other opportunities are simply the inverse of related threats (instead of activity being lower than planned, it might be higher). But there are also “pure opportunities” unrelated to threats, uncertain events or circumstances which would produce real additional benefits, if they could be captured proactively and exploited. As well as identifying and addressing threats, it is equally important to seek and maximise opportunities, in order to optimise achievement of objectives; the risk management process can address both threats and opportunities.

### 6. How does the Risk Management Strategy support the Trust's Plans?

Risk management is a key component of the Trust's Strategic aims and objectives.

The Trust Strategies set out the future direction of the Trust, whilst highlighting how financial pressures are growing.

At the same time it recognises that the public

rightly expects continuing improvements in the safety and responsiveness of services to patients' needs and for the NHS to take advantage of clinical and technical developments.

The Risk Management Strategy underpins each of the Trust's six strategic aims and is focused on continuously improving the quality of our patient's experience.

All members of staff have an important role to play in identifying, assessing and managing risk.

#### 1.1 The Trust's strategic and operational aims

Details of the Trust's strategic and operational aims are set out on the following page in table 1.



Table 1: the Trust's strategic and operational aims

What are SaTH's short – medium term goals?
<b>Our Patients and Community:</b> “we deliver safe and excellent care, first time, every time”
<b>Our Patients and Community:</b> “we work closely with our patients and communities to develop new models of care that will transform our services”
<b>Our People:</b> “our staff are highly skilled, motivated, engaged and ‘live our values. SaTH is recognised as a great place to work”
<b>Our People:</b> “our high performing and continuously improving teams work together to support and enable the delivery of high quality patient care”
<b>Our Service Delivery:</b> “our services are efficient, effective, sustainable and deliver value for money”
<b>Our Service Delivery:</b> “we deliver our services utilising safe, high quality estate and up to date digital systems and infrastructure”
<b>Our Partners:</b> “we have outstanding relationships with our partners, and collectively strive to improve the quality and integration of health and case services
<b>Our Governance:</b> “we are a learning organisation that sets ambitious goals and targets, operates in an open and transparent way and delivers what is promised

## SaTH Risk Management Strategy RM01

The risk assessment process enables risks, which may prevent realisation of any of the Trust's aims, to be appropriately managed. This Strategy will also help the Trust to manage risk opportunities as health and social care providers are expected to work together to find new ways to improve services at the same time as saving money.

**Table 2: The Trust's operational plan setting out key corporate aims that energise the strategic aims:**

Our patients and community	Our people	Our service delivery	Our partners	Our governance
Quality improvement strategy and plan	Leadership capability and development	Urgent and Emergency Care	System improvement plan	Oversight, assurance, roles and accountabilities
Reducing mortality and excess deaths	Clinical standards, skills and capabilities	Restoration and recovery (incl. COVID19 learning)	Develop OBC for Hospital Transformation Programme	Financial controls
Quality / regulatory compliance	Culture and behaviours	Digital transformation and infrastructure	System long term plan	Performance data, quality, insight and analytics
Quality / regulatory compliance	Communication and Engagement	Physical capacity and estate developments		Risk management
Increasing community engagement	Recruitment and retention	Improving service sustainability		Programme and project management

## SaTH Risk Management Strategy RM01

It is important to us that risk management contributes to improve patient safety by enhancing leadership in the Trust, the culture of quality of care and that it supports our ability to measure and to predict variance so that we can detect and act quickly as problems arise.

Effective employee engagement is vital to our success and aspiration to become one of the safest and most effective NHS organisations in the country. By wholeheartedly embracing our core values and behaviours in all risk management activity, this strategy and underpinning risk policy supports high performance and fosters a culture that is confident about resilience; respects diversity of opinion; involves staff, patients and partners in all that we do; and improves capacity to manage risk at all levels of the organization.

The strategy aligns to our values too:



### 1.2 The Board Assurance Framework (BAF)

The BAF identifies and quantifies the strategic risks facing the Trust and its ability to achieve its strategic aims and objectives. It informs and provides assurance to the Trust Board on how each of these risks is being effectively managed and monitored.

Each of the strategic risks has an identified owner, who is a member of the executive team. It is their responsibility to manage and report on the risk overall. The achievement of this Strategy relies on the underpinning governance framework which consists of robust assurance mechanisms and quality governance arrangements – this is delivered through the direct and indirect assurance provided through the governance meetings structure to the Board and to external stakeholders, i.e. regulators, commissioners, external scrutineers, partner organisations and engagement groups. The strategy is also dependent on robust accountability arrangements that ensure actions will be

## SaTH Risk Management Strategy RM01

taken should risk/ performance issues be judged as requiring escalation.

The Risk Management Strategy will enhance those arrangements and be delivered through the Risk Management Policy.

