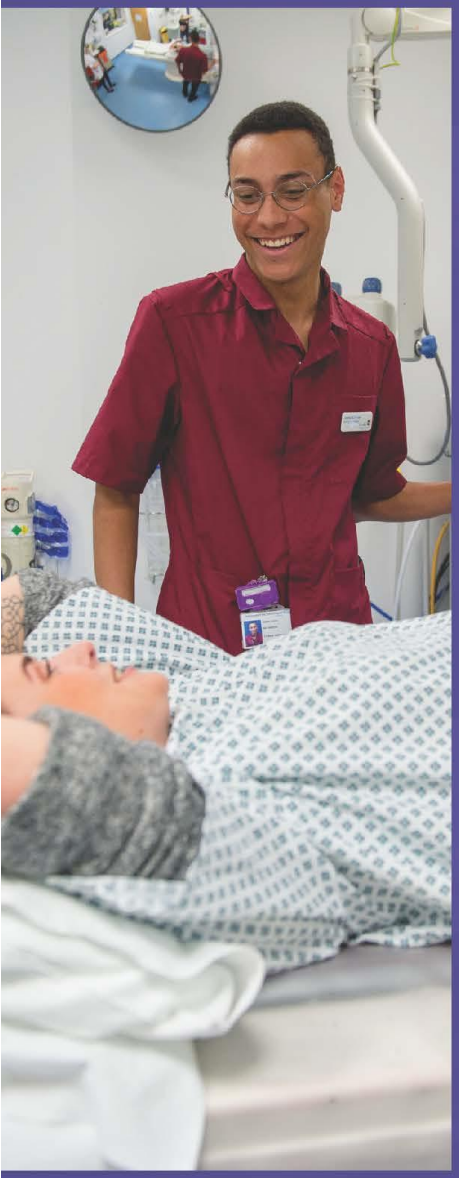
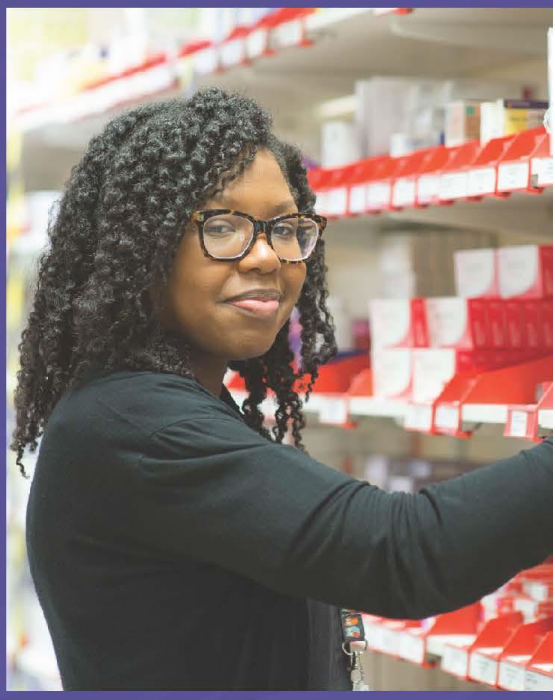
The Shrewsbury and Telford Hospital NHS Trust states the following Outline Business Case (OBC) for the Hospitals Transformation Programme was approved in December 2023. In light of this, terminology within this document predates the confirmation from NHS England (given 22 May 2024) that it supports the recommendation of the Independent Reconfiguration Panel (given in December 2023) and that the name of the 24/7 enhanced urgent care service to be provided at PRH will be an Urgent Treatment Centre (UTC).

The Trust has received formal approval of its Full Business Case (FBC) for the Hospitals Transformation Programme in May 2024.

Integrated Care System
Shropshire, Telford and Wrekin





TRANSFORMING THE ROYAL SHREWSBURY HOSPITAL AND THE PRINCESS ROYAL HOSPITAL

OUTLINE BUSINESS CASE

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Foreword

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

The right care in the right place for all our people

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

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

The Preferred Option described in this OBC will improve both hospital sites and by providing care in updated facilities, with flexibility to respond to future changes in demand and pressure, with a great environment for both staff and patients. The Princess Royal Hospital will be the site specialising in planned care, which will also offer urgent care to patients who need it through an A&E Local model (see Section 1.1.7). The Royal Shrewsbury Hospital site will become the site specialising in emergency care, offering leading emergency and critical care. These investments will make tangible improvements to the quality, accessibility and experience of the care available to all of our communities.

A significant opportunity

This investment represents a significant opportunity to invest in our region and contribute to the national Levelling Up agenda. We've made sure these proposals offer great value to taxpayers – more than many other public sector investments – in an area with a history of underinvestment, whilst balancing the capital constraints and the clinical and estate needs.

We recognise these proposals are critical to our success as an integrated care system (ICS). The delivery of the Hospitals Transformation Programme ('the HTP') forms a central part of our integrated care system strategy and recovery plan. The proposals have the full support of the Shropshire, Telford & Wrekin Integrated Care System (STW ICS); and The Shrewsbury and Telford Hospital NHS Trust (SaTH or 'the Trust'). Together, we have resolved to take action to make the changes that were agreed in 2019 following public consultation. The quality and service changes included in this proposal are critical to support our recovery from COVID-19 and in helping us to build towards a sustainable health system.

The HTP is one part of an overarching vision to transform health and care services across Shropshire, Telford & Wrekin by delivering sustainable system-wide change.

The wider vision for the transformation of services also encompasses projects across outpatients, integrated place-based commissioning, local care services and workforce planning. Together, these projects will deliver earlier intervention and support for patients, better health outcomes, more streamlined care pathways and help our population to access the care they need closer to home.

Implementing these proposals will allow us to rapidly improve care for our patients. We now need to honour the commitments we have made and take forward the Preferred Option outlined in this OBC.

Simon Whitehouse
Integrated Care Board
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NHS Shropshire, Telford and Wrekin

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Document Control

Document title	
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Version	Date	Description
1	21 April 2023	Draft submitted to FPAC and Board for approval for submission to NHSE
2	05 May 2023	Draft to be submitted to NHSE
3	25 May 2023	Updated draft submitted to NHSE
4	31 May 2023	Updated draft for HTP, Trust and ICB governance
5	05 July 2023	Final draft submitted to NHSE

Document Sign-off

Approver/governance body	Date
STW ICB	31st May 2023
HTP Committee	5th June 2023
FPAC	5th June 2023
Trust Board of Directors	8th June 2023
Delegated Board members approval to submit to NHSE and JIC	4th July 2023

Contents Page

Executive summary

The current configuration and layout of acute services in Shrewsbury and Telford will not support future population needs and presents an increasing challenge to the staffing, quality and continuity of services. The public consultation (Future Fit) completed in 2018 concluded that the recommended solution should be implemented without delay. Following the consultation, in 2019 we made a strong public commitment to reconfigure our services and resolve longstanding issues. COVID-19 has highlighted the urgent need to reconfigure. The Strategic Outline Case (SOC) for investment in our hospitals which was approved by Joint Investment Committee (JIC) in July 2022. This OBC builds on the recommendations from SOC and the feedback from JIC and is consistent to solution outlined at SOC.

Delivering the agreed clinical model is essential for providing long term, sustainable, high-quality care and will also achieve a range of significant benefits for all our local communities.

This OBC appraises several strategic options that will deliver the service reconfiguration, thereby addressing a number of the health system's most pressing acute challenges. It builds on the appraisal undertaken within the SOC and sets out the details plans for how we will procure, finance and deliver the Preferred Option.

Consistent to the SOC, our Preferred Option is to invest £312m in Royal Shrewsbury Hospital and Princess Royal Hospital to provide improved facilities that will better meet the needs of our patients. It will put in place the core elements of the service reconfiguration described in the Future Fit consultation, help us to address our most pressing clinical challenges, and establish solid and sustainable foundations for further improvements. However, significant risks will remain, and whilst these can be managed in the medium term, they will need to be addressed in the long term. The Preferred Option is fully aligned with local health system objectives and is one of a number of strategic initiatives that will transform the health and wellbeing of the population of Shropshire, Telford & Wrekin, and Powys.

Our proposals offer excellent value for money for taxpayers, with a higher benefit-cost ratio (BCR) than many public sector schemes (4.43) and a significantly positive net present social value. However, this appraisal highlights that if further capital were to become available, Option 4 would deliver greater value to the UK through the increased net present social value and BCR of 4.52.

ProCure 23 (P23) has been selected as the procurement approach for this scheme. To deliver the planned design and investment, the Trust expects to appoint a Principal Supply Chain Partner (PSCP) in May 2023. The Trust will retain our appointed cost consultants and our construction technical advisors for project management after the PSCP is appointed. The Trust has bolstered its technical team to ensure that it has the technical competencies to oversee and manage the PSCP arrangement.

Implementing the HTP is financially advantageous, generating [redacted] improvement to our financial position by 2037/38 compared to the BAU option, and thus enabling financial sustainability for Shrewsbury and Telford Hospital and Shropshire, Telford and Wrekin Integrated Care System (STW ICS).

The Trust has established governance arrangements (which also involve system colleagues) to support the successful delivery of this project and has a track record of delivering complex infrastructure developments. There are robust risk management arrangements in place to ensure successful delivery. Project timelines are dependent on securing timely progress through gateways. If there are delays in delivery timelines, inflationary pressures are likely to impact capital costs and increase the funding required to deliver the Preferred Option and there is a risk of service failure.

This OBC has been developed in line with HMT Project Business Case Guidance and the HMT Green Book. The OBC also complies with the latest NHS England (NHSE) Business Case Checklist.

This OBC seeks approval to progress to the Full Business Case (FBC) with the Core Decision Making Business Case (DMBC) 'Do Minimum' option as the Preferred Option, with a capital funding requirement of £312m. This OBC also seeks approval for the drawdown of additional capital funding totalling £6.6m to support the development of the FBC and £25m for the delivery of the enabling works scheme.

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

Our urgent case for change

As a System and a Trust, we face multiple long-running challenges that mean we need to change how services are configured and supported. The current clinical service configuration does not meet the needs of patients. There are two inadequately sized emergency departments, split site delivery of key clinical services (including critical care which presents a significant risk in continuing to safely staff and operate across two sites), insufficient physical capacity (particularly affecting elective services), mixing of planned and unplanned care pathways, and poor clinical adjacencies. Additionally, this results in duplication of some services across sites, and single site delivery of some key emergency specialities. This results in harm to patients and is both financially and operationally inefficient, also causing confusion for patients with varying standards of care, and double running costs (e.g. ED and Critical Care).

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

As a System, we committed to making these changes. NHSE and the Department of Health and Social Care (DHSC) also agreed to make the required capital investment.

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

Our critical issues

- The clinical model is not fit for purpose because of an outdated service configuration that prevents us from addressing quality and operational issues, contributing to an 'inadequate' CQC rating
- The workforce situation is not sustainable if we continue to duplicate services across both sites, with a particular risk to safely staffing two critical care units with the current configuration
- Our infrastructure does not support our future digital technology ambitions
- Our population is older than most areas, with a high burden of chronic conditions – creating additional pressure on our services
- There is significant health deprivation and inequality across the two districts
- Our buildings do not give us the capacity, space or layout we need for modern healthcare – and do not provide adequate support for infection control
- The local health system has one of the largest financial recovery challenges in the NHS and there is a risk that the financial position will deteriorate further if we do not change the way we operate

Scope of this business case

This OBC builds on the work completed previously and the agreed configuration of services and intends to move the Trust towards the outcome agreed within the DMBC and SOC. This previous work concluded that PRH would be the site specialising in planned care and RSH would become the site specialising in emergency care. Alternative configurations (including single-site options) were considered at DMBC stage, but were discounted due to these options not offering the right solution for our patients and the taxpayer.

In 2019, it was recommended that the chosen solution should be implemented without further delay. COVID-19 and recent challenges have only underlined the need to move quickly to the agreed solution. Feedback from wider NHSE colleagues has confirmed that we must consider an option that only utilises the allocated funding. As this will not enable the delivery of all of the wider

Future Fit ambitions (due to the impact of inflation), this OBC assesses the options against their delivery of the core DMBC requirements and how much of the wider Future Fit ambitions they deliver. A number of the options explore the additional benefits that would be realised with a larger investment, if further funding were to become available.

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

- Targeted Investment Fund (TIF2) funding for Planned Care Hub at PRH – this is delivering the day case components of the Future Fit consultation.
- The energy centre at RSH – this will deliver a site wide solution for the Trust that will enable a Net Zero Carbon solution for our new building in the future. The Trust is reviewing external funding sources to ensure this is secured as part of its wider estates strategy.
- Planned capital funding for renal dialysis – this will deliver critical components of the strategic estates plan based on the more recent public engagement[1].
- The digital transformation programme being implemented in conjunction with the HTP and funded through alternative NHS sources.

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

Delivering the core DMBC requirements and moving towards the wider Future Fit ambitions is the priority investment objective of this OBC. This underpins the development of the options, and as such all OBC options (except the Business As Usual (BAU)/ Economic Comparator) must support the Trust in the delivery of the outputs of the consultation.

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

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

Benefits of investment

- Significant improvement in the quality of care
- Appropriate capacity, well-designed facilities and more space improving both patient and staff experience
- Improved access to services
- Fewer cancellations, shorter waiting times and reduced infection rates
- Becoming an employer of choice within the local health system
- Alignment with the Trust's digital strategy
- Improved performance and efficiency

Table 1 outlines the benefits of the HTP at each site.

[1] Renal dialysis services at PRH - SaTH

Table 1: Benefits of transforming our hospitals

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

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

Delivering the required changes will require investment in appropriate facilities and services. This OBC considers the options for this investment, building on the options analysis completed as part of Future Fit and the SOC as well as considering the feedback received from JIC.

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

Figure 1: The HTP investment objectives

We have considered a range of options for reconfiguring services and improving care for our patients. We have appraised them against our Critical Success Factors and identified a Preferred Option.

Critical Success Factors (CSFs)

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

Options for delivering our commitments and investing in our hospitals

Based on the HM Treasury options framework, we considered a wide range of options and generated a long-list that is consistent to the options identified at SOC stage [redacted] These options build on the conclusions of Future Fit and the DMBC and consider the different ways to implement the agreed clinical model to support the delivery of improved services for all of our population across Shropshire, Telford & Wrekin, and Powys.

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

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

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

Comparing the options

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

We reviewed all opportunities for value engineering to minimise the capital requirement. This included reviewing inflation[2], the impact of modern methods of construction, opportunities for standardised and repeatable design, and key benchmarks (including New Hospital developments).

The long-list appraisal identified the options within the options framework to carry forward to the short list appraisal.

The following short list options were identified for the detailed appraisal This includes an additional option compared to SOC (option 0), which considers the situation with no additional capital expenditure (vs the Trust agreed plan) as this was requested by JIC, and this is now considered as the BAU option (as per the JIC conditions):

- **0. Business As Usual (BAU) (c. £0m/ minimal):** Continuation of current arrangements, with no additional capital expenditure beyond the existing backlog plans. Additional revenue expenditure will absorb some of the excess demand where possible.
- **1. Additional Comparator (c. £72m):** Continuation of current arrangements, with additional investment in the estate to provide increased capacity to meet some increases in demand.

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

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

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

0. Business As Usual (BAU) (c. £0m/ minimal)

Continuing with BAU is not a viable way forward, with no additional capital expenditure beyond the existing capital plans. This option does not deliver the consultation outcome and does not provide sufficient capacity for future demand. The resultant impact is that the Trust will be required to service excess demand through outsourcing and longer working hours, both of which attribute revenue cost at a premium. [redacted]

It will also see the condition of the estate and clinical environment deteriorate without additional investment in the estate, as well as continued significant workforce challenges. It is not a clinically safe option and will not solve performance and quality issues. The current market situation is unlikely to be able to absorb outsourced capacity, resulting in a significant number of patients being without care. This option has been added since SOC [redacted]

1. Additional Comparator (c. £72m)

The additional comparator (consistent to the BAU within the SOC), would provide a small amount of new ward accommodation, and additional capital (c.£5m a year) to address estates challenges.

This scenario would not achieve the DMBC requirements and move towards the wider Future Fit ambitions. The Additional Comparator option fails on several Critical Success Factors, will not support future population needs and will present an increasing risk to the staffing, quality and continuity of services. This option does not deliver the changes to services that are critical for clinical and financial sustainability and increases longer term risk. This option offers negative value for money, as it does not drive significant benefits sufficient to outweigh the costs of the option. In particular the Additional Comparator will also be unable to meet the full extent of the forecasted future demand and thus there will still be premium revenue costs attributed.

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

2. Core DMBC ('Do Minimum') (c. £312m)

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

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

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

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

This option meets all the qualitative CSFs defined for the scheme and delivers significant benefits to patients and staff, however, it does not deliver the further benefits associated with addressing key estates risks and further integration of health services.

This options also meets all the quantitative CSFs. It delivers a significant portion of the potential benefits driven largely by the new clinical model and changes in the configuration of services. This results in a strong BCR of (4.43) and a strong net present social value (c.£1.3bn). The option provides a small improvement in I&E position relative to BAU, demonstrating revenue affordability and is within the original allocated capital funding of £312m.

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

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

This option would include the following, in addition to the scope outlined for Option 2:

- new ward accommodation at RSH that meets current standards (including 70% single rooms) – improving the physical environment and reducing estates risk
- redeveloping the ward block to repatriate off-site support services, administration, and education
- upgrading theatres - improving the physical environment and reducing estates risk
- upgrade of pharmacy
- departmental relocations at PRH

This option meets all the qualitative Critical Success Factors and provides some further incremental improvement compared to the Core DMBC ('Do Minimum') option.

This option meets the value for money and affordability quantitative CSF, but not the capital affordability quantitative CSF. The option delivers substantial benefits and a strong BCR (3.83), however, it is marginally below that for the Core DMBC ('Do Minimum'). The option also and has a strong net present social value (c.£1.5bn) and makes a positive revenue contribution but is not affordable within the allocated capital envelope.

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

Seeks to maximise the opportunity for redevelopment and improvements to overall sustainability. Delivers the core DMBC requirements and most of the wider Future Fit ambition – including

additional new wards, theatre refurbishment, improving the physical environment, substantially reducing the estates risk, optimising estate layout across both sites and facilitating more integrated health and wellbeing services.

This option would include the following, in addition to the scope outlined for Option 3:

- further redeveloping and upgrading pharmacy (focusing on improved workflow)
- redeveloping and upgrading outpatient departments (increasing effectiveness and improving patient and staff experience)
- developing estate to support wider system integration plans and health and wellbeing services
- further optimising site layout to improve flow, adjacencies and utilisation
- new Integrated Care Hub at PRH

This option meets all the qualitative CSFs and provides the most benefits to the Trust compared to the other options.

This option meets the value for money and affordability quantitative CSF, but not the capital affordability quantitative CSF. This option delivers the strongest BCR (4.52), greater than that of option 2 and 3 and has a strong net present social value (c.£1.7bn). This demonstrates the significant incremental benefits and value resulting from the further investment that Option 4 provides. It provides a positive revenue contribution, but like Option 3, is not affordable within the allocated capital envelope.

Summary of the appraisal

As outlined above, all the 'do-something' options pass the qualitative CSFs, with the larger investments delivering greater qualitative benefits for the Trust and the local health system. The qualitative benefits of each option are explained in more detail in the Economic case.

When considering value for money, Option 4 is preferred as it delivers the greatest BCR and NPSV. However, Option 3 and 4 both fail the capital affordability CSF as they are greater than the currently allocated £312m.

Therefore, when considering all aspects of the appraisal, Option 2, the Core DMBC ('Do Minimum'), is the Preferred Option. The option drives a strong BCR and is the only 'do-something' option that is affordable within the allocated capital envelope.

Option 2 offers significant clinical, workforce and operational benefits vs. BAU and helps address the issues we are facing. It delivers the core, critical clinical service changes require to minimise risk and provides sustainable health care for the population of Shrewsbury, Telford and Wrekin and Powys. Furthermore, this option delivers significant value for money, as well as delivering the greatest BCR and being affordable in revenue terms, with cash releasing/ financial benefits offsetting costs of capital.

Table 2: Summary of options appraisal outputs

Category	Metric	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
Qualitative appraisal summary		Fail	Fail	Pass	Pass	Preferred
Capital cost		-	£72m	£312m	£481m	£534m
Annual cash releasing benefits (22/23 prices)			£4m	£20m	£24m	£28m
CIA model output	Incremental costs	n/a	(£100)	(£385)	(£518)	(£548)
	Incremental benefits	n/a	£99	£1,703	£1,981	£2,479
	Risk-adjusted Net present social value (NPSV)	n/a	(£1)	£1,318	£1,463	£1,931
	Benefit Cost Ratio	n/a	0.99	4.43	3.83	4.52
Appraisal conclusion		Fail	Fail	Preferred Option	Explore if further capital became available	Preferred qualitative and VFM; explore if further capital became available

[redacted]

Procuring the required services (Commercial case)

The alternative procurement (Service delivery) options were evaluated as part of the Long-list Appraisal. **Framework procurement** was selected as the Preferred Option as it was preferred against the other options in relation to all the relevant CSFs. The NHSE checklist also provides a clear default position for Framework procurement. As part of OBC development, we also investigated the potential procurement frameworks. We evaluated 5 different frameworks against our selected criteria. The evaluation concluded that the P23 framework is expected to offer the best value for money and help us move quickly to implementation and build, while also aligning with guidance from NHSE and the wider public sector. Based on the analysis of alternative procurement frameworks, **P23 has therefore been selected as the procurement approach** for this scheme. This ensures that the delivery of the scheme is fulfilled, as per the JIC conditions.