### 7. What are the objectives of the strategy?

#### **Where do we want to be and what will success look like?**

This Strategy stretches the ambition of the Trust in its management of risk in response to that context, via the following key performance Indicators (KPI's)

We will:

#### **KPI 1 - Define the organisation's risk appetite.**

We will further develop the Trust's risk appetite by:

- Reviewing the Trust's appetite statement on an annual basis as part of the business planning process;
- Including risk appetite and risk assessment in the annual business planning process, including at Divisional and corporate levels;
- We will utilise the Board's agreed risk appetite measures.

#### **KPI 2 - Ensure a single and comprehensive risk management process.**

All risks relating to projects/initiatives will be subject to the risk management process and be managed locally with oversight from the governance department / Senior Risk Manager. This will seek to ensure risks associated with service Improvement and other programmes are monitored and managed; and ensuring that the structure and process for managing risk across the organisation is reviewed and monitored annually. This will require the development of systems and processes to facilitate risk management being integrated into the current functions, and in embedding a high performance culture.

#### **KPI 3 - Increase the coverage and utilisation of appropriate risk assessments throughout the Trust.**

The incident reporting process will identify where risk assessments have not been completed and remedial actions identified from the failures from each individual adverse event will be addressed by the relevant manager.

Divisional meetings and underpinning structure will be used to monitor gaps in risk assessment, using monthly reports and the ward and department assurance reports to provide the relevant evidence.



**KPI 4 - Increase the use of Trust wide data to inform the risk management process.**

To use a full range of intelligent risk information from risk assessments, patient safety, workforce, patient experience and business data to improve the management of risk and improve quality. This information will also inform the overall business planning/investment process in the Trust.

**KPI 5 - Enhance the knowledge and skills base of staff in risk management across the Trust, thereby also further encouraging an open and transparent reporting culture.**

We will further develop the mechanism for gaining feedback from those responsible for managing risk to ensure that lessons are fed back to those involved in all aspects of the Trusts activities.

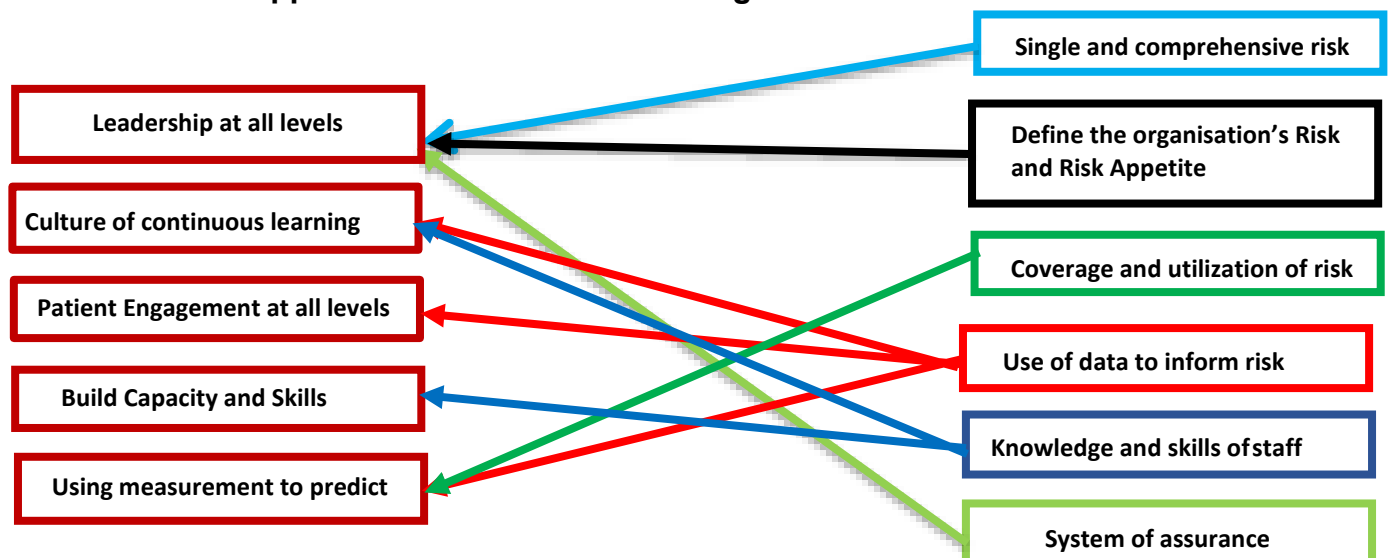
As well as including training in the trust’s risk management processes, we will use the organisation- wide programme to help to embed a consistent language of risk management, including concepts such as controls, mitigations, assurances, residual risk and proximity. We will therefore review the existing training programme, training materials and provide general communications regarding strategic and operational risks to ensure appropriate knowledge and skills in risk management at different levels of the organisation.

**KPI 6 - Strengthen the system of assurance regarding risk through to Board level.**

The Board Assurance Framework is a concise reporting tool which enables the reader to review a summary of the framework with a more in-depth analysis being provided if required.

The BAF will be subject to a rigorous annual review, which takes into consideration comments from the Board of Directors, senior management and other interested parties. The document will include a front page summary of the risk assessments, with specific detail listed on individual pages.

**How KPI’s will support the Trust’s overall strategic direction:**



## SaTH Risk Management Strategy RM01

### 8. Implementation and Monitoring

An action plan for this strategy will be approved by the Audit and Risk Assurance Committee. The Director of Governance & Communications as the Executive lead for risk will monitor the requirements of this strategy via the Executive Risk Management Committee, Audit and Risk Assurance Committee and the Trust Board. A report will be made no less than annually on progress and achievement of goals as set out in the action plan.

### 9. Compliance and Assurance

The Assurance Framework provides the Trust Board with a vehicle for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being met to satisfy internal and external requirements. In turn it will inform the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance. This allows the organisation to respond rapidly.

All NHS bodies are required to sign an Annual Governance Statement (AGS) and must have the evidence to support this statement. The organizational risks, and risk registers, support the process to produce the AGS.

In order to identify the risks against delivery of principal objectives and gaps in control/assurance the Trust Board is required to have a comprehensive Performance Management Reporting framework. The Trust Board agrees its own indicators for Performance Reports which will act as assurance on service delivery and quality. Any significant gaps in assurance or control within performance reports must be identified, translated onto the Assurance Framework and remedial action agreed.

The designated Assurance Committees of the Trust Board monitor the Assurance Framework process overall on a quarterly basis. It is the responsibility of the Assurance Committees to report to the Trust Board any new risks to the Trust's objectives, identified gaps in assurance/control, as well as positive assurance on an exception basis. If a significant risk to the Trust's service delivery or gap in control/ assurance is identified then this should be reported immediately via the Executive Directors. It is important for the Trust Board to be able to evaluate the quality and robustness of the Assurance Framework and to have arrangements in place to keep it updated in light of evidence from reviews and actual achievements

## SaTH Risk Management Strategy RM01

The Trust Board and Audit and Risk Assurance Committee will formally review the Assurance Framework. The Director of Governance & Communications will ensure that the Risk Management Strategy remains dynamic and is integral to the Business Planning cycle.

Each Department will continue to carry out Risk Assessments which feed into the Divisional Risk Registers. A single framework for the assessment, rating, and management of risk is used throughout the Trust; this process is described in detail within the Risk Management Policy available on the intranet.

Each Division will continue to maintain a comprehensive risk register, which will be formally reviewed at monthly intervals through the Divisional Meetings. At these meetings the Divisions will be expected to report on their risk register, highlight any new or emerging risks to service delivery and present action plans for minimising and managing those risks. The meeting should identify those Divisional risks which also pose a corporate threat and so require inclusion on the Trust Risk Register.

The risk register should be seen as a dynamic process as ranking/prioritisation of risks will change as risk reduction practices take place. Any risks identified in Divisional meetings that score 15 or above and cannot be controlled locally, will be reviewed, ultimately, by the Board, thus allowing for a bottom up/top down approach to identifying the Trust's key risks and informing the Assurance Framework. This proactive approach to risk management should be holistic and identify all risks to the organisation, including clinical, organisation-wide, health and safety, business, reputational and financial.

### 10. Horizon Scanning

Horizon scanning is an important element of the risk management framework and refers to the identifying, evaluating and managing changes in the external risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing mechanisms to horizon scan the Trust will be better able to respond to changes or emerging issues in a coordinated manner. Issues identified through horizon scanning should link into and inform the business planning process.

The outputs from horizon scanning will be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development.

The scope of horizon scanning covers, but is not limited to:

- Legislation
- Government white papers
- Government consultations • Socio-economic trends
- Trends in public attitude towards health
- Department of Health publications
- Local demographics
- Seeking stakeholders' views

#### References

- NHS England, Framework partnership agreement relating to the commissioning of health and social care services, 2016
- GGI, Risk Appetite Board Assurance Prompt, 2015
- GGI, Board Challenge: Fiduciary Duty, 2016
- GGI, Scrutiny the new assurance? A good governance discussion document, 2017
- ISO 31000 Risk Management (2018)
- National Audit Office, Good practice: Managing risks in government, 2011
- NHS England, Framework partnership agreement relating to the commissioning of health and social care services, 2016



## HTP

### 11. Scoring

Once identified, risks are rated based on their probability and impact according to this table:

L↓ C→	Negligible	Minor	Moderate	Major	Severe
Almost certain	5	10	15	20	25
Likely	4	8	12	16	20
Possible	3	6	9	12	15
Unlikely	2	4	6	8	10
Rare	1	2	3	4	5

<b>Low (1 – 3)</b>	<b>Moderate (4 – 6)</b>	<b>High (8 – 12)</b>	<b>Extreme (15 – 25)</b>
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Risk Score	Risk Level	Management Level
15-25	Extreme Risk	All risks with a score of 15 or above are escalated to the Trust via DATIX. They must be reviewed and approved at both the Speciality Governance and Divisional Governance Meetings.  Risks are dealt with at a Programme Level.
8-12	High Risk	
4-6	Moderate Risk	
1-3	Low Risk	



Extreme risks are reviewed by the Trust on a **monthly** basis.