Through the development of this OBC, the Trust has defined clear procurement objectives and services required to deliver these objectives. This ensures that the Trust's commercial approach

is in line with the Government's Net Zero Carbon (NZC) priorities and considers social value and utilises Modern Methods of Construction (MMC). The precise commercial and contractual arrangements will be set out at FBC stage.

To deliver the new clinical model of care and provide the above goods and services, the Trust expects to appoint a PSCP by the 26th May 2023. The Trust requires these services from RIBA Stage 3 spatial co-ordination and design through to Stage 7 operational use of the new build and refurbished elements of the scheme. This contractor will work alongside the Trust's existing Hospitals Transformation Team. The professional services required by the appointed contractor will include architectural, financial, mechanical, electrical, structural, and civil in both pre-construction and construction phases of the programme.

The process to formally appoint a contractor began at the end of the RIBA Stage 2 design process. This ensures that the design has reached a level of maturity to allow the contractor to meaningfully engage with enough information to allow them to begin market testing and reduces costs associated with additional support from the contractor. The Trust will then work collaboratively with the contractor to develop the design. This approach will ensure that the PSCP is able to market test construction packages of work on behalf of the Trust. This means that essential elements can be market tested to demonstrate value, providing cost certainty for FBC completion. The PSCP will be able to immediately feed into the RIBA Stage 3 design process as a result.

We intend to novate the existing design team (including architects, structural, civil, mechanical, and electrical engineers) to the PSCP when there is formal regulatory approval to engage the PSCP beyond RIBA Stage 3 (as per the JIC condition). The Trust will maintain their appointed cost consultants / quantity surveyors after the PSCP is appointed and will also retain its incumbent construction professional technical advisors for project management. The team will be supplemented with other professional technical advisors to quality check any PSCP design changes from OBC appointment through to FBC and delivery of the enabling works. This will include architects, fire consultants, environmental advisors, mechanical and electrical engineers, structural and civil engineers, and a clerk of works. These advisors will be appointed separately through traditional frameworks, in addition to the PSCP appointment, ensuring no loss of technical services once the PSCP is on board.

The scope of the procurement involves implementing the Preferred Option. The Preferred Option has total capital costs of £312 million based on the latest PUBSEC indices. The gross internal area (GIA) of the new build areas as part of the HTP at RSH in the Preferred Option is 28,611m^2. The GIA of the refurbished areas in this option is 5,128m^2 at RSH and 660m^2 at PRH. Total GIA for the Preferred Option as part of the HTP is 34,399m^2. Since SOC stage, the design has been changed to accommodate for budget constraints. This has involved the relocation of major building work from the northwest to the southeast of the RSH site. The Preferred Option is expected to be completed by 2026/27.

Once appointed, the PSCP will:

- Feed into the completion of the RIBA Stage 3 designs
- Complete the next stage of design for the scheme (RIBA Stage 4)
- Undertake package pricing – working with the supply chain to obtain costs for individual packages of work
- Collate package pricing to prove a Guaranteed Maximum Price (GMP)
- Carry out the enabling works. These works will run in parallel to the completion of the FBC. The PSCP will then begin implementation of the main works for the Preferred Option in August 2024. [redacted]

The proposal is deemed to be commercially feasible and deliverable by the Trust and relevant project advisors. Engagement with PSCPs has confirmed that the programme timelines are achievable and appropriate. The capital cost of the scheme is also in line with the original allocated funding and is broken down in further detail in the OB Forms [Appendix E-05]. 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 they support the appointment.

Affording the investment in our hospitals (Financial case)

Implementation of the Preferred Option requires capital investment of £312m over 2022/23 – 2026/27,as described in the Economic Case. This investment is essential to delivering the clinical model, necessary improvements to quality and safety, dedicated capacity, pandemic resilient hospital facilities and financial sustainability in both the Trust and the ICS.

At the end of March 2023, the Trust has an underlying deficit of £34.4m. This is part of a wider ICS underlying deficit within STW of £87.9m for financial year-end 2022/23. The ICS is currently in the National Recovery Support Programme with a specific requirement to develop an approach to recovering the deteriorating financial position. This is also in the context of the quality and safety challenges that the system faces. As part of the development of an ICS sustainability plan, the System has been working closely together, including with regulator colleagues, to develop challenging and stretching plans that will improve system financial sustainability and reduce underlying deficits locally.

[redacted].

Noting the current uncertainty, particularly around pay and non-pay inflation, the Financial Case detailed the impact of sensitivities on the financial position, showing the impact of volatility. [redacted]

The impact of a delay to implementing the Preferred Option has been modelled and is underpinned by corresponding OB forms. The resultant impact is a net reduction in the Trust's position as higher capital charges are generated and the implementation of benefits are delayed, however, the position remains affordable.

Delivering the investment in our hospitals (Management case)

Governance

We have a clear governance structure as part of the HTP, which has been updated since SOC stage and builds on the lessons learnt from many other large NHS capital schemes.

The Hospitals Transformation team was set up at SOC to provide a dedicated project team, with sufficient experience and capacity to undertake work and activities required. The team will continue to be augmented so that it remains fit for purpose as the project proceeds to ensure sufficient resources throughout the project. Throughout the OBC we have strengthened the programme team and we are confident we have the appropriate leadership, project management, communications & engagement, clinical and technical expertise required for delivery of the next stage of the HTP. More detail on the skills and expertise of the project team is set out in the Management case. The project is being led and driven by senior members of the Trust Executive and management team, all of whom have previous experience of business case development and project delivery across the NHS. The Hospitals Transformation team consists of the core members involved in the planning for and delivery of the HTP on a day-to-day basis. At least one member of the Hospitals Transformation team is involved in each of the Governance Groups outlined in the HTP governance structure.

Clear roles and responsibilities were established within both the Trust and health system executive teams at SOC stage. These have been adapted for OBC stage and will continue to be

reviewed throughout the remainder of the business case process. Changes to governance have been developed in discussion with the relevant clinical and management teams and reflect the need to support and maintain clinical leadership. These updates allow for the increase in activity and detail that is required for developing an OBC.

Since SOC stage, the project team has expanded to include a Technical Advisor, who has provided experience in delivering capital programmes, and a Programme Delivery Director. Additional administrative support has also been introduced at OBC stage. We have also established a Technical Oversight Group (TOG) since SOC, to support the integration of the PSCP into our existing structure.

Delivery plan

The Core DMBC ('Do Minimum') is expected to be completed in November 2026. We will therefore begin realising benefits in 2027, including reduced cancellations and elective waiting times, additional emergency, and elective capacity, and improved clinical quality. If further funding became available for Options 3 and/or 4, these options are planned to be phased incrementally to the Core DMBC option and could be undertaken in two further phases.

To enable the targeted implementation timelines for the Preferred Option to be met and to reduce the impact of inflation, the Trust is seeking the early release of c.£25m for an enabling package of work at the RSH site. The costs associated with the enabling works are included within the overall capital costs of the Preferred Option (£312m). The enabling works are planned to take place during the FBC period, with a separate short form business case provided to secure approval to commence these works.

This enabling work is specifically aimed at expediting the delivery of the essential elements within and around the new Emergency Department. These works are anticipated to commence in August 2023 and are expected to take 12 months, finishing in August 2024. The enabling works are expected to start once the OBC is approved and will be carried out by the appointed PSCP. These works will run in parallel with the completion of the FBC. Once the FBC is approved, the main works will commence and there will be an element of dual running of enabling and main works for the ED at RSH.

The enabling works will also reduce the duration of the overall scheme and the ability to complete the enabling works in parallel with completion of the FBC will reduce preliminary contractor costs which is likely to reduce the inflationary impact on the scheme.

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

The project relies on maintaining an ambitious delivery schedule supported by timely approvals. This document seeks approval for:

- The Core DMBC option as the Preferred Option, with confirmed funding of £312m
- The ability to proceed with the FBC for the Preferred Option (expected to be complete by January 2024)
- Drawdown of c.6.6m to support development of the FBC
- Drawdown of c.£25m for the completion of the enabling works that are due to begin in August 2023

The key approvals for the entire scheme are summarised below.

Table 3: Key milestones for Preferred Option

KEY DECISION/APPROVAL	KEY DATES
Submission of full planning application	April 2023
Completion of OBC	April 2023
Appoint PSCP	May 2023
Full planning decision	July 2023
NHSE and Joint Investment Committee approval of OBC	July 2023
NHSE, DHSC and Joint Investment Committee approval of funding	July 2023
Joint Investment Committee approval of Temporary works funding	August 2023
HMT approval of OBC	September 2023
Completion of FBC (Including PSCP GMP)	January 2024
Joint Investment Committee approval of FBC	February 2024
Begin implementation of the Preferred Option	February 2024
Completion of the Preferred Option	November 2026

We have begun consultation with both local planning authorities (Shropshire, and Telford & Wrekin) as part of this process. Initial meetings with these local planning authorities confirmed that they were verbally supportive of the scheme with the main consideration being to ensure appropriate car parking solutions on the site. We have also received pre-application advice from Shropshire Council. The letter from the Shropshire Council is included in Appendix C-03. We have ongoing engagement with the Air Ambulance, West Midlands and Welsh Ambulance Services and Shropshire Fire and Rescue. This will continue throughout the remainder of the process. Site visits have taken place and a full planning application was submitted on 30th March 2023 and the full planning permission process is underway. PRH consists of internal reconfiguration and therefore doesn't require planning permission but building regulations will be adhered to within the detailed design.

These ambitious timelines are dependent on JIC giving approval to the OBC and approval to proceed with the Core DMBC option ('Do Minimum') in July 2023, as well as authorising the early release of c.£25m of funding for the enabling works.

Managing key dependencies

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

Key inter-dependent programmes are described below:

1. ICS wide programmes (e.g., Local Care Transformation Programme (LCTP) / ICS Urgent and Emergency Care Transformation Programme), critical for the delivery of the system wide demand and capacity assumptions, such as delivering the out of hospital shift and addressing the current Medically Fit For Discharge (MFFD) challenges.
2. Implementation of a Planned Care Hub at PRH, critical for the delivery of the broader clinical model outlined in Future Fit
3. For the HTP to achieve NZC targets within the new build, the provision of electrical energy to power the Energy Centre is required.

4. Digital Transformation Programme, required to support the new hospital plans, for example in reducing paper records in the new hospital facilities
5. Human Resources and Organisational Development (HROD) / people, critical to support the workforce transformation required for the HTP.
6. Car parking, required to ensure there is appropriate parking to support staff and visitors at the new build.

These key interdependent programmes are monitored by members of the Hospitals Transformation team which ensures that they are aligned to the HTP and means that there is commitment from all relevant parties. For each, there is representation for the HTP at the relevant project / programme governance, ensuring a clear alignment with regular updates on progress and risks.

Benefits and risk management

Benefits

We recognise the importance of benefits realisation to successful project delivery. Benefits realisation will run through the design and delivery stages but is predominantly focussed on the post-handover stage. As part of the OBC, the benefits realisation plan has been developed. This includes specific owners, metrics and timescales for benefits realisation to support assurance and delivery as we move towards implementation. Responsibility for the operational and clinical delivery of the identified benefits will lie with the HTP Delivery group, which will report to the HTP Programme Board, in line with the existing governance arrangements. These governance arrangements will be kept in place following the completion of the capital build to monitor and manage the delivery of the planned benefits.

Risks

The management of risk forms part of the Trust's overall approach to governance. All risks will be managed by the programme, and feed through to the necessary Trust governance as appropriate (based on risk type and scores). Each risk is owned by the relevant workstream lead who has responsibility for the risk. All programme risks are reported at HTP Delivery Group, and all extreme programme risks are reported at the HTP Programme Board and HTP Committee to ensure that key members of the Hospitals Transformation team are aware of the biggest risks to the HTP.

Stakeholder engagement

Since 2019, there has been stakeholder engagement with our staff (clinical and non-clinical), service users, patients, public and system partners. Our communication and engagement plans will continue to be implemented throughout the assurance and implementation phases. It is fundamental to have a clear understanding of the interests of our key stakeholders and implement a strategy to address their needs, with an aim of responding to their concerns and ensuring the benefits for healthcare across the communities we serve are clearly communicated.

Since SOC stage, we have established a Communications, Community Engagement and Organisational Development Group (CE&OD) for the HTP, who meet weekly to discuss the delivery of the implementation of priority actions and ensure the communications and engagement workstream remains on track. It provides regular updates and seeks involvement from the monthly ICS Communications and Engagement group, including representation from NHS, local authorities and Healthwatch partners.

Our Communications and Engagement Strategy outlines 5 critical stages that we believe are essential for engaging and involving local people throughout the process. We have a detailed stakeholder plan in place for each stakeholder group that is outlined in the Management Case. So far, we have utilised existing mechanisms for communications and engagement, including existing patient, carer and public forums across Shropshire, Telford & Wrekin, and Powys and developed bespoke Focus Groups linked to each of our workstreams. Feedback from these Focus Groups to date has been positive. We have also worked closely with the Public Assurance Forum

at SaTH to inform our approach. We launched our campaign in January 2023 to encourage people to be part of the change and have a group of key spokespeople who are media trained and will represent the programme.

We understand the importance of considering subsequent phases of the HTP and we have robust plans in place to continue to engage relevant stakeholders as we move towards implementation using Focus Groups, 'About Health' events, newsletters as well as developing a range of resources including clinical videos and visual representations of the HTP.

Preparing for implementation

As part of OBC development, we have started planning for the transition of services. These plans will continue to be developed as part of the wider transformation of the clinical model. The overarching principles for the transition of services include:

- Minimising disruption to patients
- Minimising double running where possible

Our plans to continue to prepare for the transition of services include:

- Creation of a Logistics Cell within the Programme to plan for the transition of services
- Utilisation of Focus Groups
- Engagement with wider stakeholders

Conclusion and next steps

This OBC highlights that:

- **There is a clear and compelling case for change** to implement the outcomes of the Future Fit consultation and build on the case set out at SOC stage. There is strong system level support for this proposal, which is a critical path of the ICS Plan and ICB joint forward plan. This investment will enable us to provide modern, safe, and effective emergency and planned care from dedicated facilities, leading to improvements in the health of our population and their experience of care. It will also make our Trust and our health system a much more attractive place for our staff to work within.
- Our Preferred Option represents an appropriate balance between the full ambition behind the Future Fit consultation, delivering to modern healthcare standards and the availability of capital funding.
- **Our proposals offer excellent value for money for taxpayers, with a higher BCR than many public sector schemes (4.4) and a significantly positive net present social value (c.£1.3bn).** We will continue to test the value for money of this scheme and identify ways to improve it through the business case process.
- **We have a viable and attractive commercial route to procure the services required.** This will be through the P23 framework, and we expect to appoint a PSCP in May 2023.
- **Our Preferred Option is not only affordable from a revenue perspective but will generate a significant improvement to the Trust's financial position** compared to the BAU. Without implementation of the HTP, both the Trust and the System will struggle to achieve long-term financial sustainability.
- **The Trust has established rigorous governance arrangements** (which also involve system colleagues) to support the successful delivery of this project and has a track record of delivering complex infrastructure developments to time and budget.

This OBC seeks approval to progress to the Full Business Case (FBC) with the Core DMBC ('Do Minimum') option as the Preferred Option, with a capital funding requirement of £312m.

This document also seeks approval for the drawdown of additional capital funding totalling £25m for enabling works and £6.6m for fees to support the development of the FBC.

Timely regulatory review and approval processes will be essential to maintaining the timescales for implementation outlined in this OBC and to minimising the impact of inflation on the capital funding requirement.

About this document

This document is the latest stage in implementing the Future Fit consultation decision to reconfigure services across the Royal Shrewsbury Hospital and the Princess Royal Hospital sites and builds on the recommendations from SOC.

The OBC has been developed by The Shrewsbury and Telford Hospital NHS Trust Hospitals Transformation Programme, working closely with the Shropshire, Telford & Wrekin Integrated Care System and system partners, including Shropshire Community Health Trust, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, and previously Shropshire and Telford & Wrekin Clinical Commissioning Groups (STW CCG), which have now been superseded by STW ICS.

It follows the Future Fit decision-making business case (DMBC), which decided the preferred clinical model for hospital services in the area. In 2019, the Independent Reconfiguration Panel (IRP) and the Secretary of State for Health and Social Care endorsed this decision and the proposed configuration and clinical model. It also follows the approval of the Strategic Outline Case in July 2022, which endorsed the preferred way forward and approved the development of this OBC.

The SOC appraised strategic options that could deliver the service reconfiguration agreed through the Future Fit consultation, addressing a number of the health system's most pressing acute challenges. In this Outline Business Case (OBC), we have further refined this appraisal and have set out the detailed plans for how we will procure, finance and deliver the Preferred Option.

The OBC assesses the options for delivering the business case and recommends a Preferred Option. The Preferred Option is an indication of the Trust Board of Directors' preference, which will inform preparations made ahead of the financial closure and award of contracts at the next business case stage – Full Business Case (FBC). The Preferred Option could be subject to change at FBC stage if anything the OBC is based on should need to be revised and therefore may cause the Board to select a different option.

This OBC incorporates feedback from NHSE and DHSC in preparation for the JIC meeting in July 2023.

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

[redacted]

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NHS Trust

1 Strategic case

1 Strategic case

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

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

We have an agreed way forward to resolve these challenges and support the wider transformation of the ICS. This involves significant changes in service configuration and we need to move quickly to implement them. We have consulted the public on a clinical model that will address these challenges by reconfiguring services at RSH and PRH. We have agreed that RSH will specialise in emergency care and PRH will specialise in planned care. Both hospital sites will continue to provide 24/7 urgent care, and routine services such as outpatients and diagnostics, meaning most people will continue to receive care at their local site. Additionally, the Strategic Outline Case (SOC) for this investment was approved by the JIC in July 2022, enabling the Trust to proceed with developing the detailed plans for this investment, and this OBC. As part of this, the JIC set out a number of conditions for the scheme to adhere to. These have been addressed through this business case.

Delivering the agreed clinical model is essential for providing long term sustainable, high-quality care and will also realise a range of significant benefits for all local communities. The planned reconfiguration will deliver a step change in clinical care for patients by delivering the improvements in emergency and planned care that was committed to in 2019 through the Decision Making Business Case. It will provide quicker access to specialist consultants, improve the quality of the care we can provide, and help us to address our workforce gaps by bringing teams together more effectively. This is being delivered through our strategic estates plan that leverages the sources of capital we have available. This includes investment in a Planned Care Hub at PRH (funded by the Targeted Investment Fund), and the agreed reconfiguration of renal dialysis. Our strategic plan includes a phased approach to the delivery of our long-term goals enabling us to build on these foundations as capital becomes available.

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

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

- **ensuring we can provide safe and high-quality emergency and planned care** by consolidating services and improving access to specialists – meaning patients will see the right clinician at the right time when they need specialist care,
- **addressing the service fragility, particularly in emergency medicine and critical care**,
- **separation of emergency and planned patient flows**, improving efficiency and patient experience, reducing cancellations, and improving infection control,
- **modern, fit-for-purpose facilities**, including increased capacity and departments, better layouts, and more single rooms,

- **offering a more attractive place to work**, with sustainable staffing models, suitable working environments and an effective clinical model,
- **quicker access to care**, with reduced waiting times for emergency and planned care, and
- **enhanced resilience and infection control**, including fit for purpose facilities to care for infectious patients.

At SOC stage, we appraised strategic options that could deliver the service reconfiguration agreed through the Future Fit consultation, addressing a number of the health system's most pressing acute challenges. In this OBC, we have further refined this appraisal and have set out the detailed plans for how we will procure, finance and deliver the Preferred Option.

Our proposals were supported by the Independent Reconfiguration Panel (IRP) and the Secretary of State for Health and Social Care who highlighted in 2019 that ***"…the proposal to establish a single emergency centre at RSH with a full range of complementary services at PRH, Telford, is in the interests of health services in Shropshire, Telford & Wrekin and should proceed without further delay…".*** Since then, the need for this change has increased as a result of the growing demand for services, compounded by the impact of the COVID-19 pandemic.

If this reconfiguration does not progress, there is an increasing risk to the ability to provide continuous, sustainable core services at both sites.

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

1.1 Case for change

1.1.1 Clinical strategy

The current clinical service configuration does not meet the needs of patients. There are two inadequately sized emergency departments, split site delivery of key clinical services (including critical care), insufficient physical capacity (particularly affecting planned services), mixing of planned and emergency care pathways and poor clinical adjacencies. Additionally, this results in duplication of some services across sites, and single site delivery of some key emergency specialities. This results in harm to patients and is both financially and operationally inefficient, with varying standards of care, and double running costs. The Trust is currently operating at the minimum viable level of planned activity to allow additional capacity for emergency activity; this is a trend that has been increasing since the COVID-19 pandemic. This creates an additional adverse societal impact that is explored in the BAU scenario within the Economic case.

One key impact of the current model of care seen in recent years has been difficulties with recruitment and retention; it has become harder to ensure that there are the right number of highly skilled medical, nursing and other healthcare staff at both hospitals to provide the wide range of services for patients. This is evident daily where many of the departments and wards are staffed with a high proportion of agency staff and morale is regularly negatively affected by a lack of progress (as demonstrated in the 2022 NHS Staff Survey).

There is a pressing need to address these issues, which has only increased since we made a strong public commitment to solve our problems by reconfiguring services. COVID-19 has further highlighted the need to reconfigure our services and the 2021 CQC report highlights our quality and safety challenges. If we cannot make changes, there is a real and increasing risk to both the staffing, quality and continuity of core clinical services at both sites in the absence of a viable alternative provider.