High risks are reviewed **bi-monthly**.

Moderate / Low risks are reviewed **quarterly**.

DATIX notifications will be set to prompt action.

Risks are then reviewed by the following groups:

- **HTP Technical Oversight Group** – oversees the technical programme risks and clearly identified those risks that are shared with the Principal Supply Chain Partner (PSCP) via a **Design and Construction Risk Register**. These costed risks are reviewed and updated on a fortnightly basis and recorded on a separate system.
- Via the **PMO and** administered through the DATIX system, a monthly meeting is held to review the **Programme Risk Register**:
  - accept potential new risks identified by the clinical and non-clinical workstreams (except Technical Oversight Group) and previously signed off by the Chair/Deputy Chair of the PMO Risk Meeting
  - review and update current clinical and non-clinical workstream risks (except Technical Oversight Group) held on the Programme Risk Register
  - review extreme risks arising from the **Design and Construction Risk Register** held by the Technical Oversight Group, that need adding or amending on DATIX by the PMO.
  - filter the extreme risks that could have a significance consequence on the Trust.

These two groups report into the:

- **HTP Delivery Group** – each workstream reports risks through their relevant highlight report.
- HTP Programme Board – reporting of extreme risks. Alignment with Integrated Care Board (ICB) risks
- **HTP Committee** – reporting of extreme risks, attended by a Non-Executive Director of the Trust

The flow chart of the process can be found in Appendix 1.

### 13. Issues

Issues (qualitative risks) will be recorded on DATIX as described above.

### 14. Risk Ownership

**Risk Owner:** This is the member of staff who will be ultimately responsible for the risk and will have ownership and oversight of the risk. This doesn't mean that all actions will be assigned to the risk owner; allocation of actions may (and often is) delegated to other members of staff. It is important that the risk owner is the most appropriate person – i.e., someone who has the relevant experience and expertise within the area of the risk and can understand and envisage what is required to mitigate the risk.

**Delegated Risk Owner:** This is the member of staff that has been delegated to manage and update the risk on DATIX on behalf of the risk owner.

The Risk Owner and Delegated Risk Owner and clearly identified through Design and Construction Risk Register and the Programme Risk Register.

## 15. Board Assurance Framework (BAF)

This proposed reconfiguration of hospital services helps to address a number of the strategic risks on the Trust Board Assurance Framework (BAF). The BAF identifies and quantifies the strategic risks facing the Trust and its ability to achieve its strategic objectives. The BAF risks have been significantly refreshed since SOC. Each of the strategic risks has an identified owner, who is a member of the executive team. It is their responsibility to manage and report on the risk overall.

The BAF risks are outlined below:

- BAF 1: Poor standards of safety and quality of patient care across the Trust results in incidents of avoidable harm and/ or poor clinical quality.
- BAF 2: The Trust is unable to consistently embed a safety culture with evidence of continuous quality improvement and patient experience.
- BAF 3: If the Trust does not ensure staff are appropriately skilled, supported and valued this will impact on our ability to recruit/ retain staff and deliver the required quality of care.
- BAF 4: A shortage of workforce capacity and capability leads to deterioration of staff experience, morale and well-being.
- BAF 5: The Trust does not operate within its available resources, leading to financial instability and continued regulatory action.
- BAF 6: Some parts of the Trust's buildings, infrastructure and environment may not be fit for purpose.
- BAF 7a: Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation.
- BAF 7b: The inability to replace digital systems impacts upon the delivery of patient care.
- BAF 8: The Trust cannot fully and consistently meet statutory and/ or regulatory healthcare standards.
- BAF 9: The Trust is unable to restore and recover services post-Covid to meet the needs of the community/ service users.
- BAF 10: The Trust is unable to meet the required national urgent and emergency standards.
- BAF 11: The current configuration and layout of acute services in Shrewsbury and Telford will not support future population needs and will present an increasing risk to the quality and continuity of services.
- BAF 12: There is a risk of non-delivery of integrated pathways, driven by the ICS and ICP.
- BAF 13: Trust-wide services/ resources may be further affected by the publicity and negative media attention following publication of the final Ockenden Report.
- 

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.

The implementation of the HTP will contribute towards reducing the likelihood of many of the BAF risks. The BAF risks aligned to the HTP are BAF 1, 2, 3, 5, 6, 8, 9, 10 and 11. In relation to BAF 11, the new clinical model that will be introduced as part of the HTP will contribute to improved configuration of services and improved patient pathways. In relation to BAF 10, the HTP addresses one of the biggest strategic challenges by separating the emergency and planned care flows, improving the Trust's ability to meet the emergency care needs of the local population. The workforce planning that has taken place as part of the HTP also helps to address BAF 3. Regular review of the BAF risks with the HTP in mind ensures continued alignment where possible.