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

The draft 2023 Clinical Services Strategy [Appendix S-16] includes delivery of the clinical model described during consultation with a clear purpose for our two hospital sites. In our new service model, we consolidate specialist services onto single sites (with the required clinical adjacencies). That means when patients need specialist care, they will get the best care available at the right time from the right clinicians in the right clinical setting. Both hospital sites will provide 24/7 urgent care, and routine services like outpatients and diagnostics, so most people will carry on being cared for at their local hospital site.

This includes:

- **A site specialising in planned care at PRH** dedicated to planned day cases and inpatients. This will minimise the disruptive impact of emergency admissions as these patients will be admitted to the site specialising in emergency care. It will also avoid mixing the flow of planned and emergency patients which can often lead to the cancellation of planned care and increased risk of infection. The site specialising in planned care includes inpatient beds with enhanced therapy services for patients on a planned pathway of care following an emergency admission to the site specialising in emergency care. It will also provide enhanced 24/7 urgent care services (an A&E Local Model), which will ensure c. 65% of patients who currently attend the emergency department can be seen on the site – meeting the recommendations set out by the Independent Review Panel (IRP) in July 2019 (enabling as much clinically appropriate care to be delivered at PRH as possible) and relevant urgent care guidance. This will

enable most patients to continue to be treated at their local hospital and the model is supported by clinical staff at the Trust. The Trust continue to work with NHSE on this new, and enhanced, service model and are aligning with national priorities for the development of Urgent and Emergency Care. This ensures care continues closer to home where clinically appropriate.

- **A site specialising in emergency care at RSH**, including an extended dedicated emergency department and Critical Care Unit, supported 24/7 by all the required medical and surgical specialities, including W&C inpatient services. Alongside the emergency department will be on-site 24-hour urgent care services and a same day emergency care centre with specialist medical, paediatric, and surgical assessment areas.

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

These benefits are defined further in Section 1.1.7.

Our draft Clinical Services Strategy [Appendix S-16] sets out the direction of our Trust services to support the transformation of the ICS over the next five years, of which this business case and investment is a critical component. This will continue to be refined as we move into implementation aligned with local, regional, and national priorities (see Section 1.2). For example, these include the integration of Community Diagnostic Centres (CDCs) and the Planned Care Hub. More broadly, the draft Clinical Services Strategy sets out:

- Our role in the system and how we will deliver it
- The clear purpose for each of our hospitals
- How we will approach provider collaboration
- The plans for the LCTP
- Priority plans for prevention and reducing health inequalities
- How we will drive health innovation through world class education, teaching and research

1.1.2 Organisational overview

We face significant clinical, operational and workforce challenges; these result from the current configuration of services, and an estate which is unsuitable for modern healthcare and unable to efficiently cope with demand. There is a broad duplication of services across two hospital sites but with the delivery of some key emergency specialities from only one site, as shown in Table 4. The resultant costs and inefficiencies from this further exacerbate other challenges and drives an additional structural cost that contributes to the Trust's financial deficit. Investment in reconfiguring services presents a crucial opportunity to address the longstanding quality and sustainability issues that we face.

We are the main provider of acute hospital services for Shropshire, Telford & Wrekin and mid Wales (Powys), at our two main sites: RSH in Shrewsbury and PRH in Telford.

- Both hospital sites provide a wide range of acute hospital services including emergency services, critical care services, diagnostics, outpatients, adult trauma, most inpatient medical services including, for example acute medicine, respiratory medicine, endocrinology and renal services.
- Inpatient urology, abdominal, general and vascular surgery, as well as gastroenterology and oncology services, are provided at RSH.
- Inpatient paediatrics, head and neck, breast surgery, planned orthopaedic surgery, acute stroke and stroke rehabilitation services, cardiology, gynaecology, and consultant-led obstetrics services are provided at PRH.

We also provide community and outreach services such as:

- consultant-led outreach clinics (in Powys, Shropshire and Telford & Wrekin).
- renal dialysis outreach at Ludlow Hospital; and
- community services including audiology, heart assessment services, therapies and maternity services.

The community outreach sites include:

- Apley Private Practice Suite
- Bishops Castle
- Bridgnorth Community Hospital (SaTH)
- Bridgnorth Hospital
- Bridgnorth Maternity Unit
- Charlton Medical Practice
- Court Street Medical Practice, Madeley
- Donnington Medical Practice
- Euston House
- Ludlow Community Hospital
- Ludlow Hospital
- Ludlow Maternity Unit
- Madeley Court, Telford
- Marysville Medical Practice
- Oakengates, Telford
- Oswestry and District Hospital
- Pontesbury Medical Practice
- RJAH Orthopaedic Hospital
- Severn Fields Health Village (SATH)
- Shrewsbury Nuffield
- Shropshire Skin Clinic
- Southwater Library
- Spire Cheshire Hospital
- Stirchley Medical Practice
- Telford and Wrekin Primary Care Trust
- The Woodside Medical Practice
- Whitchurch Community Hospital
- Williams Farr House
- Wrekin
- Newtown

Additional providers across the ICS include a Community Trust (Shropshire Community Health Trust), the Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH) in Shropshire, and a Mental Health Trust (MPFT) which covers Shropshire and Staffordshire. The region is served by the West Midlands Ambulance Service University NHS Foundation Trust (WMAS). The Wales Ambulance Service NHS Trust serves the Powys region, for which we also provide acute hospital services. Services are commissioned largely by STW ICS.

Table 4: Our current service configuration

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

In in 2021/22, we saw c. 110,000 admitted patients and c. 127,000 emergency attendances. Annual trends are shown below.

Table 5: Volume of patients across time*

	19/20	20/21	21/22
Emergency admissions	49,974	40,018	47,499
A&E attendances	143,000	103,199	150,144
Outpatient appointments	620,050	480,527	584,366
Paediatric inpatients	10,616	5,926	8,783
Day case and electives	67,258	44,455	60,876

To deliver this, we have a workforce of around 7,000 staff that cover the full spectrum of disciplines including medical staff, registered nursing and midwifery, allied health professionals, healthcare assistants and other support, scientific, therapeutic, technical, administrative, clerical and management staff. As a result of the existing fragmented clinical and workforce models, we find

attracting and retaining substantive staff intensely challenging. This results in heavy reliance on temporary staffing which further impacts the quality of care provided. Staff costs as a % of operating expenditure are higher than the average of our peers [redacted] Upon completion of the HTP, we will improve staff experience and satisfaction that will help us to improve staff recruitment and retention giving us more control over our workforce numbers and associated costs. This is because the new facility and clinical model will to lead to a reduction in sickness and absence rates due to a predicted reduced rate of burn out, improved mental health and a reduction in musculoskeletal injuries. This will result in a reduction in the agency premium. Reduced turnover costs, such as advertising and recruitment fees due to the improved facilities and the new clinical model will also contribute to a reduction in staff costs. The workforce benefits are highlighted in the analysis of the workforce model that is reviewed in the Economic case.

*Note, the above activity excludes some specific activity to ensure continuity with the SOC:

- Outpatients – includes OPPROC activity and only includes PRH and RSH sites. Also includes DNAs wich are excluded from the planning calculations.
- Elective and day case activity excludes local HRG exclusions which are included in the planning submission
- A&E activity is types 1 and 3The

1.1.2.1 The local population

The populations across the area have a range of different needs for health and social care services[3].

Telford & Wrekin has a large, younger urban population with some rural areas and is ranked as the **60th** most deprived local authority in England (out of a total of 316 lower tier authorities). Twenty-nine areas within Telford & Wrekin are ranked in the 20% most income-deprived nationally. The population is approximately 180,000 and has an unemployment rate of 5.1%, compared to the UK average of 4.5%.

Shropshire covers a large rural population with problems of physical isolation and low population density and has a mix of rural and urban ageing populations. Although it is ranked as the **192nd** most income-deprived local authority in England, with only 6% of its population living within the top 20% most income-deprived areas in England, the relatively affluent county masks pockets of deprivation. Shropshire has a population of approximately 320,000 and an unemployment rate of 3.7%.

The ICP Strategy [Appendix S-04] outlines the key population health indicators as part of the Public Health Outcomes Framework. Table 6 shows a selection of these indicators that highlight the specific population challenges and the health deprivation and inequality across the two districts as well as demonstrating problems for Shropshire and Telford & Wrekin relative to England as a whole. Our draft Clinical Services Strategy [Appendix S-16] anticipated these results and our Demand and Capacity calculations have been adjusted accordingly.

[3] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

Table 6: ICS Analysis of Population Health Outcomes

Indicator	Telford & Wrekin	Shropshire	Unit
Adults classified as overweight or obese	70.6	68.0	%
Children in relative low-income families (under 16s)	21.4	16.8	%
Children overweight in reception (including obese)	26.1	22.6	%
Smoking at time of delivery	14.3	11.0	%
People aged 16-64 in employment	72.9	76.4	%
Excess mortality in adults with severe mental illness	475.4	477.6	Per 100,000
Admissions for alcohol related conditions	512	460	Per 100,000
Smoking attributable mortality	246.1	173.7	Per 100,000
Early mortality from preventable cancers	66.2	38.7	Per 100,000
First time entrants to the youth justice system	108.9	64.2	Per 100,000
Early mortality from preventable CVD	38.4	24.8	Per 100,000
Homelessness (households owed a duty under the Homelessness Reduction Act	12.3	7.9	Per 1,000
Teenage pregnancy	16.8	11.5	Per 1,000

This evidence, along with the outcome of our Local Authority Joint Strategic Needs Assessments (JSNAs) (which can be found in Appendix S-04), highlights the following problems:

- Adult smoking rates are key drivers of inequality between the districts. Smoking during pregnancy is a particular issue and is higher than the national average, however, this is now coming down in the area.
- Excess weight is the most significant lifestyle risk factor in the population, with the level of adult excess weight in both Telford & Wrekin and Shropshire significantly higher than the England average
- Unhealthy weight in children and young people in Telford & Wrekin is higher than the national average
- Mental health is a key cause of poor health amongst our communities
- The level of alcohol related hospital admissions in Telford & Wrekin are also significantly higher than the England average
- Early death rates from preventable cardiovascular disease and cancer in Telford & Wrekin are significantly worse than the England average

The Quality and Outcomes Framework (QOF 2021/22)[4] provides further evidence of deprivation in the local area. This Framework shows that the population of the Shropshire, Telford, and Wrekin ICS experiences worse outcomes in comparison to national levels for 16 out of 21 common chronic conditions, including:

- Hypertension (16% vs 14%)
- Depression (15% vs 13%)
- Chronic Kidney Disease (6% vs 4%)
- Cancer (4% vs 3%)
- Diabetes mellitus (7.5% vs7%)
- Asthma (7% vs 6%)
- Secondary prevention of coronary heart disease (3.5% vs 3%)
- Atrial fibrillation (3% vs 2%)
- Stroke and transient ischaemic attack (2.4% vs 2%)
- Chronic obstructive pulmonary disease (2% vs 1.9%)
- Osteoporosis: secondary prevention of fragility fractures (1% vs 0.9%)
- Heart failure (1% vs 0.95%)
- Epilepsy (1% vs 0.8%)
- Rheumatoid arthritis (0.9% vs 0.8%)
- Dementia (0.9% vs 0.7%)
- Peripheral arterial disease (0.8% vs 0.6%)

Our JSNAs also highlight inequalities in life expectancy between the two local authorities. The life expectancy for males and females in Telford & Wrekin is lower than the national average and has stalled in recent years. Whereas the life expectancy for males and females in Shropshire is higher than the national average.

Table 7: Life expectancy at birth (years)[5]

Region	Male (2018-2020)	Female (2018-2020)
Shropshire	80.2	83.7
Telford & Wrekin	78.2	81.9
England	79.4	83.1

There are also inequalities in life expectancy within both districts, evidenced by our JSNAs. This is driven by mortality from cardiovascular disease, followed by cancers. The gap in life expectancy between the most and least deprived areas within each local authority:

- for men is 7.3 years in Telford & Wrekin, compared to 7.2 years in Shropshire
- for women is 4.1 years in Telford & Wrekin, compared to 5 years in Shropshire

These statistics reflect the need for change to reduce inequalities across the ICS. The role of the Local Care Transformation Programme (LCTP) alongside HTP will be critical in driving this change.

Table 6 confirms that inequalities are particularly prevalent in Telford. Opening the Planned Care Hub will improve accessibility for residents, which supports improved population health outcomes. In particular, early mortality from preventable cancer is prevalent in Telford and will be addressed through the improved clinical model enabled by HTP.

[4] https://app.powerbi.com/view?r=eyJrIjoiYWI4Y2VkZTEtMThhMi00ZGZkLTgxYWEtNTU3NGM1ZGE3OTI0IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

[5] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/datasets/lifeexpectancyestimatesallageuk

Additionally, reduced occupancy rates, reduced length of stay, ringfenced capacity for planned care and increased care in the community will all contribute to better population health outcomes and support reductions in inequalities across the population. These are all enabled by HTP and the LCTP.

By working together at Place level, with Primary Care, the voluntary and community sector, community services, care and council services, business, and people themselves, we will take a proactive approach to identifying risk in the population and supporting people to reduce their risk.

Proactive prevention is threaded through the system's place-based programmes of work alongside developing resilient communities. As a key partner we will continue to support the system wide proactive prevention approach building on what is already in place across Shropshire and Telford & Wrekin.

1.1.3 Our challenges and case for change

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

Our core messages are:

1. **This investment will improve care for everyone (the services that we provide to all of our communities will be improved)**
    - Planned care services will be available throughout the year, primarily on our site specialising in planned care. This will lead to increased efficiency; a better patient experience with fewer cancellations and delays for operations; and greater resilience in the face of a pandemic.
    - Improved emergency care services will be delivered from a right-sized, purpose-built Emergency Department collocated with all the medical and surgical specialist teams. This will mean that patients who are most severely ill or injured will be seen more quickly, with shorter stays and faster ambulance handover times.
    - Enhanced and adequately sized 24/7 urgent care services for most patients who currently attend ED will be available 24/7 on both sites and be delivered through a new A&E Local Model in Telford, staffed by a team of health, care and community specialists.

2. **Our plans will deliver two thriving hospital sites:**
    - We will continue to invest in both of our sites e.g. the new £24m Planned Care Hub at PRH will upgrade facilities, increase capacity and improve services for the local population, fully aligned with the HTP's objectives.

3. **We cannot continue as we are:**
    - Our emergency patients regularly experience delays in accessing the right specialist teams (as a result of configuration)
    - There are immediate staffing issues in our emergency medicine and critical care services and failure to reconfigure and consolidate on a single site will result in failure of these services
    - Our emergency medicine departments are inadequately sized and configured for modern healthcare

- Our planned care patients have to compete with emergency flows to access to our hospitals, resulting in cancellations and delays in care and therefore a poor patient experience
- Some of our wards are not suitable for the delivery of modern healthcare
- We are currently facing significant failure of multiple emergency medicine targets and our future model of care is aligned with the tenets of the NHS Delivery Plan for Recovering Urgent and Emergency Care Services 2023.

4. **We must put the available funding to good use:**
    - We are facing a challenging national fiscal situation.
    - A significant amount of funding has been allocated to improve our clinical model and we must ensure that this funding provides the best care value for money.

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

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

To overcome the significant challenges described in this OBC, we urgently need to change how services are configured across our sites and invest in appropriate facilities to support this – and we have an agreed solution. The Future Fit consultation looked at these issues, consulting the public on a new configuration of services in 2018.[6] In 2019, our commissioners confirmed the decision to reconfigure services and develop RSH as the site specialising in emergency care and develop PRH as the site specialising in planned care.

Given the pressing urgency of our challenges, we need to continue to move quickly – implementing these changes cannot wait, with the Independent Reconfiguration Panel (IRP) recommending that the proposals put forward should go ahead without further delay in 2019.

Since then, the need for change has only increased with COVID-19. Our latest CQC report rated the Trust as 'Inadequate' with improvement in some areas and deterioration in others. If the reconfiguration does not progress, there is an increasing risk to both the quality and continuity of core clinical services at both sites.

We now need to move rapidly to implement these changes and secure investment in our hospitals. Following a significant response to the COVID-19 pandemic, which further evidences the challenges we face, we now need to mobilise and deliver our transformation plans quickly. As the population grows, increasing pressure is put on our sites. Certain areas of our hospital are currently operating at around 98% utilisation, which is unsustainable both from a patient and financial perspective. Furthermore, we have seen a shift towards higher ED utilisation post pandemic, which is putting increasing pressure on both our staff and our facilities.

In 2022, the JIC approved our SOC to secure £312m investment in our clinical facilities. This was a significant milestone for the programme and this OBC represents the next critical milestone in the development of plans to invest significantly in healthcare facilities for the people of Shropshire, Telford & Wrekin and Powys.

We have an agreed Preferred Option (outlined in the Economic Case) to resolve these challenges involving significant changes in configuration and need to mov quickly to implement the outcome of the Future Fit consultation described above.

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

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

1.1.5 Current challenges

Our immediate challenges – which we face every day and that limit the care we can provide now – include an outdated clinical model trying to deliver emergency medicine on two sites with different levels of support of specialist services, critical staffing gaps and buildings that need improvement. These issues create clinical and operational risks and issues daily and are reflected in the care we provide.

1.1.5.1 An outdated clinical model with duplication and fragmentation of services

We have experienced significant difficulties achieving clinical performance targets for many years due to core issues with the current clinical model. For example:

- Our 4-hour performance in the ED has been consistently poor and is currently forecast to continue to be below the national target.
- Compliance with the 62-day cancer target has not been achieved since July 2020 and with the present system, we are unlikely to be able to achieve it on a sustainable basis.
- Referral to Treatment (RTT) targets have seen a marked decline since April 2018 with the provision of planned care services regularly impacted by the admission of emergency patients at both of our hospital sites.

The current clinical model was not designed to meet the needs of twenty-first century healthcare. It has emerged as a result of many tactical interventions over decades rather than through strategic planning. Unnecessarily complex pathways often result in patients being seen in inappropriate settings with poor facilities. The combination of duplicated and single site services generates problems for patients, staff and visitors. The poor integration of duplicated services further impacts patient experience and can lead to patients being unable to see the right person at the right time. Additional operational issues and the lack of available skilled staff to cover these fragmented services results in poor patient experience.

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

The Trust has continued to be rated as inadequate by the CQC in a number of domains over recent years, demonstrating the significance of the issues posed by our clinical and operational models (which are linked directly to the layout and quality of our estate). Our 2021 CQC report rated the safety and responsiveness of services as ‘Inadequate’. For urgent and emergency services, CQC reported that “patient outcomes were worse than national averages”, and we remain the one of eight NHS Trusts rated as ‘Inadequate’ by CQC.

Table 8: Trust CQC reports[7]

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

We recognise that the current configuration of our emergency care services is not fit for purpose and that this greatly inhibits our ability to provide the right level of care to our patients. Delivering care across the two very different emergency sites creates challenges in applying best practice and national guidance in a consistent manner. We currently have different levels of support to emergency medicine services across both sites with different access co-located emergency specialist services at each site. Having two separate hospitals accepting emergency patients to their EDs where the emergency teams are not supported by a full suite of specialists, means that patients, transported by ambulance or by their own transport, may not go to the most appropriate place for the right care and treatment. Additionally, having specialist teams working across sites creates inefficiency and further pressure on fragile services, including challenges staffing both sites to meet 7-day working standards and variable delivery of national guidance.

Given the size and nature of our Emergency Departments on both sites, it is challenging to continue to provide the required staffing with access to the associated services that they require to run efficiently. Additionally, the majority of patients that attend the Emergency Department do not have life threatening conditions, which means that the majority of patients can be treated within dedicated urgent treatment centres that will be established as part of the new model of care. The current model of care results in a mix of minor and major injuries and ailments presenting to the same Emergency Department which in turn results in the department being overwhelmed adversely impacting clinical outcomes, patient experience and operational performance.

As discussed throughout this business case, the proposed model of care will ensure that patients access the right care, at the right place at the right time, reducing delays in treatment and improving patient outcomes.

1.1.5.2 Infection control and managing the COVID-19 pandemic

Our response to the pandemic was rapid and included significant efforts to manage the pandemic from an inappropriate and outdated estate. Many of these changes have been positively received by both patients and staff and have formed the basis for updating our model of care as the case has developed:

- A number of ward moves took place at considerable pace to accommodate patients with respiratory problems.

[7] Care Quality Commission

- A COVID-19 Assurance Committee was established and met weekly, attended by the Chief Executive, Trust Chair, Chair of the Quality and Safety Assurance Committee and other executive directors to provide assurance to the board on the approach being taken.
- We worked closely with local system health and care partners to ensure that all aspects of care, both in, and out of hospital, were considered.
- We significantly changed the way we worked, with large numbers of support staff moving to home working, which slowed the spread of the virus and freed up additional space.
- We moved to telephone and virtual outpatient appointments, where this was appropriate.

Though our proposed model of care was developed before the emergence of COVID-19; it was further reviewed through the development of the SOC and this OBC to ensure it remains current. The lessons learnt in the pandemic and the initiatives that we put in place, outlined above, have influenced our draft Clinical Services Strategy [Appendix S-16]. By consolidating care, and providing dedicated and separated facilities, the new model will ensure we can better address future pandemic challenges and better control infection (see Section 1.1.7). Our plans will allow us able to be more resilient to infection prevention and control (IPC), in particular within our ED, acute medicine and critical care departments [redacted] The key enabler to this will be separating emergency and planned care and increasing single rooms (up to 72% of new build rooms will be single rooms upon completion). Our draft Clinical Services Strategy now also takes into consideration the potential requirement to separate our flows in the event of a future pandemic. To allow for this, clinical spaces including the acute medical floor will have the ability to cohort infected patients in one place by creating distinct areas within the departments, creating increased resilience in the event on an infectious outbreak. As well as this, the pandemic helped us to understand the importance of agile working to fulfil our clinical support functions whilst working across two sites and this was considered when developing our draft Clinical Services Strategy.