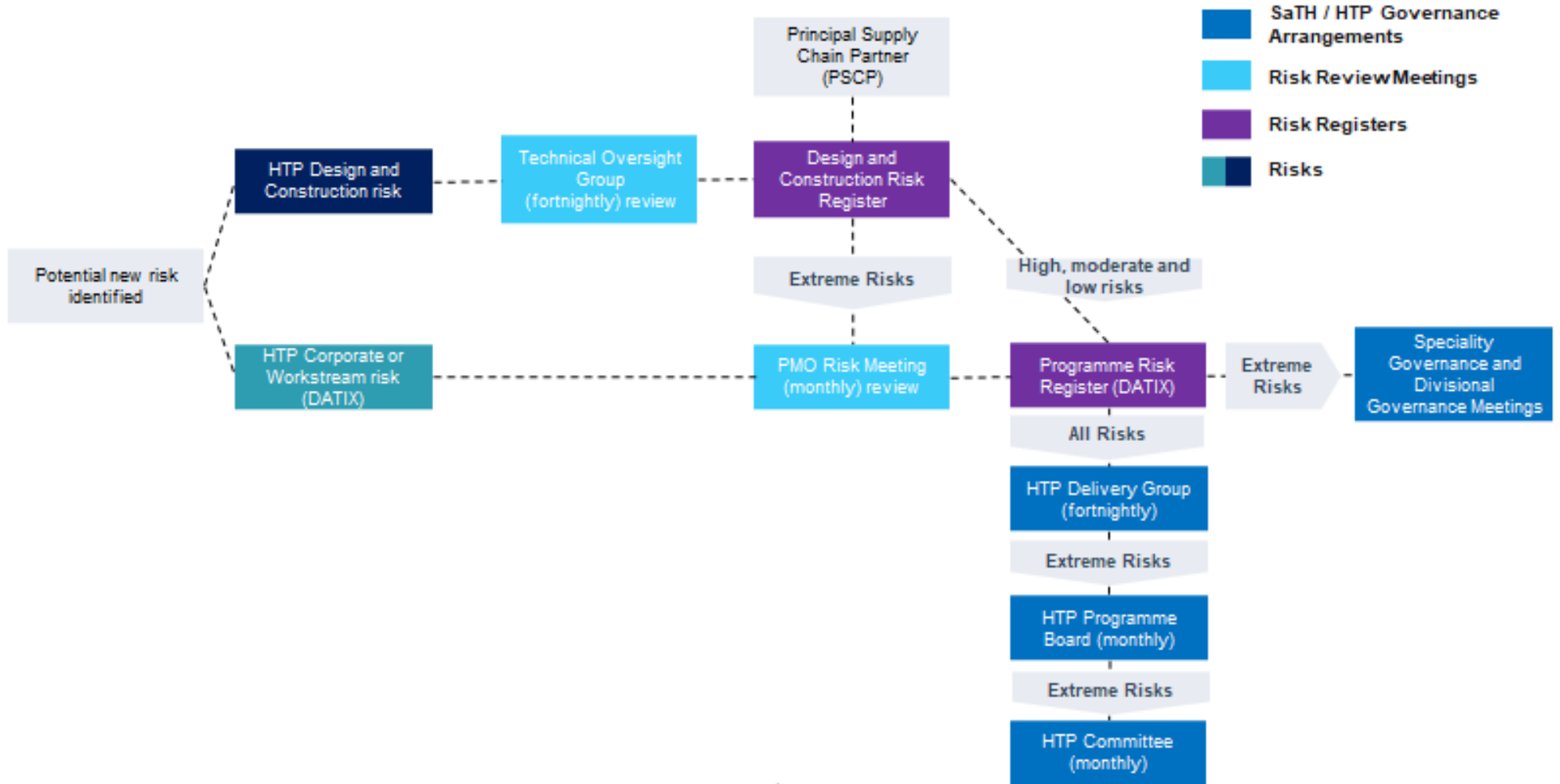
## 16. Interdependent risks from other projects or programmes

Interdependent risks from other projects or programmes that have the potential to impact on the HTP programme, whether being delivered within the Trust or by external partners will be recorded as a HTP



risk and added onto the Programme Risk Register. Further work will be undertaken to understand where the interdependent risk(s) is being reported in a more detailed way, to ensure cross reporting and maintaining an up-to-date position.

Appendix 1 – Identifying and Reporting HTP Risks



# THE SHREWSBURY AND TELFORD NHS TRUST

## HOSPITALS TRANSFORMATION PROGRAMME

### GOVERNMENT SOFT LANDINGS STRATEGY

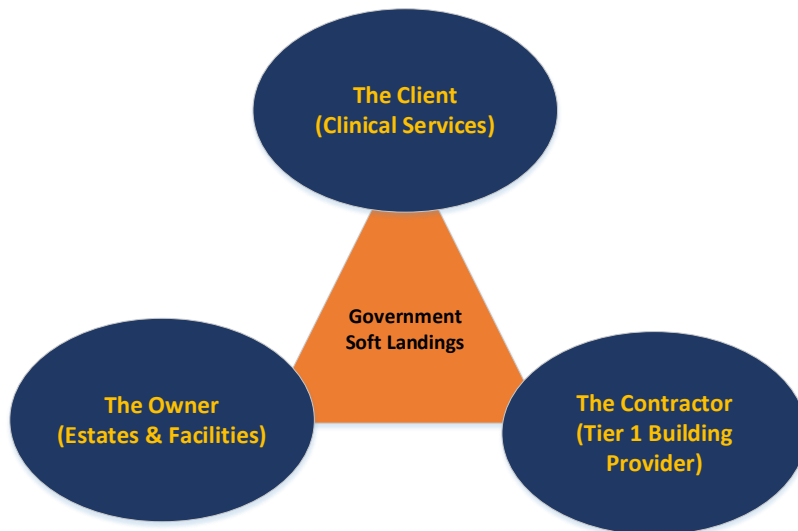
## 1.0 Introduction

- 1.1 The Shrewsbury & Telford NHS Trust (SaTH) Hospitals Transformation Programme (HTP) sits within a national programme which will determine standardised approach to Government Soft Landings (GSL) across new hospitals. This strategy details the approach that the HTP intends to adopt in the delivery of its GSL.
- 1.2 The Shrewsbury & Telford NHS Trust (SATH) operates across two main hospital sites, the Royal Shrewsbury Hospital (RSH) & the Princess Royal in Telford (PRH) located approximately 16 miles apart.
- 1.3 The current configuration of acute services across the Trust will not support future population needs of the county and presents an increasing risk to the staffing, quality, and continuity of existing NHS services. Public and staff consultations completed in 2018 provided the then Clinical Commissioning Groups (CCGs) with a comprehensive understanding of how critical services could be effectively configured to resolve longstanding issues across both Trust sites. The output of the consultation led the creation of the Hospitals Transformation Programme (HTP) designed to drive the clinical change described within Future Fit.
- 1.4 This Strategy details the approach the HTP intends to adopt in the delivery of the new clinical model utilising the GSL process.
- 1.5 It is recognised with the Trust that the GSL approach plays an integral role in enabling a smooth transition from strategic case to design, through to construction and operation. It also helps the Estate & Facilities Department (E&F) to assure the performance of an asset (building).
- 1.6 This approach is a key objective of the UK Government. GSL must also be fully aligned with the UK BIM Framework (including ISO 19650 and BS 8536) and industry best practice and is fully interlinked within the final detailed design and logistic approach for the HTP.
- 1.7 The Construction Playbook (HM Government 2020) states

*'We need to prepare early for operation by adopting a government soft landings approach and transparently evaluate the success of projects and programmes.'*

The SaTH GSL strategy takes the fundamental principles of GSL as described in the Cabinet Office Government Soft landings 2015 (Section 1) and BS 8536, and applies additional elements that will ensure the effective delivery and operation of fit-for-purpose healthcare premises. The success of this depends on the ability to deliver clear lines of communication between the fundamental stakeholders:





## 2.0 SaTH Approach to GSL

### 2.1 GSL WORKSTAGES

- 2.1.1** There is a range of specific activities which, when undertaken together throughout the project lifecycle, provide evidence of the ‘golden thread’ that ensures successful delivery of the asset.
- 2.1.2** Clear targets and activities will be set for the required business outcomes at the start of the project. Appendix 1 identifies those targets aligned to the Royal Institute of British Architects (RIBA) stages.
- 2.1.3** These targets will be aligned with strategic objectives, and they will be cascaded through the internal operational and external supply chain. These targets and their measures will be reviewed during design, construction, and operation. In setting targets and measures consideration will be given to statutory requirements, government policy, previous experience, operational knowledge, and end-user needs both clinical (user) and E&F (owner).
- 2.1.4** The P23 GSL Toolkit will be adopted and tailored to suit the organisation, clearly identifying the targets required whilst ensuring delivery of the required outputs and principles of the GSL approach aligned to the RIBA stages.

The work stages being:

- Strategic
  - Outline Business Case
  - Full Business Case
  - Construction
  - Aftercare
- 2.1.5** As projects progress, a detailed project specific GSL Plan will be developed. The level of detail in this plan will increase as the scheme develops. Project committees will have oversight of this plan and hold responsibility for monitoring its implementation.