This model of care is aligned with the direction of travel of many other acute providers in England (such as Northumbria Healthcare, Epsom and St Helier and Nottingham University Hospitals) and internationally. The concept of separated planned and emergency care has been endorsed by the Royal College of Surgeons, who highlighted the benefits,[8] and in numerous reports by the King's Fund[9].

1.1.5.3 Staffing high quality, safe services

Our greatest asset is our staff. At the end of 21/22 financial year, we employed 6,860 FTEs, skilled staff members who strive to deliver high quality patient centred care, all day, every day. However, we do not have all the staff we need in the right places, and we are faced with difficulties in recruiting to essential medical, nursing and AHP clinical roles within the emergency departments, critical care services and across the Trust. These challenges are driven by a need to operate services across two sites and through arrangements that are not conducive to the delivery of excellent care.

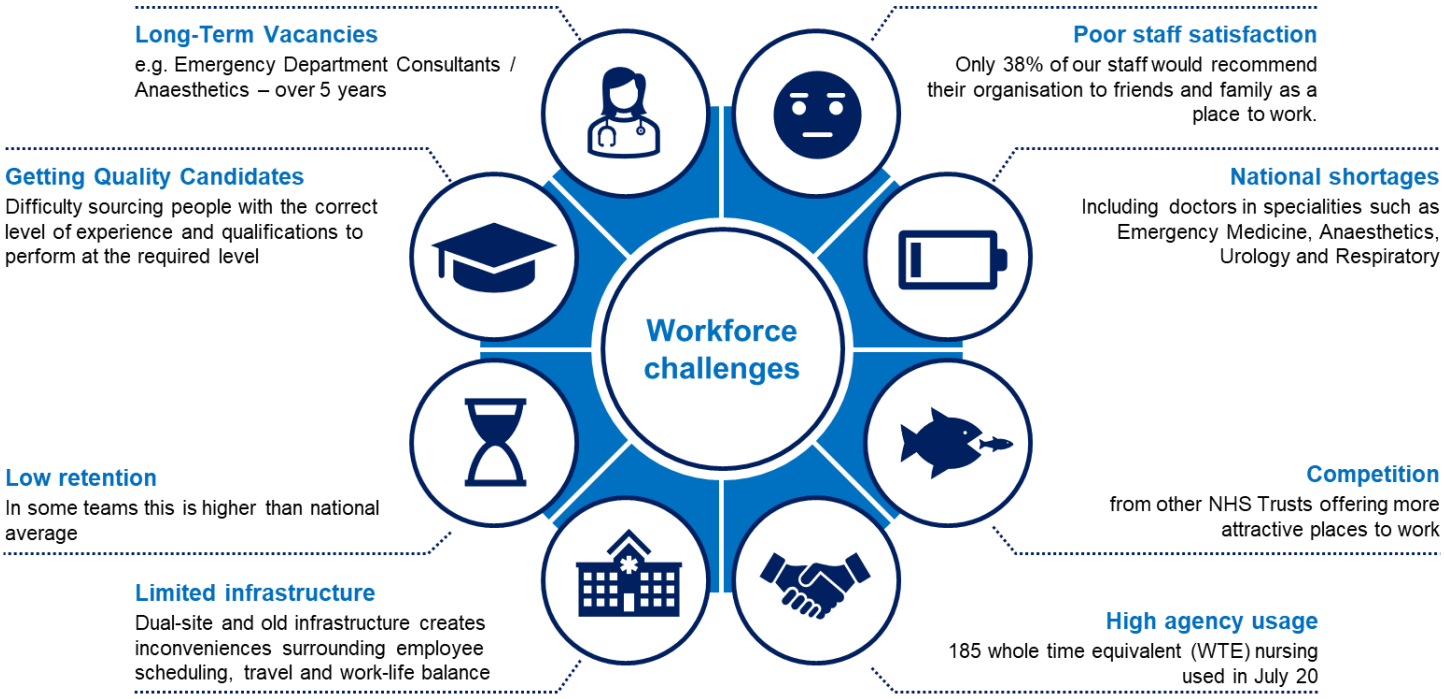
As a result of the existing clinical model and fragmentation of services, we find attracting and retaining substantive staff intensely challenging. This results in a heavy reliance on temporary staff and increased pressure on teams, which further impacts the quality of care provided. Staff costs as a percentage of operating expenditure are higher than peers, as is agency spend as a percentage of total staff costs.

To deliver services across the organisation, we have supplemented the substantive workforce with significant levels of agency support over several years. [redacted]

[8] Separating Emergency and Elective Surgical Care: Recommendations for practice — Royal College of Surgeons (rcseng.ac.uk)
[9] Reconfiguring clinical services | The King's Fund (kingsfund.org.uk)

[redacted]

Figure 2: Our key workforce challenges



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

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

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

These initiatives have had a significant and positive impact. Since 2019, the Trust has recruited 380 international nurses. Once fully trained and in post, this will significantly reduce our reliance on agency nurses, providing more continuous care, improving quality and contributing to financial sustainability. In addition, the Trust supports c.80 apprentices each year in a range of professions including clinical roles such as Operating Department Practitioners (ODPs), Allied Health Professionals (AHPs) and Nursing Associates. However, these initiatives will not be sufficient to address long term sustainability issues unless we also reconfigure our clinical services. Day-to-day operational plans are in place to ensure the care and safety of patients within our clinical services, but a long-term strategic solution is urgently needed to make us an attractive place to work, with sustainable staffing arrangements.

Running duplicated services across two sites presents many workforce challenges and results in a poor employee experience for our medical and non-medical teams, compounding the challenging recruitment situation. For the medical workforce, the current service configuration and the requirement for consultants and other specialist staff to cover emergency admissions can, at times, limit the ability to provide senior patient reviews. Currently, we are unable to achieve seven-day services clinical standards in our duplicated services. In addition, we are unable to achieve

safe staffing guidance standards (such as RCEM[10] and RCP[11]) in many areas. For the non–medical workforce the challenges are similar. Senior expertise is split across two sites and the learning environment and provision of workforce development is challenging.

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

The possibility of the new clinical model and service reconfiguration has attracted staff to some key specialties and failure of delivery of the HTP raises significant risks of loss of staff and the potential for failure of these specialties to be able to deliver care to our communities. The most significant areas are emergency medicine and Critical Care, which already has significant staffing concerns.

Our current buildings create operational issues that mean staff are unable to perform their roles efficiently. This creates a poor staff experience in comparison to other, fit-for-purpose, hospitals at a time when competition for talent in the NHS is intense. The HTP is not intended as a complete solution to this however the delivery of specifically designed areas of emergency medicine, acute medicine, oncology and haematology as well as critical care will be transformative for staff who work in these areas.

Our low digital maturity also has a detrimental effect on our attractiveness as an employer, as our processes remain paper-heavy and labour-intensive. There is a need for the Trust to be equipped with digitally enabling infrastructure to allow the organisation to fully move away from paper processes and automate time-consuming elements of both clinical and administrative roles, to help free up staff for value-adding tasks that directly improve patient care. The Trust are investing heavily in this area through the delivery of the Trust's digital strategy, and HTP is a key component in improving the Trust's digital infrastructure. Both HTP and the wider digital programmes have been developed in tandem to ensure implementation is efficient and aligned as possible.

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

1.1.5.4 Buildings in need of modernisation

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

The latest Estates Return Information Collection (ERIC) data, outlined in Table 9, highlights the need to address £39.1m of backlog maintenance. Importantly, the £22.6m of high and significant backlog cannot be addressed through the current level of allocated capital resources. As a result, regardless of which option we proceed with, a substantial amount of capital will be required. Failure to maintain the estate will see an increase in unsustainable revenue costs, as patients require their treatment to be outsourced. Further, this will see adverse societal impacts from delayed and inconsistent care which are explored in detail within the Economic case.

[10] https://rcem.ac.uk/workforce/
[11] https://www.rcplondon.ac.uk/projects/outputs/safe-medical-staffing

Table 9: Maintenance backlog (2021–2026) in Trust estate[12]

Estates Criteria	PRH	RSH	Total
Gross internal floor area (m²)	54,009	67,708	121,711
Not functionally suitable occupied floor area (m²)	12,316	43,115	55,431
Backlog maintenance Year 0 (£m)	15.7	23.4	39.1
Of which high and significant risk (£m)	***9.2***	***13.4***	***22.6***

In addition to the ERIC submission, a six-facet survey refresh was commissioned in 2021. It demonstrated that the estate is expected to require investment of c. £96m over the coming five years (see Table 10) to improve patient flows and address privacy and dignity issues. There is less than 2% of unoccupied space at PRH and less than 3% at RSH, which does not provide the Trust with suitable accommodation for expansion without significant capital investment. In addition, the lack of available space does not provide existing resilience for the operational estate to use in times of crisis.

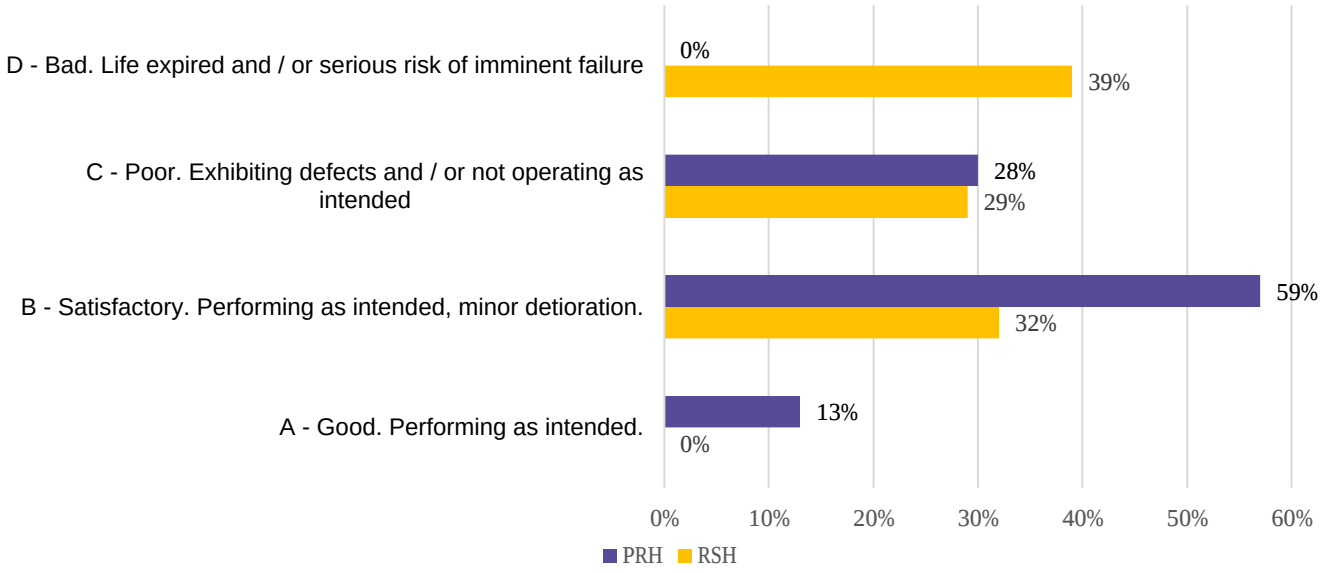
Table 10: Maintenance investment required (2021–2026) in Trust estate[13]

Estates Criteria	PRH	RSH	Total
Further remedial work likely to be required in next five years (£m)	6.9	6.5	13.4
Total investment required in estate (£m, exc. on costs)	23.4	37.8	61.2
Total investment required in estate (£m, inc. on costs)	36.7	59.4	96.1

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

[12] 2021/22 ERIC return. Further remedial work likely to be required in next five years based on site surveys completed May 2021. On costs include fees, VAT, builder preliminaries and optimism bias.
[13] 2020/21 Six Facet Survey

Figure 3: Condition of estate at PRH and RSH, six-facet survey results



The investment in the services to date has been to fix immediate issues. This has been operationally beneficial but has not been sufficient to allow us to develop a long-term solution. As a result, operational challenges with the current estate remain, including:

- **Accident and Emergency:** ED investments in 2019/20 and 2020/21 targeted the urgent and significant CQC issues around enhancing the delivery of patient care. While these investments have sought to address the most pressing estate constraints, the building rating has only marginally improved to 'poor' status. At PRH, the ED has evolved over time with extensions to the clinical area; poor adjacencies have created an inefficient use of staff time and resource. The size and volume of accommodation is inadequate compared to modern standards and nursing staff must often care for patients in areas that do not allow for easy observation. Whilst every effort is made to ensure that the pathway for an adult and child is separate, the layout and availability of space often makes this difficult to achieve. Currently, existing wards within the ward block accommodate 37 beds at 979m^2. New ward standards for 32 beds are approximately 1,237m^2, providing a 258m^2 larger footprint with less beds and more side rooms. This will reduce issues surrounding patient privacy, dignity, and infection control.
- **Inpatient wards:** There are currently no dedicated isolation rooms at either PRH or RSH. COVID-19 required the introduction of six temporary pods in critical care, however this does not address the longstanding issues that will be further exacerbated by COVID-19, norovirus and influenza in winter. At RSH – a site with over 400 inpatient beds – there are only 23 single rooms with ensuite facilities; this equates to approximately 5%, compared to a national standard of 70%. Due to the age of the wards, there are an inadequate number of toilets, showers and storage. The design of these areas does not support the dignity of patients nearing the end of their life, bariatric patients, or those with dementia. The existing buildings do not enable us to fully address the COVID-19 segregation requirements as many wards are constrained by their existing footprint and therefore unable to meet the Health Building Notes (HBN) bed centre spacing standards of 3600mm. In many areas, the Trust has bed spacing of 2,400mm centres, which affects the ability to improve patient privacy, dignity, and infection control rates. In addition to this, the lack of space in existing buildings and the resultant lack of storage in clinical areas creates additional challenges and risks for maintaining fire safety. This is because essential equipment has to be stored in aged clinical areas and corridors.

- **Clinical adjacencies and layout:** Overall, the clinical adjacencies between departments are extremely poor. There are major issues with patient privacy and dignity (e.g. due to curtain separation for major treatment, and a lack of appropriate and dedicated lifts for patients, goods and services) ,. Due to the ad-hoc layout, wayfinding is a challenge resulting in delays, frustration and poor patient experience. The new design involves the separation of public-facing lift access and patient clinical lifts, helping to solve these issues. Additionally, key departments will have improved adjacencies / co-location, enabling staff to more easily and efficiently meet and discuss patients and treatment plans.
- **Patient privacy and dignity:** We are currently rated 147th out of 159 providers for patient privacy, dignity, and wellbeing. The condition of the estate as described above, is a factor in our ability to provide high quality care in relation to these three areas as maintenance is a constant challenge in a poor, inadequate estate.
- **Poor WIFI and 4G connectivity for both patients and staff:** Currently, access to reliable WIFI or 5G across the Trust remains patchy, with many "black spaces" where access is limited or entirely unavailable. The reliance on strong WIFI or 4G data is fundamental to the future direction of digital excellence in healthcare. The increase in mobile devices including tablets, laptops and mobile phones has increased the expectation on performance from the data network and accessibility of WIFI.

The HTP is a transformational investment and is intended to drive significant improvements across clinical quality and productivity, patient experience, workforce experience – and improvements to the estate. It is not intended to resolve all of our extensive estates issues, but it will enable critical changes required to serve our growing populations needs and set us up for future transformative phases. Critically, it will enable us to implement a modernised clinical and workforce model that will help us to move towards a position of more operational and financial sustainability.

1.1.5.5 Our digital case for change

Our infrastructure does not support our future digital technology ambitions.

Despite the challenges of the COVID-19 pandemic, we have successfully delivered digital solutions that enable our staff to work remotely, updated 98% of our laptops and mobile devices and enhanced our safety and security by upgrading our approach to cyber and resilience. Following the pandemic, we have also inherited more technologically advanced ways of delivering care, such as virtual appointments for patients via Attend Anywhere software.

We have developed an ambitious 3-year Digital Strategy [Appendix S-05] and roadmap [Appendix S-06] to securing a future as a digitally enabled organisation. The Digital Strategy builds upon the work to date and will take us from where we are now to a position where we are able to provide a better care experience for our patients, while also making the most of digital opportunities in the future. We have been making great strides towards achieving the aspirations of our strategy – see more in Section 3.1.1.3 – however, we realise that more remains to be done.

Despite the progress we have made towards digitisation, our organisation remains digitally immature, falling short of nationally set minimum digitisation standards, as outlined in Section 3.1.1.2. Our 3-year Digital Strategy [Appendix S-05] will support us in working towards Level 5 on the HIMMS EMRAM digital maturity model and aligning with core capabilities in the NHS England Frontline Digitisation Minimum Digital Foundations.

A current barrier to improved digital maturity is our infrastructure: our network and infrastructure does not support the implementation of electronic patient records and the systems that would allow the Trust to become paper lite and provide higher quality of care to patients. At present, our infrastructure does not enable the shift for both patients and staff to increase the use of portable devices both on and off the hospital site. Although 4G signal is available across both of our sites, access to network on portable devices is not comprehensive. WIFI access on the existing estate

is patchy, with many “black spaces” where signal is limited or unavailable for both staff and patients. In addition, we have significant work to do on ensuring our data is cleansed, is of good quality and can integrate across multiple systems.

Furthermore, the Trust's hospitals are based in rural, isolated parts of the country, where patients can often struggle to consistently engage with face-to-face care, due to difficulties with travel. We understand the need to move towards a model where patients only attend the hospital when it is required, however, acknowledge that our current infrastructure does not allow the flexibility for patients or staff to undertake appointments, receive care and engage with services, in more technologically advanced ways.

Though we have a long way to go, we are committed to becoming a technologically driven organisation and HTP gives us a unique opportunity to bring our digital technology ambitions to life. Whilst it will not address all the digital challenges we face, we plan to embed the Trust's plans and aspirations for digital technology into the fabric of the estate through HTP, ensuring that the new hospital has the modern, smart infrastructure to enable further digital development. We will be able to ensure that our network infrastructure can support our exciting plans for the future and that we have the right number of devices to support a more mobile and digitised model of patient care.

Building the new hospital estate to support the digital strategy and digital requirements for the future will ensure that the new hospital is an enabler for delivering ambitions of both our Trust and the Integrated Care System as a whole, mitigating the impact that rural geography has on patient care and moving ever closer towards a model of care closer to home.

1.1.6 Projecting forward into the future

Our strategic challenges will worsen if we do not act. STW faces growing pressures that make our current service configuration unsustainable. These issues of future demand and sustainability increase the need to progress this proposal as the HTP is a priority scheme within the ICS Plan and is part of the STW ICB JFP.

1.1.6.1 The opportunity for change within STW ICS

Health and social care providers in STW are all facing significant challenges. Key challenges that the system faces include:

- High levels of avoidable admissions
- High occupancy rates
- High levels of MFFD patients
- Poor patient flow
- High system deficit

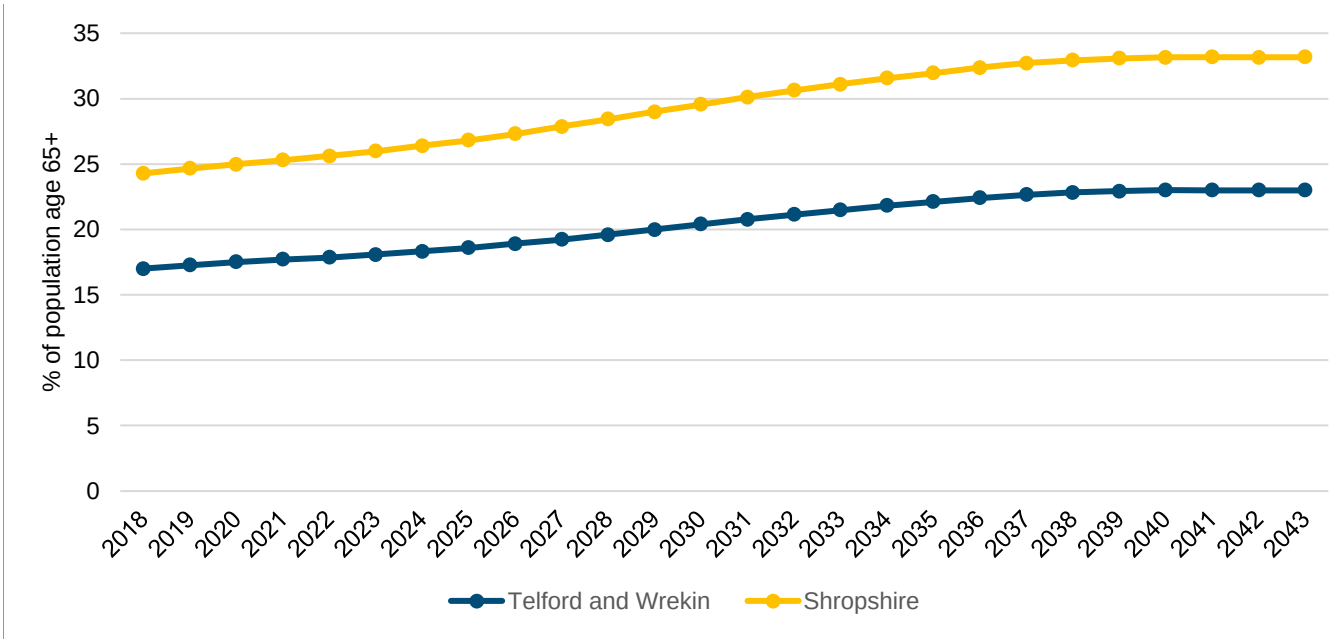
Current demand for services within STW continues to rise and outstrips the funding available (with historic underfunding of community and local services), putting pressure on hospitals, GP practices and social care. The populations across the Shropshire, Telford & Wrekin and Powys areas have a range of different needs for health and social care services. This need depends on several factors, including population demographics such as age and deprivation (with more younger people in Telford & Wrekin); as well as whether people are living with one or more long term health condition, such as diabetes, asthma, or a mental illness (with more long-term conditions in Shropshire).