## 3.0 Building Information Model (BIM)

- 3.1** Building Information Model (BIM) is a process for creating and managing information on a built environment asset throughout its whole life cycle.
- 3.2** The key objectives are to use BIM methodologies to enable the designated responsible party, to receive the required information deliverables (models, documents & datasets) at the appropriate time in the right formats. To engage with the appropriate stakeholders, drive project delivery and efficiency, and make the right project gateway decisions, and to supply appropriate information at handover, to operate, maintain and assess the performance of the delivered asset, and to integrate the delivered asset and its information into the employer's asset estate, creating content once and in the right format for multiple uses thereafter.
- 3.3** The key SaTH objectives that shall be delivered by the BIM Execution Plan of the Lead Appointed Party and their Supply Chain are:
- Deliver validated, verified, and structured information and data that can be shared across the supply chain to support project stage gate decisions, engagement with project stakeholders and integration of data repositories for Operation and Maintenance (O&M) manuals, Health and Safety (H&S) files, and Asset Information
  - Deliver the project into the Appointing Party's Asset Information Model and populate operational and line of business systems that will support strategic, operational and asset management decision-making and streamlining following the practical completion of the construction works and installations.
  - Authorise lead appointed party's technical design using BIM tools.
  - Understand and confirm full programme, sequence and logistics implications using BIM tools, including future Planned Preventative Maintenance requirements.
  - Form the basis for post operational performance evaluation and learning.
  - Assess and address safety and security issues using BIM tools.
  - Check the proposed scope compared to briefing requirements using BIM tools.
  - To consolidate all its individual repositories and all building information into a single repository, to ensure that the correct drawing is used when needed and proper change and access control can be achieved.
- 3.4** SaTH associated information regarding the BIM strategy can be found in the following documentation.
- Organisational information requirements,
  - Employer's information requirements
  - Asset information requirements.

## 4.0 Delivery Structure

- 4.1 The Shrewsbury & Telford NHS Trust will adopt a bespoke delivery approach to GSL. This is in part due to the skill set within the Project Team whereby delivering not just the asset but also the additional stakeholder in the structure - that being the building 'user' (see section 1).
- 4.2 With both a building 'user' and building 'owner' involved, SaTH have sought to ensure the appropriate and necessary project structure is in place to ensure that right from Strategic Outline Case through to occupation, the requirements of the asset and the ability to care for and maintain it are never lost.

## 5.0 Roles and Responsibilities

- 5.1 The GSL champion is not undertaking the same functions as a project manager or a facilities manager. BS 8536-1 sets out GSL champion activities, but both will be supported by the Project Managers assigned to each element of the project.
- 5.2 A Responsible, Accountable, Consulted, Informed (RACI) Matrix can provide more specific information about roles and responsibilities than might be possible with a simple tick-box responsibilities matrix.
- 5.3 The approach to the delivery of the project with regards to resources will be as identified in Appendix 2. In addition to the typically seen programme and project manager's roles is that of two types of GSL leads who will effectively represent both the technical (building owner) and clinical service (building user) aspects of the project.

## 6.0 GSL Technical Champion

- 6.1 The GSL technical champion will be appointed as early as possible in the project (by the owner; Capital Projects) and will be a continuous, active presence throughout the project then into facility operation and beyond.
- 6.2 Their main objective is to ensure that design and construction is planned and controlled to enable a smooth transition into operation and for the defined periods of aftercare (BS 8536-1 clause 4.6.2).
- 6.3 The GSL technical champion will be a dedicated HTP team member. They are fundamental to the integration of the operator, operations team or facility manager(s) in the design and construction process.

## 7.0 GSL Clinical Services Champion

- 7.1 The GSL clinical services champion effectively offers a voice for building users. They are central to the collaborative ethos of a project ensuring that the objectives of the aligned clinical strategy and the ability to function effectively within the space are delivered.
- 7.2 They will be lead on all matters clinical and operational to ensure that when the clinical service relocates to the new facility all aspects of service delivery can operationalise effectively.
- 7.3 The GSL clinical service champion will be an individual from within each affected clinical services who will have been nominated by the service, linked into the HTP Clinical, Nursing and Operational Leads.

## 8.0 Summary

- 8.1** This Strategy describes the Shrewsbury & Telford NHS Trusts approach to the delivery of Government Soft Landings – ensuring the efficient design and delivery of an asset that is fit for purpose for both the owner and the user of the built facility.
- 8.2** It identifies the important aspects that are imperative to success: Building Information Model process and collaboration between contractor and client, clear structure supported by dedicated resources and clarity from beginning to end with regards to the building function.

## 9.0 References

- Government Construction Strategy 2016-2020 BS 8536 - 1:2015 Briefing for design and construction & Cabinet Office Document: Government Soft Landings Section 1 - Introduction.
- HM Government, The Construction Playbook – Government Guidance, v 1.0 December 2020

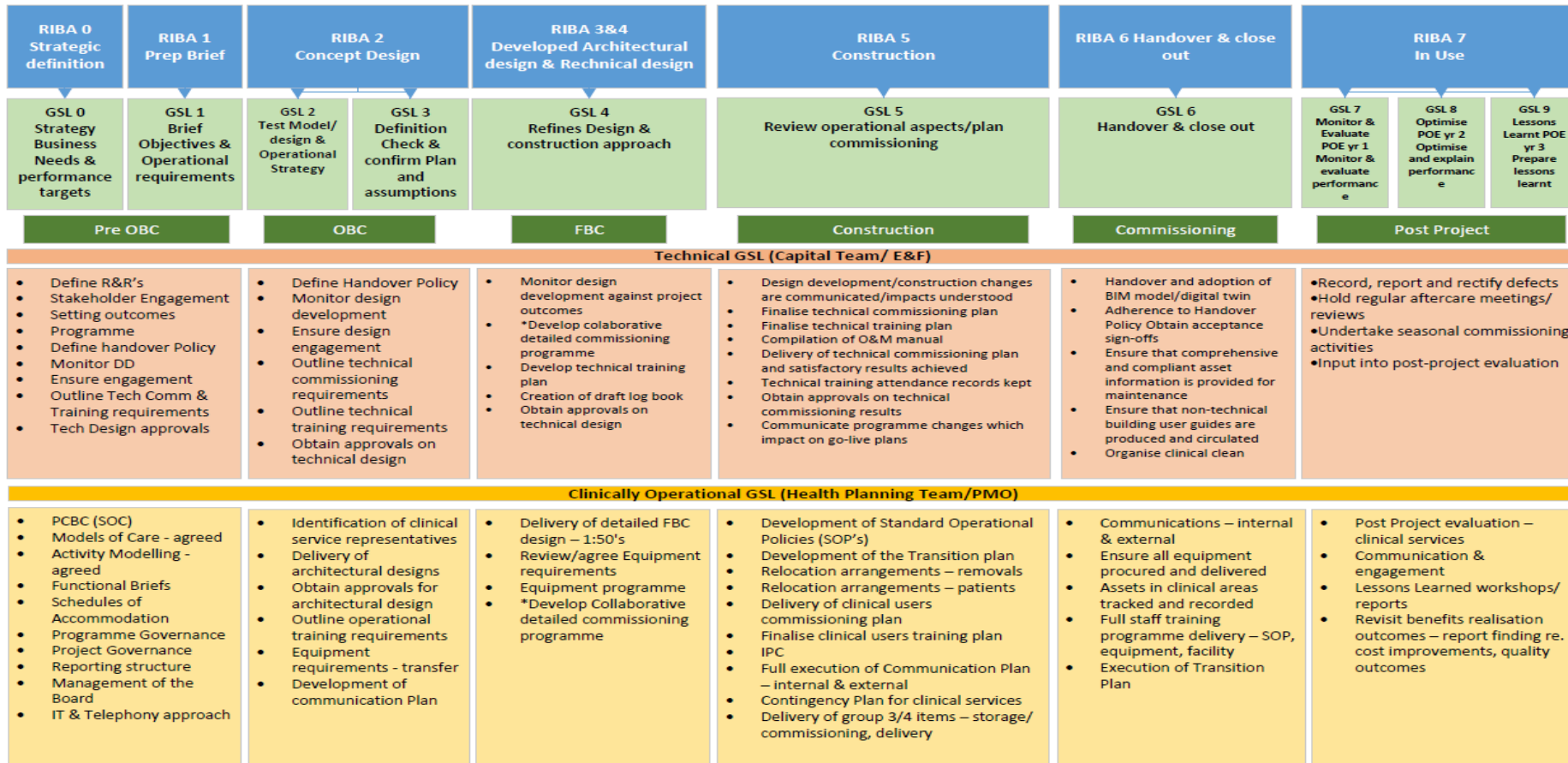
## 10.0 Glossary of Terms & Definitions

Acronym	Term	Definition
BIM	<b>Business Information Model</b>	
E&F	<b>Estates &amp; Facilities Department</b>	UHL technical department for the management of the physical estate and facilities function delivery
GSL	<b>Government Soft Landings</b>	Strategy to which this document refers
RACI Matrix	<b>Responsible, Accountable, Consulted &amp; Informed</b>	A matrix of activities aligned to people who take responsibility under each heading
RIBA	<b>Royal Institute of Architects</b>	Stages of design development in-line with Business Case production
SaTH	<b>The Shrewsbury &amp; Telford NHS Trust</b>	Healthcare Trust where Strategy is apparent
HTP	<b>Hospitals Transformation Programme</b>	Central Government organisation managing a Programme of new hospital premises
	<b>GSL Clinical Service Champion</b>	Representative who in conjunction with the Health Planning Project Manager plans for and facilitates the operational commissioning of the clinical services
	<b>GSL Technical Service Champion</b>	Representative who in conjunction with the Capital Project Manager plans for and facilitates the technical commissioning of the building



Acronym	Term	Definition
	<b>Lead Appointed Party</b>	Main Construction Contractor appointed to deliver the facility
	<b>P22 GSL Toolkit</b>	A template that details the activities and timelines required to deliver a successful GSL strategy
	<b>Supply Chain</b>	The sub-contractors appointed by the main contractor
	<b>The Construction Playbook</b>	Mandated Government Document for central government (encouragement for public sector organisations to comply) that lays out the recommendations for a best practice framework to achieve improved project outcomes.

# APPENDIX 1 – SaTH approach to GSL



## APPENDIX 2 – Example HTP approach to GSL