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

2043[14]. This is higher than national profile which shows c.18% of the population is over-65 in 2018, growing to c.21% by 2030 and c. 24% by 2043[15].

The pattern of demand for services within STW has shifted; there is a greater need for services that can support frailer people – often with multiple long-term conditions – to continue to live with dignity and independence at home and in the community. The configuration of local care services across STW are not currently equipped to cope with this pattern of demand. As well as this, STW has a number of hard-to-reach areas. Most of the geography is more than 30 minutes from a hospital, with some areas requiring over an hour of travel, creating additional challenges.

Figure 4: Population growth of people over the age of 65



An additional challenge in the provision of healthcare within Shropshire and Powys is the number of patients that live in remote, rural settings; this presents a challenge to developing consistent, sustainable services with equity of access and is highlighted in the ICP Strategy [Appendix S-04]. Multiple local authorities within the area can also be described as low wage economies, despite Shropshire being a relatively affluent county. Consequently, the wider determinants of health including education, access to employment and housing are significant issues to consider when developing services that support good physical and mental health. Further detail on the challenges that face our local population including a summary of the ICS JSNA is provided in Section 1.1.2.1. The implications of meeting this demand and new models of care are described in Section 1.1.9.

1.1.6.2 Out of hospital care (Local Care Transformation Programme)

To address the problems outlined above, the ICS seeks to fulfil the following objectives:

- Improving health outcomes for local residents.
- Implementing a community based integrated health and care delivery model.
- Focussing on prevention and early intervention.

At the core of this is a greater focus on integrated care services, with all providers in the system joining up to focus on early intervention and increased prevention. Through multi-professional teams, joined up across providers, with access to consistent information, pathways and approaches, we will ensure patients tell their story once, with a holistic treatment and management plan and approach. This will enable us to ensure our population stay healthy, in

[14] ONS Population projections
[15] ONS Population projections

their own homes and receive the right care, at the right time, in the most suitable location. We will utilise a Place-based working approach with a focus on addressing health inequalities.

As part of this, the ICS has identified the LCTP as one of six 'Big Ticket Items' across ICS that will address the needs of the local population.

This programme will see the demonstrable shift to an integrated model of service delivery. This includes a radical transition from services that are reactive to illness, to models of care that focus on proactive prevention and early intervention. The ambition of the LCTP is that:

In Shropshire, Telford & Wrekin, our system will build on existing good practice and develop more systematic, preventative, integrated interventions that will support the independence and wellbeing of residents in our local communities.

The LCTP will deliver on its ambition to shift to an integrated model of service delivery through five key activities:

1. Avoiding admissions to hospital for patients where care is better received in another location.
2. Implementing a discharge to assess model where patients are assessed in their own homes.
3. Opening 250 virtual ward beds focussing on frailty, respiratory and cardiovascular patient cohorts.
4. Employing an anticipatory care approach for residents identified as having a high risk of non-elective admission.
5. Proactively managing the community bed base.

The timescales to deliver the LCTP are in-line with the implementation of the Acute Clinical Model – Winter 2026/27.

The LCTP has significant interdependencies with the HTP and as such, the two programmes are working closely together throughout delivery. As outlined above, population health intelligence and insights predicts a growth in STW's ageing population, with an expected increase in demand and need for health and care support. Our forecasts suggest an increased demand (for adult general beds, excluding ELDC, critical care, paediatric maternity, and neonates) equivalent to 169 beds by 2026/27.

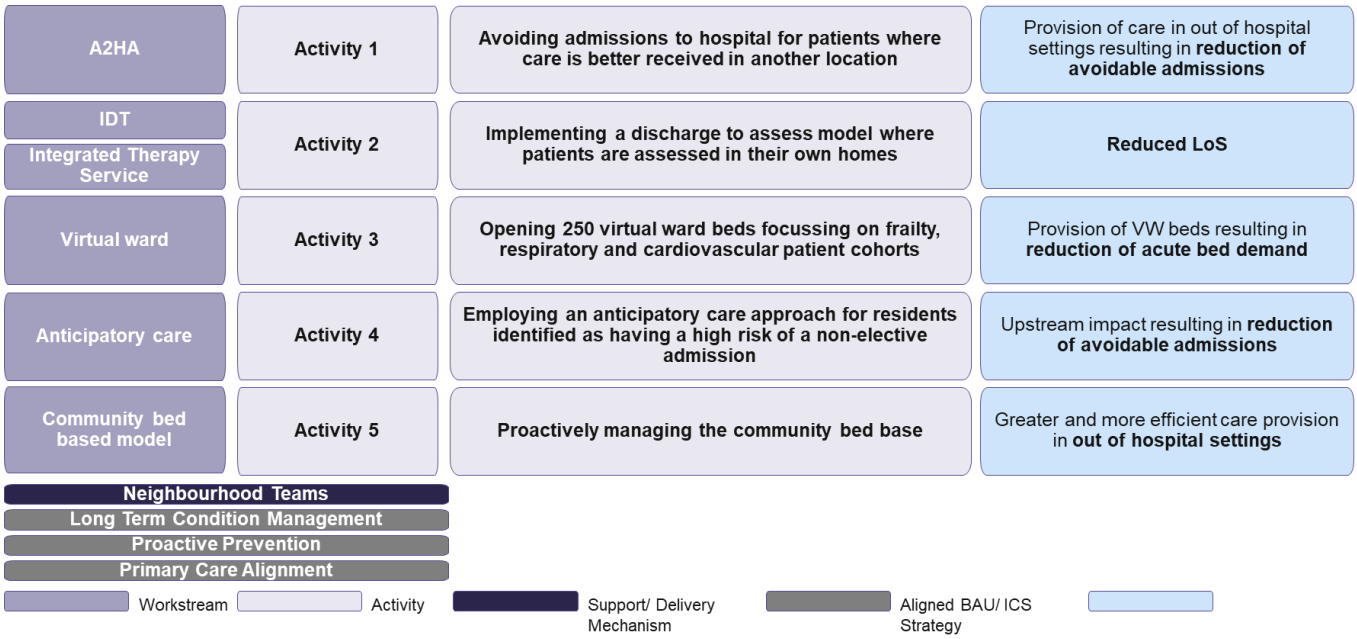
The bed modelling for HTP (Section 1.1.9) assumes a growth suppression equivalent to 151 beds through 'community shift' by 2026. The LCTP will be the driver for this community shift. The activities within the LCTP will contribute to reducing pressure on the acute parts of the system through reducing non-elective bed days.

There are three benefit areas of the LCTP that will contribute to the 151 bed-demand reduction by 2026 through the community shift and integrated services:

1. **Avoiding non-elective admissions** through interventions in community and primary care settings, where care could be provided in out-of-hospital settings.
2. **Shortened Length of Stay** due to more timely and efficient discharges through the implementation of a **Discharge to Assess** model.
3. **Reducing demand on acute beds** through more care provision in a **Virtual Ward** setting.

The LCTP has been in its current formation since the summer of 2021; although system architecture has evolved since its inception. The 5 focus activities of the programme are supported in planning, implementation, and delivery by its workstreams, as outlined below in Figure 5:

Figure 5: LCTP Focus Activities



The programme workstreams will go through design, testing, implementation, evaluation and transition to business as usual phases to become fully operational. Some workstreams, such as Alternative to Hospital Admission (A2HA), are currently operational while others, such as anticipatory care, are still in planning stages. It is expected that all workstreams will have transitioned to BAU by Q1 2026/27.

As outlined above, both programmes are working closely together to support each other. A key part of this is the inclusion of the Senior Responsible Owner of each programme on both Programme Boards. In addition, the LCTP feeds into the weekly HTP Delivery Group on updates and progress and provides an opportunity for the programmes to join up in suitable areas and maintain alignment.

A key enabler to implementing the LCTP will be securing the required funding to support new models of service delivery. It is one of three transformation initiatives being funded through national seed funding and system allocation from achievement of growth suppression. A small, central LCTP programme team has been in place since 2022/23 to provide strategic leadership, oversight, and support to the design, delivery, and implementation of LCTP transformation initiatives, funded through the Recovery Support Programme (RSP) financial allocation. The system has submitted a bid to bolster this team with further RSP funding and an outcome on this bid is anticipated shortly.

Ongoing pathway redesign is incorporating workforce planning and modelling in a coordinated and sequential way, to ensure that sufficient corporate, clinical, care and support staff are recruited to achieve programme targets. Non-recurrent investment will also be required. Some funding will be sourced from ICS central funds, and this will be achieved through reorganising and freeing up resources by identifying system inefficiencies and improving working practises. Business cases for each workstream are currently in development to secure the necessary funding.

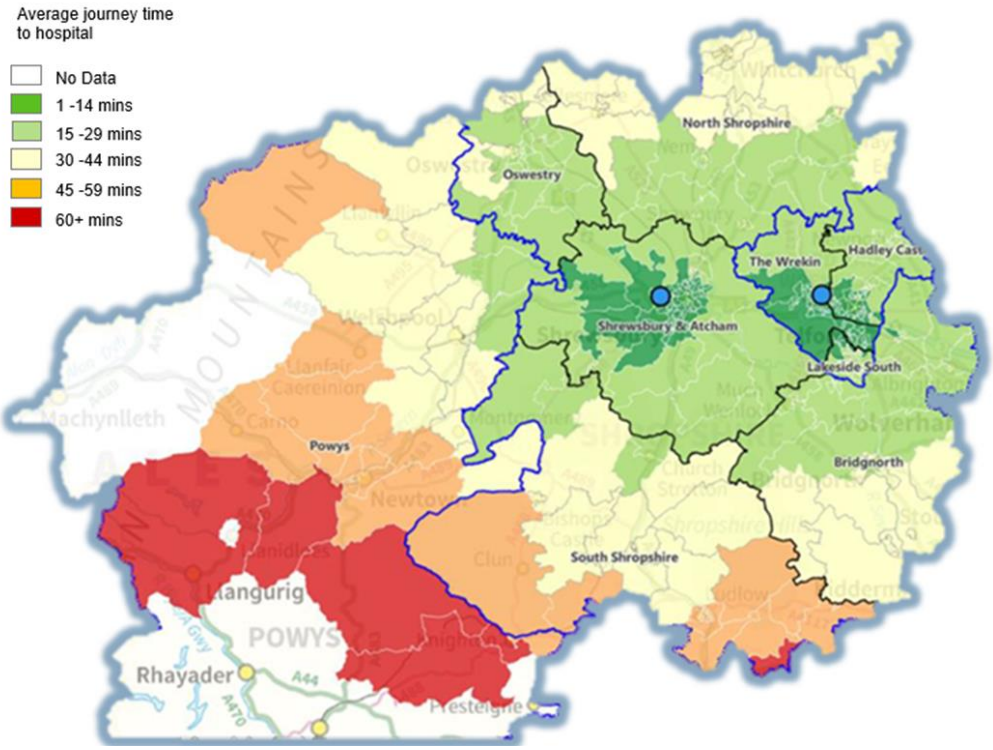
The strategic narrative is set out in Appendix M-10, which provides detail around the workstreams, benefits, impacts, funding and risks associated with the LCTP. As the programme develops more detailed service solutions, and tests these, further detail will be available on how these new services will work, improving integration across acute, community, primary, social care and third sector partners, as well as with our new UTC and ED model.

1.1.6.3 Responding to the needs of the population

As a Trust within STW ICS, we face many of the challenges outlined in Section 1.1.6.1. We are the main provider of Secondary Care Services from two hospitals, PRH and RSH, serving around half a million people in Shropshire, Telford & Wrekin and Powys.

The growing and ageing population within STW highlights the need for the HTP. Our services are unable to cope with demand currently and this will only deteriorate as the pattern of demand continues to change. Figure 6 also shows patient travel times to each of our sites, which helps to highlight the problems for the local population in hard-to-reach areas. The changes to the clinical model as part of the HTP will help to reduce health inequalities, often associated with these hard-to-reach areas. This is discussed in more detail in Section 1.1.8.

Figure 6: Our geography (average current journey times to nearest hospital)



1.1.6.4 A local healthcare system in deficit

The Shropshire, Telford and Wrekin system is part of the National Recovery Support Programme – Level 4 of the NHS England and NHS Improvement (NHSEI) System Oversight Framework. The system is therefore subject to significant scrutiny around finances and financial decisions, with a specific requirement to develop an approach to recovering a deteriorating financial position.

A system financial framework was therefore developed and agreed by all organisations and all system partners are working closely together to develop a roadmap for financial recovery.

SATH is the greatest contributor to the current system deficit, representing £45.5m of the overall planned £57.1m deficit in 2023/24.

Key factors driving the deficit include:

- duplication of services across two sites and an inefficient clinical model
- increasing demand for urgent and emergency care services above planned levels, including continued use of escalation capacity, incurring agency premium costs,
- greater demand requires more workforce capacity – together with continued high levels of vacancies and less attractive working environment - this leads to high use of temporary and agency staff (exceeding the NHSE ceiling rate, see Section 1.1.5),

- increased costs of service delivery due to energy, clinical waste and higher estates maintenance costs caused by an aged building stock,
- minimal delivery of efficiency improvements, and
- unrecovered healthcare income.

Providing duplicate services across two hospital sites creates structural costs of at least c.17.2m[16] got that could be removed by consolidating clinical services. Delivery of the proposed clinical model will help to address these issues and has the potential to significantly improve the financial position of the Trust and STW. This is considered in detail within the Financial case.

The Economic case details the cash releasing benefits that will be generated from the HTP and accrued to SaTH. Broadly, these fall into the categorise of Estates, Patient Safety, Clinical and Workforce benefits, which align to the main drivers of the deficit as detailed above and will therefore contribute substantially to the System deficit. Additionally, it is important to note that without this investment, the negative societal impacts associated with capacity constraints will grow at an increasing rate. The BAU scenario outlined in this OBC outlines both the detrimental financial and societal impacts to the population of STW, should we continue to operate as we currently are.

STW is under intense national scrutiny to resolve the deficit position. The HTP is a specific enabler of the STW recovery plan – this scheme is not merely aligned to STW strategic aims, but STW is placing dependency upon successful delivery of this scheme to support its financial sustainability plans (see Section 4).

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

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

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

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

Table 11 outlines the key benefits of the proposed clinical model.

16

Table 11: Benefits of the future service model

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

A&E Local Model at PRH

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

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

Separation of emergency and planned care

The draft Clinical Services Strategy [Appendix S-16] is strongly aligned with the Royal College of Surgeons’ recommendation to separate planned surgical admissions from emergency flows. It creates a site specialising in planned care with planned day case and inpatients attending a hospital dedicated to their care (supported by post-anaesthesia care unit and capacity to stabilise and transfer patients if needed), without the additional disruptive effect of emergency admissions placing pressure on the fixed bed base. In line with recommendations made by the Independent Reconfiguration Panel, plans include the site specialising in planned care having a 24/7 urgent

treatment service, which would enable c. 65% of patients who would have attended the traditional Emergency Department to be seen on that site. The urgent treatment model would enable as much clinically appropriate care to be delivered locally as possible, incorporating a Diagnostics and Frailty Service and Same Day Emergency Care (SDEC) Service.

A dedicated emergency care centre (at the site specialising in emergency care), with a single dedicated and purpose-built emergency department (including a dedicated Paediatric Area) and critical care department would be supported 24/7 by all the required medical and surgical specialities. These are planned to sit alongside on-site, 24-hour urgent care services, and a large SDEC centre with specialist medical, paediatric, and surgical assessment areas. The capacity required has been modelled using the Directory for Ambulatory Emergency Care 6th Edition (Feb 2018).

The Trust continue to work with the national clinical director for Urgent and Emergency Care (UEC) on the development of this enhanced urgent care service and model of care to ensure that our model is consistent with current and developing models of urgent and emergency care services across England. It will be important to ensure that patients are clear on where to access the right services. Our approach to UEC is supported nationally and is aligned to key elements of the recent NHS Delivery Plan for Recovering Urgent and Emergency Care Services that was published in January 2023:

- The HTP will ensure that patients have access to the right care, in the right place, in a timely way. Delivering the ambition will support more patient centred, personalised care, accessed closer to, or at, home, as well as more integrated services.
- The HTP will help to reduce the current bed occupancy, to safer and more efficient levels due to improved patient flow.
- The HTP will increase planned bed capacity at SaTH, driven by demographic changes resolved by community schemes as well as improved occupancy rates.
- The A&E local model at PRH and the UEC / ED at RSH ensure that the sickest patients are prioritised for ambulances and that patients who don't require face-to-face treatment can be transferred quickly to services more appropriate for their needs.
- The site specialising in emergency care will help to reduce variation in care when patients arrive in A&E and provide access to SDEC so patients avoid unnecessary overnight stays.
- Both sites will have on-site SDEC facilities to ensure fewer unnecessary delays in leaving the hospital.
- The development of specialised roles for the site specialising in planned care will increase the use of advanced practitioners at SaTH.
- The enhanced Urgent Treatment Centre (UTC) at the site specialising in planned care will ensure that patients can get better, quicker care.

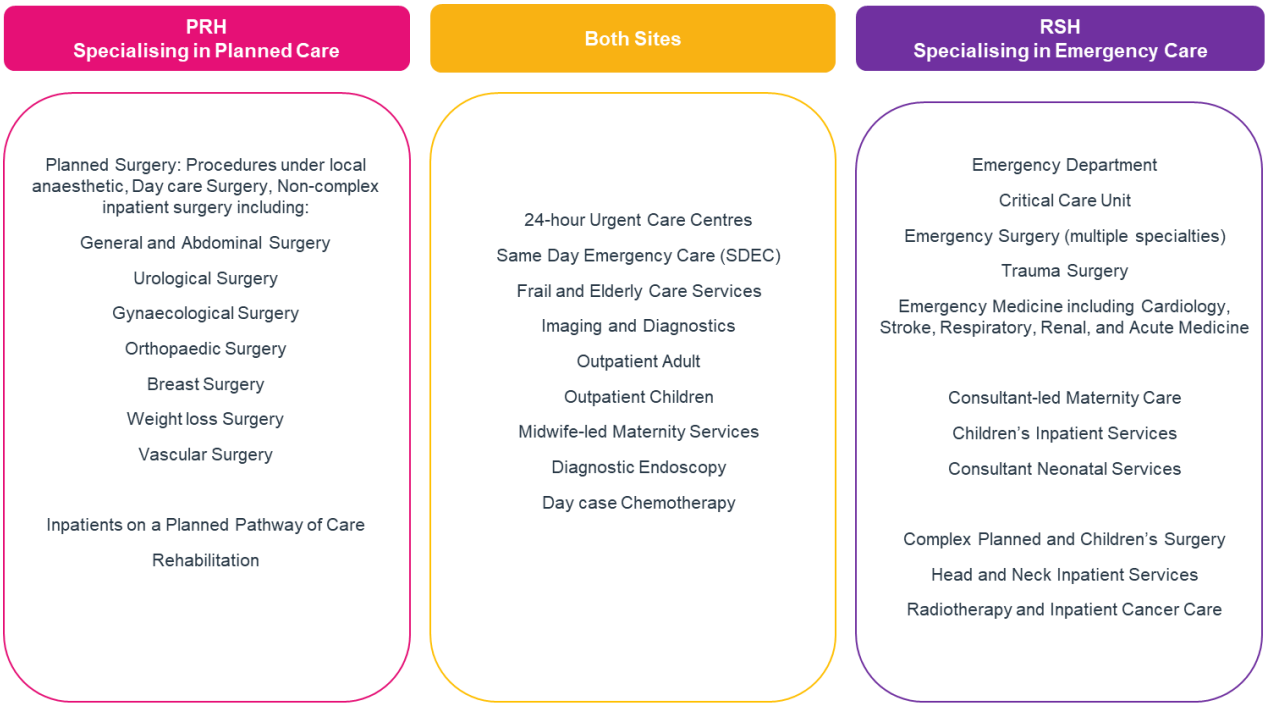
This proposed configuration will result in:

- RSH specialising in emergency care with a dedicated and purpose-built emergency department (with a dedicated Paediatric Area), where specialist doctors treat the most serious cases, the hospital is safer and provides better outcomes for patients and a reduced length of hospital stay.
- The consolidation of planned care at PRH, which will greatly improve the efficiency of the care provided, allowing for the reallocation of appropriate surgical capacity that will support the delivery of effective planned care services. All of these will contribute positively and significantly to the achievement of waiting times and RTT.
- Sustainable improvements in performance against ED standards, through more effective workforce deployment.
- Allocated beds at PRH for planned operations, without a separate competing flow of admitted emergency patients.

- Patients waiting for less time for their operation and easier access to appropriate rehabilitation, ensuring the earliest possible day of discharge.
- A reduction of short notice cancellations and delays. In 2019/20, over 500 patients had their planned procedure cancelled due to the use of beds for emergency admissions and this was further exacerbated by the impact of Covid-19.
- A reduction in the risk of hospital or community acquired infection, helping us to better manage any future pandemics.
- Reduced likelihood of operation cancellation due to bed unavailability. This will help to prevent further complications including depression, urinary tract infection, wound infection, and myocardial infarction.
- The ability to attract, recruit and retain a highly skilled and focused workforce, including both clinical and administrative teams, consolidating fragmented teams which will support improvements in the care provided.
- An environment that will support continuous service improvement.

Figure 7 outlines the services that will be available on both sites as well as the services specific to each site after the HTP has been delivered.

Figure 7: High level outline of services on each site



1.1.7.1 Improved clinical effectiveness

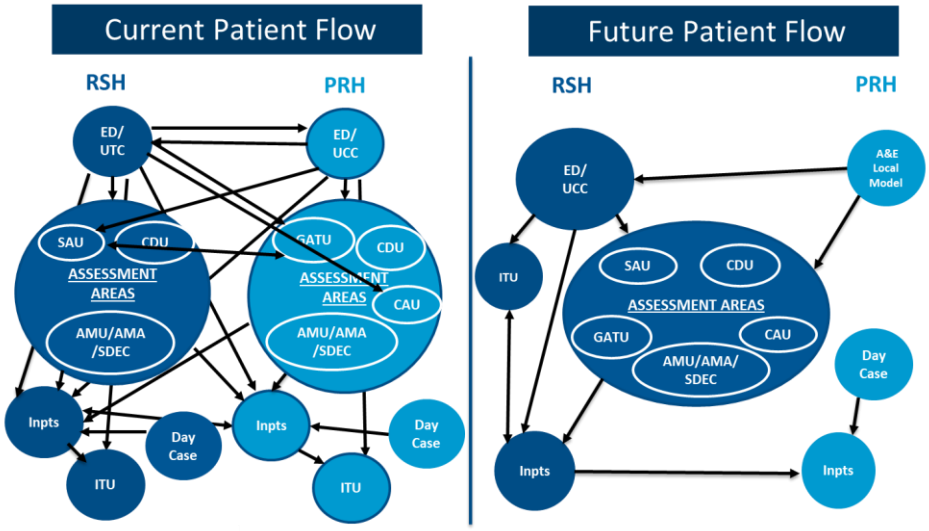
Simplification, clarification and re-mapping of patient care pathways is essential. The proposed clinical model develops planned care and emergency care acute hospital centres, leading to improved patient flow. The core element of the proposed clinical model is that all patients are seen in the right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

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

- greater availability of consultant-delivered decision-making and care,
- improved access to multi-disciplinary teams,
- delivery of care in an environment suitable for specialist care, and

- greater collaborative working for specialists who will be able to treat higher volumes of critical cases to maintain and grow skills.

Figure 8: Redesigned pathways



1.1.7.2 Well-designed physical settings with appropriate capacity

Modern design features and appropriate physical settings have been shown to yield a number of different benefits in healthcare settings. For example, evidence shows that access[17] to daylight[18] provides a reduction in the average length of hospital stay, quicker post-operative recovery, reduced requirements for pain relief and quicker recovery from depressive illness. Whilst only a proportion of the site will be new and refurbished areas, these will be designed in line with modern standards and follow best practise including the HBNs and Health Technical Memoranda (HTMs). The designs will also acknowledge guidance from the Green Book and Model Hospital as well as reflecting the requirements of MMC and including a clear strategy to implement NZC targets for the HTP and the wider Trust.

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

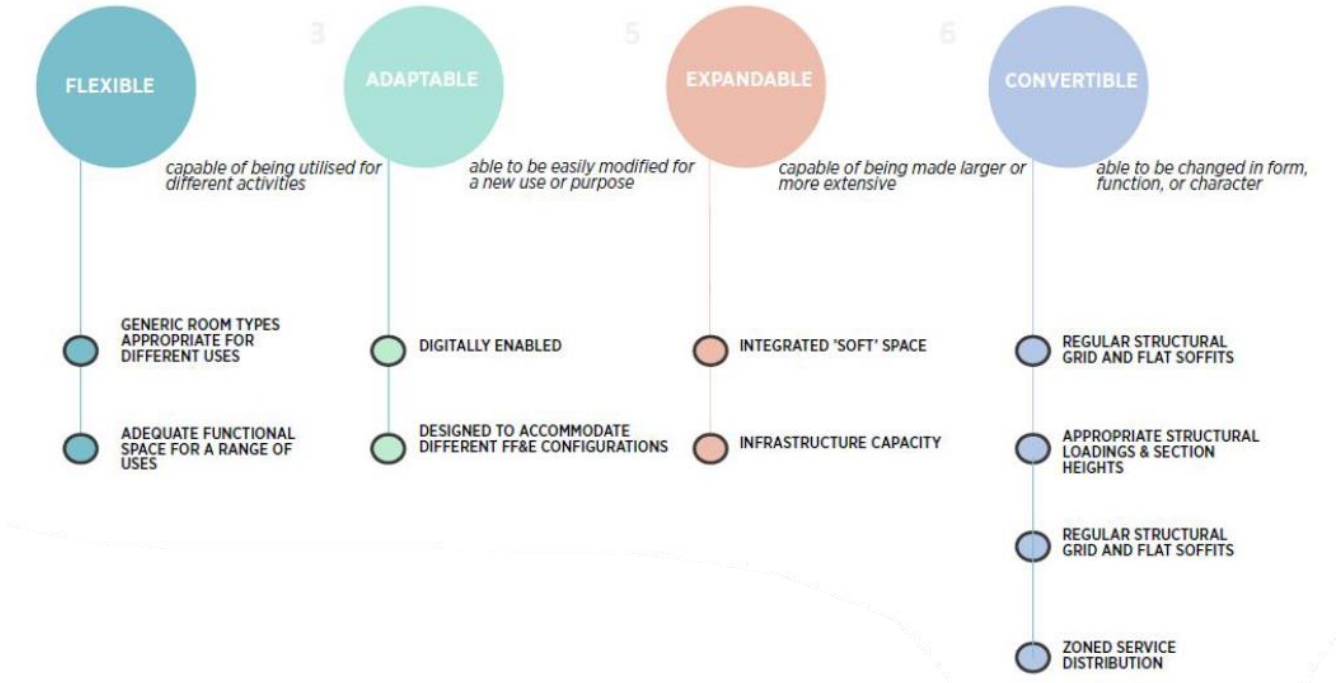
- **Improved clinical adjacencies and flows through focused redesign:** Poor clinical adjacencies and pathways and cramped facilities are not conducive to the levels of efficiency or infection control required, especially during a pandemic. Reconfiguring currently dispersed services is expected to deliver benefits in clinical flow, efficiency and safety (through ensuring that patients have access to the most appropriate services throughout their treatment), reducing their length of stay and encouraging standardised provision of specialised input.
- **Greater capacity and space in departments:** The proposed design strategy for rooms (Figure 9) is based on utilisation, improvement and expansion of the current library of repeatable rooms and then assembling these into repeatable clusters to allow expansion, adaption and flexibility. The proposed reconfiguration includes improved ward space with appropriately sized facilities. Within the design, there are 63 room types, of which 15 are repeatable including bedrooms, single, multi-clean, assessment rooms, examination rooms and kitchens.
- **Modern buildings:** Improvements to the design of the hospital will support improved flow, enhanced safety for both staff and patients and improvements in wellbeing. Newer estates and facilities help to direct clinical benefits by being easier to maintain and

[17] Access - Designing Buildings
[18] Natural light - Designing Buildings

clean. In addition, improved working environments will increase staff recruitment and retention and improve staff satisfaction in the areas undergoing reconfiguration.

- **Greater provision of single rooms:** The redesigned estate will focus on ensuring a higher proportion of single rooms (72%), within the new build areas. This will support effective infection prevention and control and improve patient privacy and dignity.
- **Appropriate measures are in place to prevent negative implications from natural disasters:** The building's design from a mechanical, electrical & HVAC perspective has been designed in accordance with the HBNs and HTMs where possible to consider variances in both internal and external temperatures. The building fabric also considers solar gains, the land has been assessed to ensure that the building is not built on waterlogged areas and rain has also been a consideration where appropriate to reduce the potential impact from surface flooding.

Figure 9: The HTP room design strategy



Through the next stage of the design and business case process, we will further refine the plans, demonstrating how the new hospital will look and feel for staff and patients. This will help bring to life how staff will work in the new facility, utilising leading digital technologies that sets the standard for the rest of the hospital through the wider transformation of the estate.

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

The future model of care addresses the key issues that arose from COVID-19 and supports us as we continue to be in post-pandemic recovery. It also helps us to prepare for future pandemics and better control infections, as outlined below:

- The clinical model proposes an integrated hospital with clearly distinct sites, one specialising in emergency care and one specialising in planned care. This approach will support the response to any future pandemic, allowing for strict infection control measures and the separation and streaming of patient cohorts.
- The site specialising in planned care at PRH will be able to continue to deliver planned care to clinically assessed low risk patients and be able to operate efficiently without interruption to planned activities. Dedicated capacity will enable us to improve throughput and reduce cancellations, contributing to system-wide planned and diagnostic recovery.

- The site specialising in emergency care at RSH will be configured to accept all of our emergency patients. Due to the future design of the emergency department, this facility will have the added ability of streaming patients into segregated cohorts based on their type of infection and aligned to the infectious respiratory pathway.
- The design of the all-new buildings will reflect learning from COVID-19 and post-pandemic infection prevention and control standards. Our design plans include increased repeatable rooms and a new single ward layout at RSH with 72% single rooms, enabling increased levels of segregation and isolation of relevant patient cohorts.

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

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

1.1.8 More equitable access and support

Changing the clinical model will ensure that clinical accessibility and sustainability of services for the local population are protected due to the increased ability to offer care in Shropshire and Telford & Wrekin. Whilst Shropshire has a relatively low inequality index, Telford & Wrekin have a relatively high index. As well as providing better care for patients overall, the new clinical model will enable a reduction in inequalities due to more timely access to care and improved access points.

A continuation of the current model would increase the likelihood of losing provision of certain specialities to neighbouring trusts. This would reduce accessibility for the local population; particularly for those who are unable to travel. The new clinical model will improve our provision of services, preventing this from happening and meaning fewer patients need to travel out of the area. This will make it easier and quicker for those in more deprived areas to access the appropriate care that they need as it will reduce the costs associated with travelling to hospital. As well as this, our ability to recruit and retain a skilled workforce will improve with the introduction of the new clinical model, further enhancing provision of care. Patients will also wait for less time in ED, wait for less time for operations and have fewer appointments and operations cancelled.

[redacted] This will allow us to assess the impact of the HTP on equality and diversity in the local community. The findings from our EHIAs are discussed in more detail in Section 5.6 of the Management case. Our results highlight the need to incorporate the potential impact on access and travel for protected characteristics groups into our plans. We will work with local transport providers to ensure the site is accessible for all. To combat health inequalities, our design also ensures provision of appropriate accommodation for parents and carers, and it will support improvement of way finding for those who are visually impaired. As well as this, our digital strategy, with a commitment to digital inclusion, incorporates accessible technologies into the design of the hospital to support our workforce and community. This work undertaken by the HTP will be supported by work done by the ICS to move towards equitable care for all.

In partnership with our ICS colleagues, together we will be able to provide better support for people with long term conditions and for people living independently. This will include earlier access to a consultant opinion, less need for hospital admissions, shorter spells in hospital when needed, and less decompensation in frail, elderly people. This will mean better care for all our patients, including the most vulnerable.

In-line with the ICS' wider plans, STW have an implementation plan to address and improve health inequalities with the support of the HTP. [redacted]

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

Managing the expected growth in demand (see Section 1.1.6) will require us to provide increased capacity, aligned to changes in the out of hospital models of care. We have estimated this growth over the coming years to understand the capacity we will require. All options considered provide the overall physical bed capacity required and new pathways of care will also ensure that the utilisation of bed capacity across both sites is optimised.

The growth expected to be seen across each point of delivery (POD) is shown in Table 12. This calculation is based on age banded demographic growth, sensitive to who the consumers of healthcare services are in each POD. The 'Core Scenario' is the activity growth projection used throughout this OBC, which is the net impact of the out of hospital shift, other planned system changes and demographic growth.

Table 12: Forecast activity growth across the Trust to 2032 with no interventions beyond 26/27[19]

POD	21/22 Adjusted	26/27 Core scenario	Compound Annual Growth Rate (CAGR) 21/22 – 26/26	*31/32 Continued Growth Scenario (to be mitigated)*	*CAGR 26/27 – 31/32*
Day Cases	52,200	65,124	4.52%	***81,113***	***4.49%***
Elective Inpatient Spells	5,333	6,652	4.52%	***8,288***	***4.50%***
Non-Elective Inpatient Spells	60,008	53,052	-2.43%	***57,468***	***1.61%***
A&E Attendances	49,547	60,223	3.98%	***73,020***	***3.93%***
UCC Attendances	105,287	127,974	3.98%	***155,167***	***3.93%***

This modelling was initially developed in late 2020 in collaboration with local system partners. It has since been refreshed and we have worked in conjunction with the ICS to ensure planning assumptions are aligned.

The activity levels shown above include a significant level of demand mitigation through internal hospital efficiencies and out of hospital shift, supported by new models of care. Critical to this is the community shift assumption, which is agreed with the ICS to see 151 beds worth of activity in secondary care move into the community through admission avoidance, length of stay reduction and provision of virtual wards by 2026/27.

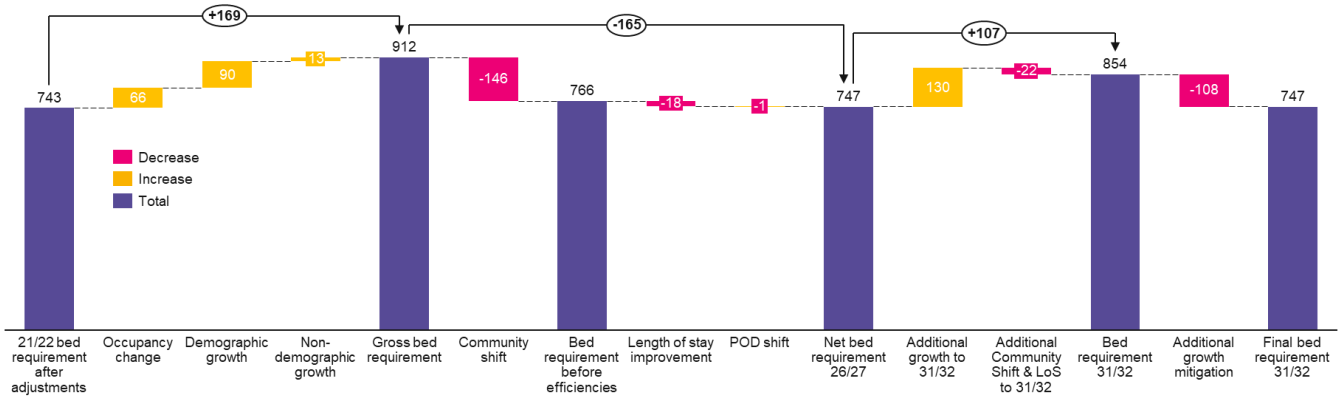
These assumptions have been discussed and approved by local stakeholders through the HTP Board and other health and care system boards and are aligned to the system planning

[19] HTP modelling, 2020

assumptions. [redacted]

[redacted] Figure 10 shows the acute bed requirements beginning from a baseline in 2021/22, applying the gross growth assumptions and showing how that growth is moderated by the community shift and system efficiency improvements.

Figure 10: Estimated bed requirements



The bed numbers shown above exclude maternity, neonates, critical care, paediatric and planned care day case capacity.

Our demand and capacity requirements were refreshed in January 2023, considering the latest ONS population projections and the latest level of system ambition for out-of-hospital-shift in light of pandemic learnings. The baseline period is 2021/22 and therefore does not reflect the increasing numbers of medically fit for discharge patients that are being managed within escalation beds. To achieve the modelling above, there is therefore an underlying assumption that this pressure is addressed by the system. Additionally, as a system we have committed to additional out of hospital interventions in 2026–2030 that will mitigate growth post-2026. This change is reflected in the demand and capacity estimate used as the basis for this OBC and can be seen in the demand projections included in Figure 10. [redacted] The assumptions that underpin the D&C model are aligned with those across the system, and with the financial and workforce plans outlined throughout this OBC.

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

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

To support improved patient flow, a reduction in bed occupancy levels is also being targeted (to align with the national standard of 89%), increasing the Trust's overall bed base requirements (see Figure 10).

Managing demand beyond 2026/27

Beyond 26/27, we have forecast what the activity will look like if it continues to grow without mitigation. The Trust is aware that this is an unsustainable position and is therefore committed to managing this to maintain safe capacity levels. The Trust and system must work together to achieve this. The system has an intention to continue working together to mitigate the growth in demand for acute services between 2026/27 and 2031/32. To do this, the system will treat

patients in more appropriate settings, closer to home where possible, and utilise new models of care, pathways and clinical interventions to improve recovery and reduce Length of Stay. Additionally, the ICS Plan [Appendix S-05] continues to focus on preventative interventions, that we anticipate will begin to have an impact in the next 5-10 years. This is outlined in further detail in the ICS Clinical Strategy.

The ICS are required to outline the specific interventions and related quantitative demand impacts that will be delivered, however, with the range of opportunities and high-level plans in place, the ICS has confidence that there are both the opportunities and plans in place to mitigate demand between 2026/27 and 2031/32.

These include:

- Continuation of the LCTP interventions beyond 2026/27. The impact of existing interventions will continue to grow as their approaches are embedded in the system. Additionally, there may be opportunities to extend the scope of existing interventions (such as virtual wards).
- Development of Phase 2 of the LCTP– the existing programme is focused on specific interventions. As they are implemented, the programme will commence planning for further interventions to ensure that patients are treated in an appropriate setting, at home and/or within the community where possible.
- Cooperative working with Powys to explore opportunities to manage care closer to patient's homes.
- The development of hospital delivered interventions utilising new pathways, new technologies and new approaches to identify, treat and manage health conditions. For example, robotic technologies in surgery are already having impacts on pathways in other systems, and we expect this type of innovation to continue and accelerate over the next 10 years.
- Preventative approaches focusing on the specific medical conditions of Musculo Skeletal health (in older age to prevent falls), Diabetes and Cardiac health and pharmacology.
- Alignment to the system's JFP (specifically in relation to UEC Recovery) by focusing on attendance avoidance, optimal discharge planning and the reintroduction of Discharge to Assess, beyond that planned between 2023 and 2026.

This work is a key part of the system's JFP and ICS Clinical Strategy and reflects the responsibilities of all organisations within the ICS to support and contribute to the plans above.

Furthermore, to support this, we, as a Trust, have undertaken some further benchmarking of Length of Stay (LOS). If the Trust were to move to the current upper decile of peer Trusts within the next 5 – 10 years, that would equate to an opportunity to save 72 beds across the Trust. This demonstrates that there continues to be significant opportunity to improve LOS (through interventions such as the above) beyond the immediate impact of this investment.

System support

The ICS are supportive of the plans that build on those developed for the SOC, to which they supported in a letter submitted to NSHE on 31st May 2022. The HTP is embedded within the ICS governance and is a priority scheme within the ICS Plan. There is ongoing ICS representation and membership at all the HTP board meetings.

1.2 Responding to the wider strategic context

1.2.1 National context

Our proposals align with Government policies and strategic priorities, delivering the NHS Long Term Plan, supporting COVID-19 response and recovery, and reducing critical risks to the delivery of healthcare. Investing in our sites represents a big contribution to levelling up

Shropshire and Telford & Wrekin and will result in the creation of two vibrant hospital sites in Shrewsbury and Telford.

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

1.2.1.1 The Long Term Plan

The Long Term Plan (LTP), published by the Department of Health (2019)[20] focuses on the need to accelerate the redesign of patient care to be able to future-proof the NHS for the coming decade.

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

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

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

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

1.2.1.2 National design principles

Throughout the development of this scheme we have sought to align to new and emerging national design principles, in particular around the focus on Modern Methods of Construction (MMC), standardisation and delivering net zero carbon (NZC). While this scheme is not part of the national New Hospital Programme, we are in dialogue with schemes that are progressing their plans through that programme, and more widely. Our programme team have experience working with other schemes and are sharing their learnings with the HTP. As other schemes progress through detailed design convergence, procurement and into FBC and delivery, we will seek to make use of these design and commercial opportunities where they have potential to contribute to our investment objectives.

1.2.1.3 Levelling up

Levelling up the country and reducing regional inequalities is “the defining mission of this Government”[21]. This includes dedicating the new Department for Levelling Up, Housing and Communities to this aim.[22] Commitments have included ***Build Back Better: Our plan for growth*** (published alongside the March 2021 budget), £4.8bn for levelling up infrastructure investments, £3.6bn regeneration fund for town centres, £2.5bn skills fund, a £12bn UK Infrastructure Bank and the relocation of 22,000 civil service jobs from London and the South East.[23]

This is an ambitious agenda to address regional inequalities. Telford & Wrekin received £23.2 million as part of the regeneration fund to support regeneration plans in June 2021. However, they received no support as part of Levelling Up Round 1, despite 25% of Telford’s

[20] https://www.longtermplan.nhs.uk/
[21] www.gov.uk/government/news/ambitious-plans-to-drive-levelling-up-agenda
[22] https://www.gov.uk/government/news/ambitious-plans-to-drive-levelling-up-agenda
[23] https://www.instituteforgovernment.org.uk/sites/default/files/publications/levelling-up.pdf; https://assets.%20publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/968403/PfG_Final_%20Web_Accessible_Version.pdf

neighbourhoods being recognised as in the 20% most in need nationally[24]. As a result, pressures on the council's budget have not been alleviated. Shropshire and Telford & Wrekin are now rated category 2 for Levelling Up and both submitted multiple bids for the next round of Levelling Up funding, highlighting the need for investment in the local area. The HTP will help to contribute to levelling up in the local area, addressing the health inequalities identified in Section 1.1.2.1and it is a step towards reducing pressures on the council's budget.

The local population suffers from high levels of deprivation and regional variation, as previously described in Section 1.1.2.2 and outlined in further detail within the ICP Strategy [Appendix S-04]. With health inequalities widening, it is important to understand the barriers that people can face in accessing our services. The ICS Plan outlines the approach to reducing health inequalities in the ICB which involves:

- Intelligence-led population health management, including equity profiling for inclusion groups
- Narrowing the gap in service and support uptake and outcomes by proactively targeting people in inclusion based on equity profiling and engagement insight
- Place-based system wide planning
- Community focused co-production

Together with these policies put in place by the ICS, the HTP will help to close the care and quality gap and alleviate healthy inequalities in the local population. The actions taken to achieve this are described in more detail in Section 1.1.8 as well as within the Management case. The HTP is therefore aligned with the Government's priorities in this area.

1.2.1.4 Sustainability and Net Zero Carbon

The Government has committed to "Build Back Greener" by decarbonising the UK economy by 2050 and the NHS aims to reach Net Zero (for direct emissions) by 2040, with an 80% reduction by 2032.[25]

We are committed to NZC, in line with the ICS and national trajectory [redacted]) that has guided the development of our options. The project aims to achieve net zero carbon operational energy-ready as part of the design and in future will meet our net zero obligations. We will, through the design and construction phases, work to meet the forthcoming NZC hospital standard for new developments. We also have a Trust Green Plan [Appendix S-07] that aligns with the objectives of the ICS. Our plans are outlined in more detail in Section 5.6.3 of the Management case. These plans will be developed further as we progress to FBC Stage.

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

1.2.1.5 The Frontline Digitisation Minimum Foundations (MDF) and NHSX Health Infrastructure Plan (HIP): Blueprint for Digitally Advanced Hospitals

Following the Covid-19 pandemic, which was a catalyst for improved digitisation of NHS services, NHSX published a delivery plan[26] aiming to digitise and connect health and care services. The main target was to continue to work towards levelling up digital maturity across health and care systems, addressing low levels of digital maturity and a high reliance on paper processes across acute trusts.

The NHS England Frontline Digitisation programme (FDP) aims to support ICSs in reaching an accepted baseline of digital maturity and accelerate the overall adoption of core technology required for real digital transformation of services.

[24] https://newsroom.telford.gov.uk/News/Details/16162
[25] https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/ ; https://www.gov.uk/government/publications/net-zero-strategy
[26] NHSX Delivery Plan - Digitise, connect, transform - NHS Transformation Directorate (england.nhs.uk)

As part of the support provided to health and care systems to 'level-up' their digital maturity, Frontline Digitisation Minimum Digital Foundation (MDF) was developed, in-line with existing digital maturity models.

Whilst we will not fully enable digitisation through the HTP design, our buildings will be fit for implementation of our Digital Strategy, which has been developed in alignment with MDF. In the development of our Strategy, we undertook high level assessments against the MDF framework as well as What Good Looks Like (WGLL)[27] and HIMSS level 5 for Electronic Medical Record Adoption Model maturity and Business Intelligence[28]. These frameworks provided a structure for planning digital delivery from 2022 to 2025 and a focused prioritisation of investment. Our programme of work puts in place the core foundations that will enable us to provide effective and safe care, while allowing us to maximise transformational and innovative opportunities in the coming years.

High-level assessments made internally at the Trust put us at Level 0 for Electronic Medical Record Adoption Model (EMRAM) maturity and Level 1 for Business Intelligence on the Healthcare Information and Management Systems Scale (HIMSS). We know that hospitals that have achieved a high HIMSS level consistently report significant reductions in medical errors, have improved readmission rates, higher operating margins, lower staffing costs, greater staff satisfaction, reductions in duplicate orders and in general have improved patient safety and the overall quality of clinical care.

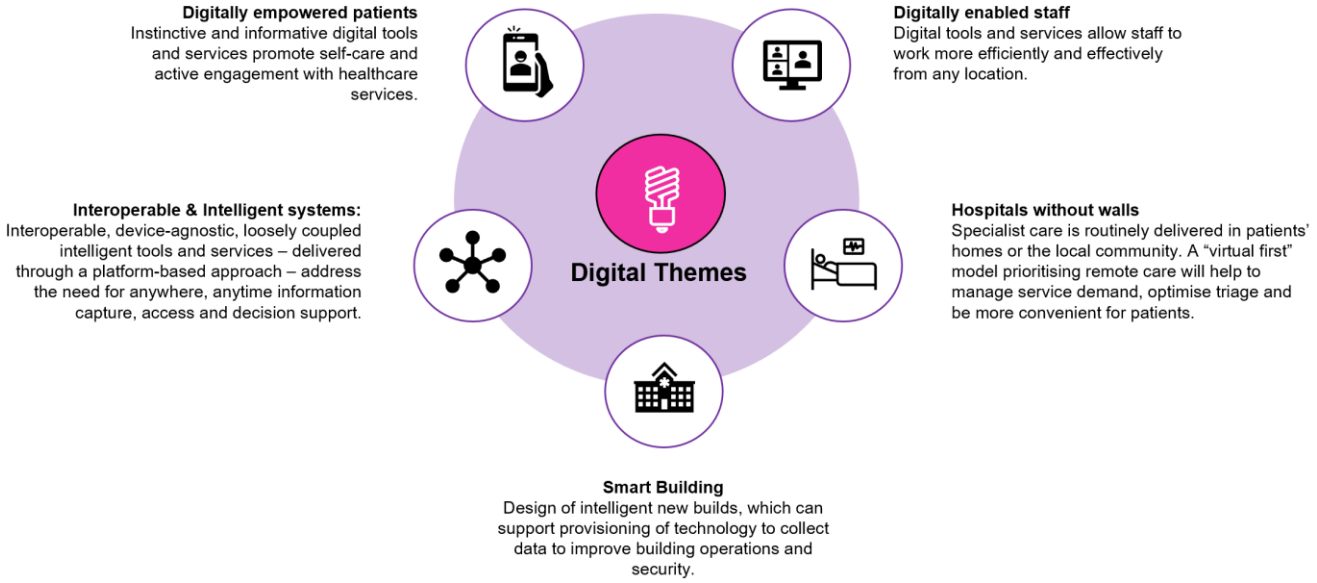
NHSX, with the support of Atos, developed the Blueprint for Digitally Advanced Hospitals in accordance with national digital priorities and frameworks. The blueprint informs the design of digital hospitals and builds on best practice and advice from industry experts around the world. It follows a set of design principles that consider the rooting of technology and data into every layer of the hospital build.

The Digital Blueprint requires digital leaders to be forward-thinking in their plans to adopt digital innovation and technology in their new hospital development plans.

The design of our new hospital estate and our Trust Digital Strategy are aligned to the recommendations within the Digital Blueprint and we will ensure that the infrastructure of our new build will be state-of-the-art and suitable for enabling the digital aspirations set out in our Digital Strategy.

27 What Good Looks Like framework - What Good Looks Like - NHS Transformation Directorate (england.nhs.uk)
28 HIMSS Maturity Models: Models for Digital Health Transformation

Figure 11: New hospital digital blueprint vision[29]



HTP includes a digital workstream, which will ensure that the delivery of the new clinical facilities / accommodation is aligned to the delivery of the digital programme. HTP will provide new infrastructure which facilitates an enhanced digital experience for clinicians.

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

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

1.2.2 Regional context

1.2.2.1 Shropshire, Telford, and Wrekin Integrated Care System

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

To meet the growing needs of the population and address regional sustainability issues (see Section 1.1.6 and 1.1.9), Shropshire, Telford & Wrekin are moving towards operating as a single health economy, working together for the benefit of the population.

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

The STW ICS Plan highlights four strategic objectives:

- Improve outcomes in population health and healthcare
- Enhance productivity and value for money
- Tackle inequalities, outcomes, experiences, and access
- Support broader social and economic development

[29] NHSX

This is underpinned by 10 ICS pledges:

1. We will improve safety and quality.
2. We will integrate services at place and neighbourhood level.
3. We will tackle the problems of ill health, health inequalities and access to health care.
4. We will deliver improvements in mental health, learning disability and autism provision.
5. We will support economic regeneration to help improve the health and wellbeing of our population.
6. We will respond to the threat of climate change.
7. We will strengthen our leadership and governance.
8. We will increase our engagement and accountability.
9. We will create a financially sustainable system.
10. We will make our ICS a great place to work so that we can attract and keep the very best workforce.

To support the delivery of our ICS strategic priorities, pledges, and broader place and neighbourhood plans, there are four key programmes that we will prioritise for delivery through our 5-year plan. These are:

- Local planning and regeneration
- Climate and green planning
- Hospital Transformation Programme
- Local Care Integration Programme

These will be supported by four enabling strategies:

- Workforce
- Digital
- Communications and Engagement
- Population Health Management

As outlined above, this programme (HTP) is a key priority for the ICS and a key part of achieving and contributing to the strategic objectives and pledges set by the ICS.

1.2.2.2 Recovery support programme

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

The new NHS Oversight Framework (NOF) for 2021/22 came into effect from the 1st July 2021. The Trust and STW are currently in Segment 4 of the NOF and part of the Recovery Support Programme (RSP) for both quality and finances - this replaces the separate quality and finance special measures programmes that were previously in place. In terms of finances, the ambition is to deliver realistic productivity and efficiency improvements over the next three years, ensuring that services are clinically and financially sustainable, supporting. the Trust to exit RSP.

1.2.2.3 Elective recovery

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

We have elective capacity constraints that persist annually, coupled with ever-increasing winter emergency surges and COVID-19, which has resulted in a significant elective backlog. Planned activity across the system has been compromised by the use of ward and day surgery unit space for inpatient non-elective medicine demand and reduced bed capacity as a result of COVID-19

related infection control restrictions. This included inpatient and day case provision, across both hospital sites. Emergency pressures within the system continue to impact on our ability to maintain pre-pandemic planned activity levels and facilitate the required growth to deliver elective recovery.

Over the last two years while operating in COVID-19 conditions, STW has lost a total of over 18,000 theatre cases. Consequently, the combined waiting list for STW (including Welsh patients) has increased from 33,244 in March 2020 to 49,456 in December 2021. SaTH has seen a rise in all urgent cancer referrals and the number of two week wait (2WW) referrals received in 2022 were 10.6% higher than in 2019.

Therefore, solutions are required to:

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

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

This will be delivered through the Planned Care Hub at PRH funded via TIF2. The new hub will significantly increase day case capacity at PRH and delivers an important element of the wider Future Fit ambition. The first scheme within the programme will become operational in June 2023, with the second scheme planned for completion by the end of March 2024.

1.2.2.4 Alignment of the Hospitals Transformation Programme

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

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

In addition to the above, the HTP will help to improve the health and wellbeing of the local population, in line with the ICS' JFP. Improved health and wellbeing are an important part of the ICS strategic direction and are integral to validating the integrated care strategy. The proposed improved integration of services with system partners will support all 'do-something' options in this OBC. The LCTP is vital to the required modelled future bed base for the HTP, and it encompasses the following schemes:

- Admission avoidance (through risk stratification and proactive case management)
- Acute / semi-acute work, such as virtual wards, crisis and rapid response teams, DAART (Assessment, diagnostics and short-term intervention)
- Early supported discharge and integrated discharge teams

These interventions will support the provision of patient care close to home for 151 beds worth of activity by 2026/27 and support in decreasing the impact of future demographic growth on modelled capacity of 106 beds by 2031/32. The ICS will develop systems for primary prevention, tackling health inequalities and supporting the development of the workforce over the whole ICS. This will also offer opportunities for digital developments and improved value for money with sharing of 'back room' functions. The community services, as well as the combination of skills that reside in primary and secondary care offers great opportunities for the development of patient focussed services.

The alignment of the HTP to the vision of STW is reflected in our investment objectives that are outlined in Section 1.3.4.

1.2.2.5 Integrated Care System (ICS) digital and integrated care digital strategy

The digital plans for HTP will allow us to pursue the digital ambitions not just for the Trust, but for the Shropshire, Telford, and Wrekin (STW) system. By 2025, in line with the Secretary of State for Health's plan for digital health and social care (June 2022), the system will be digitally equipped to deliver better care. HTP will therefore need to be able to continue to support this.

STW ICS is in the process of developing a Digital Strategy & Costed Plan. We will ensure HTP is aligned with and enables the ICS to continue to commit to the following pledges:

- Empowering our collective population and workforce, co-designing digital solutions with the people who will be using them.
- Connecting our organisations through interoperable systems that share information for efficient decision making.
- Committing to digital inclusion, through training and accessible technologies that support our workforce and community.
- Working together to improve quality and safety outcomes through digital processes.
- Using data to record, predict and respond to ill health and tackle inequalities.
- Embedding system thinking to share resources and expertise.
- Committing to innovation, transformation and doing things differently.

The key ICS programmes that we will align to include the following:

- **Shared Care Record:** The development of the One Health and Care Integrated Care Record (ICR) for STW is working to enable the best possible care by making the right information available to the right people, at the right time and in the right place. This will be reliant on SaTH having the appropriate and robust infrastructure and integration feeds to support it as well as implementation of the Careflow PAS.
- **Local Care Programmes including Outpatient Transformation:** Shared clinical models of care are being developed across the ICS, which aim to treat patients closer to home and to give patients greater control and convenience in their NHS hospital or clinic appointments. The implementation of Virtual Wards and remote technology as well as the Patient Engagement Portal will contribute to enabling this.
- **Virtual Wards Programme:** The development of a safe and sustainable model of care involving monitoring of a patient both pre-admission or post-discharge in the place of residence rather than on hospital site, using Virtual Ward technology. This will be reliant on SaTH having the technology and clinical resource funded and available to implement, along with the IT infrastructure to support the technology required.

Collectively, we will seek to improve access to appropriate care for patients, ensuring patients receive the right care and support, at the right time.

1.2.3 Local context

The HTP is a local priority and has brought together local system partners to ensure its success. It is commensurate to the Trust's vision and strategy and the Clinical Services Strategy [included within Appendix S-16], and part of the system's broader plans.

1.2.3.1 Collaboration with other organisations

We and our partners are collectively committed to delivering the ambition set out within Future Fit. In doing so, we will continue to build on the deep relationships we have with our partners in Shropshire and Telford & Wrekin where they are aligned and complementary to the clinical model and DMBC recommendations. Ultimately, these will focus on improving the quality of care and efficiency of services provided by the Shropshire and Telford & Wrekin healthcare economy.

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

- Healthwatch Shropshire
- Healthwatch Telford & Wrekin
- Powys Community Health Council
- Shropshire Local Authority
- Telford & Wrekin Local Authority
- Powys Teaching Health Board
- West Midlands Ambulance Service NHS Foundation Trust
- Welsh Ambulance Services NHS Trust
- Robert Jones and Agnes Hunt NHS Foundation Trust
- Midlands Partnership University Foundation Trust (MPUFT)
- Shropshire Community Health NHS Trust
- STW ICS
- Shropshire Doctors Cooperative Ltd
- NHSE
- Shropshire Voluntary Sector Assembly
- Telford Chief Officer Group of the Voluntary Sector

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

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

- In 2019–20, in partnership with Macmillan Cancer Support, the Lingen Davies Cancer Fund and RSH League of Friends to build a new Macmillan Cancer Support Service and extend existing services within the Hamar Centre at RSH.
- We were successful in our bid for medical leadership development funding and partnered with the Faculty of Medical Leadership and Management to deliver training and development programmes in the latter part of 2020.
- We have established a provider collaborative with the University Hospitals of North Midlands NHS Trust to deliver a range of specialist services.
- There have also been visits and discussions with other Trusts across the country who have implemented similar models of change

1.2.3.2 The Strategic estates plan

Our Strategic Estates Plan [Appendix S-12] sets out a high-level overview of our current estates and projects the direction of travel for a notional 5-year period leading up to the expected HTP transformation. It is focussed on backlog required for the estates fabric to be maintained 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. It also outlines the plans for the Preferred Option.

As part of the Trust's Strategic Estates Strategy [Appendix S-11], we are investigating alternative avenues of funding for a new energy centre. In addition, our renal dialysis service changes will deliver PRH community dialysis provision in a purpose designed facility in Telford, following public engagement post Future Fit. Renal dialysis will continue to be delivered at RSH in addition to this.

1.2.3.3 Trust Digital Strategy 2022 – 2025

A 3-year Digital Strategy (2022-25) [Appendix S-05] has been developed that puts in place the standards and technology expected of an NHS acute trust. Its aims are to:

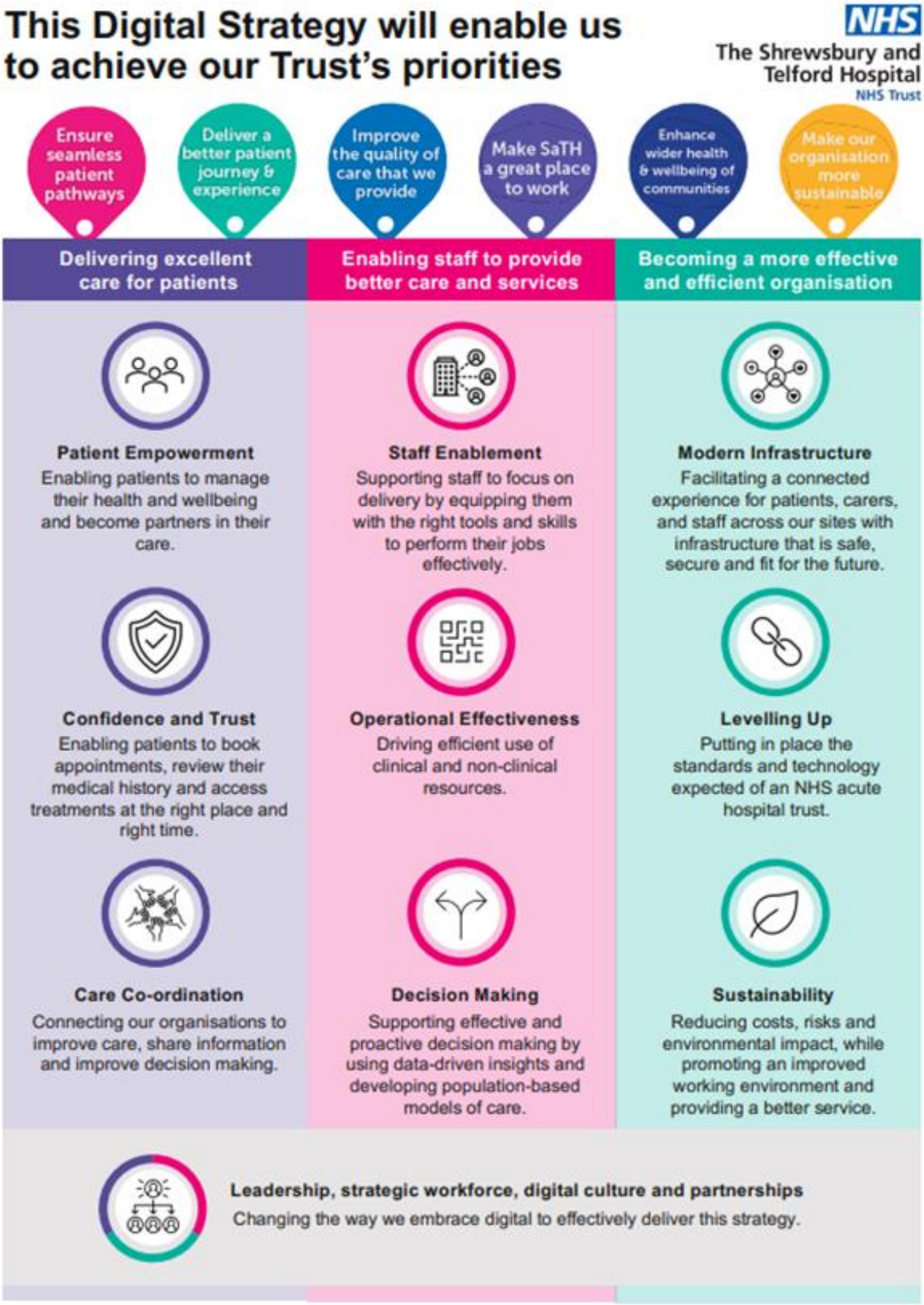
- Improve the delivery and quality of care, support our workforce and embed a culture of continuous improvement across the organisation in line with our Trust Strategy.
- Re-establish our reputation for delivering what we say we will and move beyond special measures.
- Achieve agreed performance by embedding our Quality Strategy and implementing our Maternity Improvement Plan and Getting to Good Programme.
- Achieve our agreed financial targets and establish ourselves as a sustainable organisation that is paper-lite and will support the NHS on its journey to net-zero.
- Put in place the foundations ready for the HTP and new build from 2026.

We are making progress on realising the digital change outlined in our strategy: we are implementing System C Careflow EPR, including the Careflow PAS, which is due for implementation in Autumn 2023. This is aligned to other providers within our system and wider network, such as Robert Jones and Agnes Hunt Orthopaedic Hospital and University Hospitals North Midlands (who provide Tertiary services to the Trust) who are also implementing System C EPR. We have also successfully gone live with a new theatre management system and have secured funding for refreshing our networks and other key clinical applications such as an order communications and results reporting system for pathology and radiology.

The Strategy bridges the tensions between adhering to national requirements and delivering against local plans. We are working with NHSE to ensure that our programme of digital transformation meets the needs of national funding priorities and the standards expected of us. This includes aligning to the core capabilities in MDF, WGLL and working towards Level 5 on the HIMSS EMRAM maturity model, which is designed to strengthen our performance as an organisation and achieve improved health outcomes for our patients.

Our Digital Strategy aligns with our Trust's strategic priorities and can be read in full via the appendices.

Figure 12: Trust digital strategy priorities



1.2.4 Future Fit consultation outcome

The future service model outlined in Section 1.1.6 was informed by the Future Fit consultation, led by the CCGs, which ran for 15 weeks from 30th May to 11th September 2018. It asked people from Shropshire, Telford & Wrekin and Powys for their views on the future of hospital services provided by RSH and PRH.

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

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

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

Reconfiguration proposals were agreed in 2019 and defined a new configuration of acute services in Shropshire, Telford & Wrekin and Powys. These proposals were subsequently supported by STW and Trust Board of Directors (having already received support from the Clinical Senate). Option 1 was confirmed as the future configuration of services, resulting in agreement to change how services are organised at RSH and PRH:

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

Further detail is outlined in Table 13:

Table 13: Agreed configuration of services across RSH (emergency care) and PRH (planned care)[30]

Princess Royal Hospital: Site specialising in planned care	Royal Shrewsbury Hospital: Site specialising in emergency care
• 24/7 Urgent Care Centre (it has since been agreed that this will be delivered via the A&E Local Model) • Theatres • Surgical wards • Day surgery unit (inc. planned surgery for urology, gynaecology, colorectal, head and neck, orthopaedics, gastroenterology, upper GI, vascular, and breast) • Medical wards (inc. care of the older person, rehabilitation and end of life care) • Midwife-led unit • Diagnostics (inc. endoscopy, MRI, CT, X-ray, cardiorespiratory, ultrasound scanning (inc. maternity), mammography) • Renal dialysis (it has since been agreed that this will be delivered at an off-site location in Telford)	• Emergency department, including paediatric triage • Urgent care centre • Critical Care Unit • Ambulatory Assessment • Surgical assessment (all surgical specialties inc. gynaecology assessment and treatment unit) • Theatres • Medical wards (inc. respiratory, renal, cardiology, stroke, care of the older person, dermatology, diabetes, oncology and haematology) • Surgical wards (inc. emergency and complex surgery for urology, gynaecology, colorectal, head and neck, trauma, gastroenterology, upper GI, vascular)

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

Princess Royal Hospital: Site specialising in planned care	Royal Shrewsbury Hospital: Site specialising in emergency care
• Day case chemotherapy • Breast services • Outpatients (specialties within obstetrics, children's, medicine, surgery, orthopaedics and therapies) • Pharmacy	• Children's inpatient ward (inc. day case, oncology and haematology, medical and surgical) • Children's assessment unit • Maternity wards (inc. early pregnancy assessment services, antenatal, postnatal, delivery suite, midwife-led unit) • Neonatal Intensive Care Unit • Diagnostics (inc. endoscopy, MRI, CT, X-ray, interventional radiology, cardiorespiratory, ultrasound scanning (inc. maternity), mammography) • Renal dialysis • Day case chemotherapy • Radiotherapy • Outpatients (specialties within obstetrics, children's, medicine, surgery, orthopaedics and therapies) • Pharmacy

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

In 2019, the IRP recommended to the Secretary of State for Health and Social Care that the reconfiguration of acute services should be go ahead as planned. The IRP visited the county to speak not only to clinicians, but also to those who had objected to the plans. Following this, it was the unanimous verdict of all members of the Panel that the proposals that have been put forward should go ahead "without further delay". It was noted that the current model of emergency services provided through the two hospitals compromises safety and quality and so their advice came with several recommendations, including specific recommendations that the urgent care model should enable as much clinically appropriate care to be delivered at PRH as possible and that options for, diagnostics, ambulatory emergency care and frailty assessment must be considered. We support these recommendations and will continue to explore them through the development of the outline business case and full business case.

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

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

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

The PCBC, completed in 2017 [Appendix S-01], met the four tests required by the Department of Health (DH), as well as the supplementary requirement introduced in April 2017.

- **Test 1: Strong public and patient engagement.**
  Engagement from healthcare staff and local people from the outset through the use of focus groups, surveys, roadshows etc.
- **Test 2: Consistency with current and prospective patient choice.**

Delivery of two sites, one specialising in emergency care and one specialising in planned care, with a significant proportion of activity continuing to be delivered from the same site as before.

- **Test 3: Clear clinical evidence base.**
  The programme has been clinically led from the beginning and is regularly clinically reviewed.
- **Test 3: Clinical Commissioners Support.**
  Clinical Commissioners have supported and funded the programme since its inception in 2014.
- **Supplementary requirement: Demonstrate 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.**

Considerable modelling to estimate future acute activity levels and acute bed capacity took place for Future Fit and has regularly been updated as part of HTP, demonstrating that this condition has been met.

The ability of the HTP to meet these 5 tests meant that it could proceed to public consultation.

1.2.5 Reconfiguration of local services - Overview

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

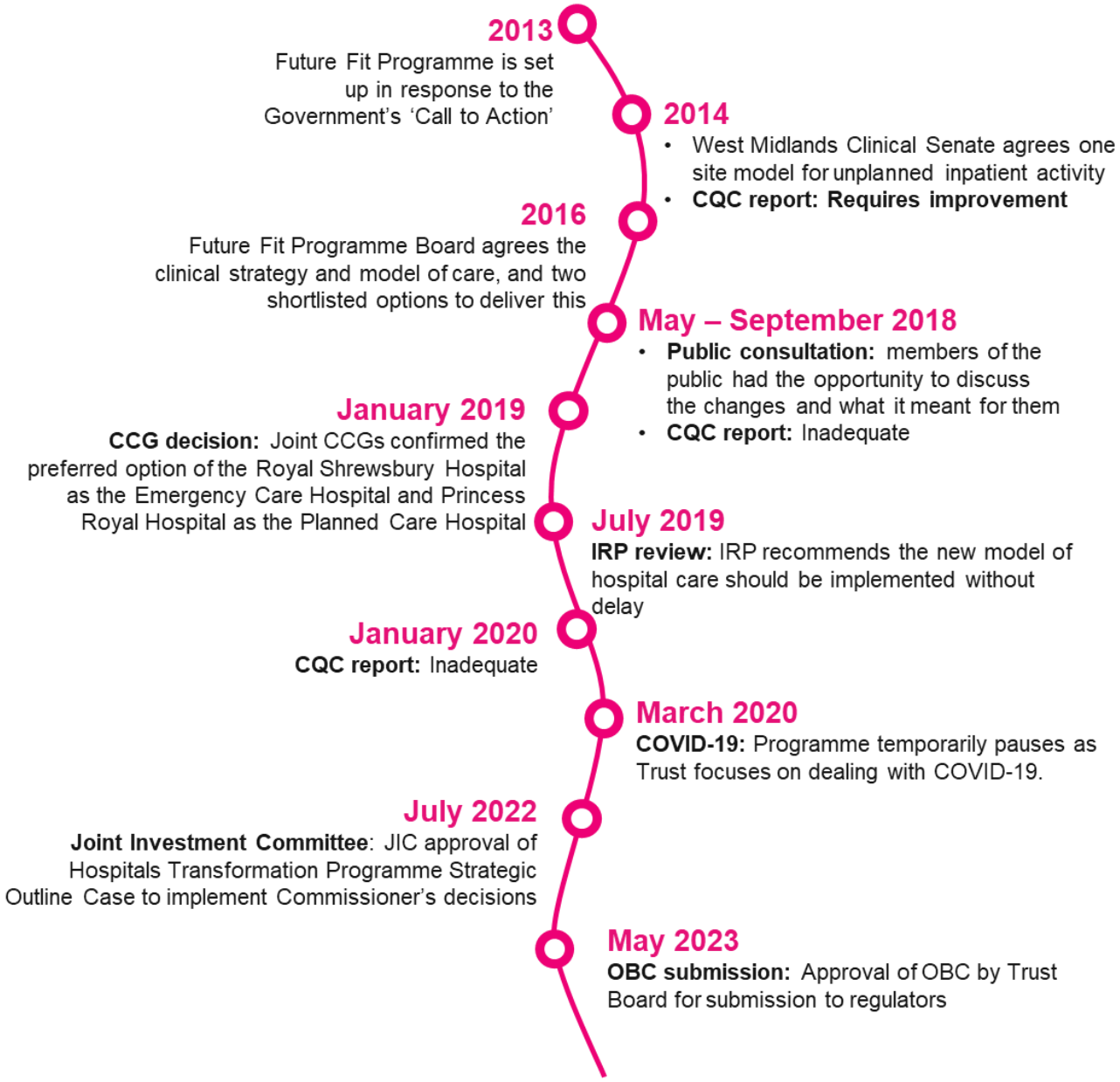
The proposal for the reconfiguration of services for Shrewsbury and Telford was developed as part of the Future Fit consultation and is now being implemented through the HTP. While the proposals have continued to be debated over recent years, the issues we face have become much more urgent.

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

In November 2016, the Future Fit Programme Board agreed the clinical strategy and model of care including reconfiguring services to deliver a site specialising in emergency care and a site specialising in planned care. This led to a public consultation from May to September 2018. In January 2019, the Shropshire and Telford & Wrekin Clinical Commissioning Groups (CCGs) confirmed the Preferred Option of RSH specialising in emergency care and PRH specialising in planned care.[31]

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

Figure 13: Background to this OBC



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

1.2.6 Scope of this OBC

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

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

Feedback from NHSE has confirmed that we must consider an option that only uses the allocated funding. As a result, a SOC was submitted to NHSE and DHSC that set out what could be achieved within the allocated funding for the HTP (£312m). As this does not deliver the entirety of the Future Fit ambitions, this OBC focuses on delivering the core DMBC requirements and how much of these wider ambitions can be delivered for the allocated funding and the additional incremental value of larger investments to deliver the wider Future Fit ambitions.

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

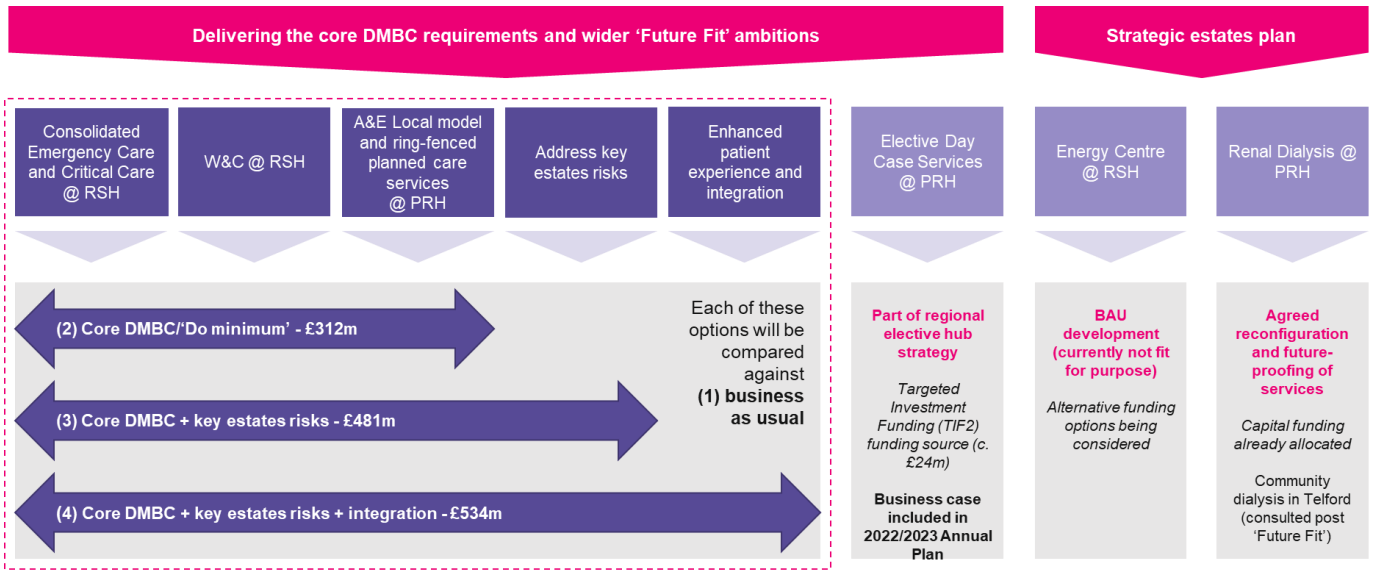
- TIF2 funding for Planned Care Hub at PRH – this is delivering the day case components of the Future Fit consultation.
- The energy centre at RSH – this will deliver critical components of the strategic estates plan. It is not funded as part of the HTP, but other external public sector funding sources are being reviewed to ensure that funding is secured before the new build is operational.
- Planned capital funding for renal dialysis – this will deliver critical components of the strategic estates plan based on the more recent public engagement[32]. The renal move is expected in Q3 2023/24.
- The digital transformation programme being implemented in conjunction with the HTP and funded through alternative NHS sources.

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

Delivering the core DMBC requirements and moving towards the wider Future Fit ambitions is the priority investment objective (outlined below) of this OBC. This underpins the development of the options, and as such all OBC options (except BAU) must support the Trust to move towards the delivery of this objective (see Economic Case).

The diagram below outlines the scope of the OBC, and the initiatives and investments outside of the scope of this OBC. As is described in the Economic Case, the programme has sought to build incremental options, enabling a phased approach for any future developments. This includes the wider strategic plans outlined above, and different levels of capital investment that all achieve the priority investment objective, and deliver more of the wider Future Fit ambition.

Figure 14: Scope of the OBC



The scope is consistent with that presented in the SOC. The options for delivering the scope outlined are discussed and assessed in more detail in the Economic Case, and build on the

[32] Renal dialysis services at PRH - SaTH

appraisal undertaken within the SOC, revisiting the long list appraisal and providing a more thorough appraisal of the short-list options.

[redacted]

1.2.8 Gateway 2 review

In June 2023 the programme underwent a National Stage 2 Gateway Review. The review was undertaken by an independent team of programme experts to provide an evidence-based snapshot of the programme's delivery status. The review provided a Delivery Confidence Assessment of Green, highlighting that the project is well led, with the necessary support and frameworks in place to move to the next phase. The review did not identify any major outstanding issues.

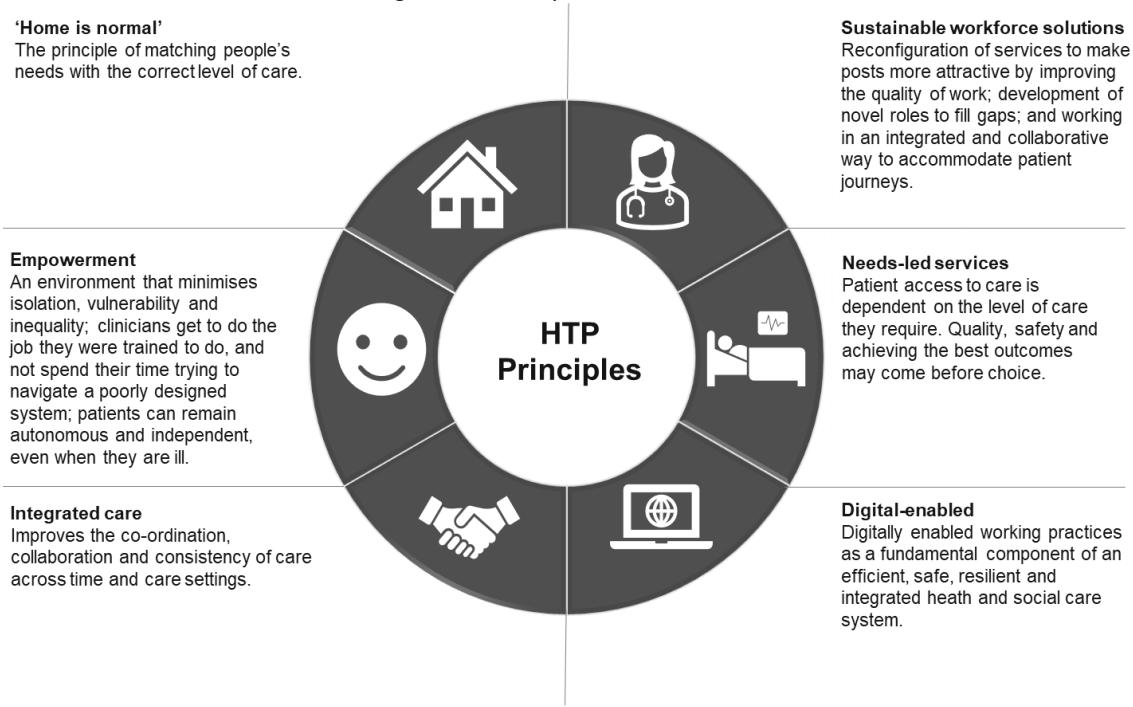
The review identified delay as a clear risk to the programme, highlighting that a delay to funding will have a detrimental effect on the ability to deliver the outcomes, create disillusion by contractors who are already on board, and diminish market appetite. The ability of the Trust to retain key staff, the reputation of the Trust and future patient care will be negatively impacted.

1.3 Implementing the Hospitals Transformation Programme

1.3.1 Overview of the programme and its aims

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

Figure 15: Principles of the HTP



The HTP's aims also align to key national and regional objectives (as described in detail above):

- **To support the delivery of the NHS Long Term Plan.** The HTP and reconfiguration aligns with the NHS Long Term Plan. The publication of the NHS Long Term Plan (January 2019) and the national drive towards more preventative, integrated care supports the clinical model in respect of the out of hospital shift, the split between planned and emergency pathways, increased access to SDEC, and the development of a more extensive urgent care model that will treat a greater proportion of our current ED patients. The model is also underpinned by greater utilisation of technology, new ways of working, and delivery of patient-centred care. Further, the financial assumptions allow the development of the analysis required to demonstrate the economic impact and financial affordability of the reconfiguration.
- **To support the national levelling-up agenda.** As described in Sections 1.1.2.1 and 1.2.1.3, 60the scheme supports this critical government priority and will transform local health services. The scheme supports major investment in two hospital sites in an area of regional inequality (25% of Telford's neighbourhoods being recognised as in the 20% most in need nationally[33]) and historical underinvestment. It will support two high-quality sites and help us become an employer of choice, providing regeneration and employment for the local community.
- **To address estates risks and deliver a new model of care.** The scheme will support modern fit-for-purpose and efficient use of estates and increase service resilience. It is envisaged that the new build requirements associated with the HTP scheme will target and alleviate some of the significant backlog issues identified across prime clinical areas at both RSH and PRH, assisting the delivery of the clinical model of care for the region. Investment into the reconfiguration of services and estate will ensure that the healthcare environments are safe and fit for use by all occupants.

The programme approach enables us to have an overarching strategy and vision which underpins all the required changes and objectives, ensuring business cases are aligned and developed effectively and efficiently across the programme. We are committed to maximising the social, economic and environmental impact of this investment. Our Social Value Model [Appendix S-08] outlines our commitments to social value and describes our local priorities. Section 3.1.4 of the Commercial Case also highlights our commitment to Social Value; a weighting of 10% was allocated to social value when selecting a contractor.

Our proposals have the support of the system (whose letters of support are included in the appendices [Appendix S-17], and we will continue to work closely together as these proposals further develop.

1.3.2 Clinical brief and requirements

Following approval of the SOC, the programme has been developing the detailed clinical brief (known as the functional brief) and requirements for the scheme [redacted] These briefs build on the clinical model agreed through the Future Fit consultation and the proposed approach outlined in the SOC to set out the functional requirements for each impacted service as part of this investment proposal. A summary of the key briefs for this scheme is provided below.

1.3.2.2 Critical Care

The revised clinical model will see all Critical Care services delivered only at RSH, the site specialising in emergency care. This Critical Care Unit will be operational 24/7, 365 days a year, with the Critical Care Outreach Team (CCOT) supporting wider services throughout this period. If a patient at PRH deteriorates and requires Critical Care services, stabilisation, and transfer of the patient to the Critical Care Unit at RSH will take place. This service is available 24/7 and is

[33] https://newsroom.telford.gov.uk/News/Details/16162

already in place under the existing model (though at FBC stage the service will be renegotiated, as it is predicted the volume of transfers will increase). The distance between the two hospitals is 17 miles, with an average transfer time of approximately 25 minutes.

The new Critical Care Unit at RSH will contain 32 beds. This is an increase from the current critical care bed base. The new unit will be made up of Level 2 and Level 3 beds. The projected establishment of 11 Level 2 beds and 21 Level 3 beds is set but the unit will have the ability to flex staff up if additional Level 3 beds are required. It is imperative that the Critical Care Unit is easily accessible from the Inpatient wards, Emergency Department and the Theatres suite. Level 1 patients will continue to be nursed within the ward bed base and will receive support from the CCOT.

1.3.2.3 Urgent and Emergency Care

The HTP will see RSH specialising in emergency care and PRH specialising in planned care. As a result, RSH will have an ED as well as a UTC which will both operate 24/7, 365 days a year. RSH will also be supported by an on-site SDEC facility and an Acute Short Stay Area. There will be an A&E Local Model at PRH, comprised of a UTC (open 24/7, 365 days a year) and an on-site SDEC facility.

Emergency care services at RSH will be provided within the 'emergency floor', which will be comprised of an emergency department, SDEC, a Medical Assessment Area and an acute medicine bed base. The ED at RSH will be a purpose-built estate, allowing better flow, and improved privacy and dignity for patients. The ED will be adjacent to the Radiology Department to allow for efficient patient flow. There will be a dedicated paediatric zone within the ED. The UTC at RSH will include several patient assessment/ treatment rooms and will be adjacent to the main emergency department. There will also be additional children's and surgical assessment areas in line with the NHS Delivery Plan for Urgent and Emergency Services 2023.

The A&E Local Model at PRH will offer a 24/7 UTC and SDEC (medical) services supported by a frailty team for same day urgent review, diagnosis, and treatment from specialist teams. It will provide a more enhanced service than the current Urgent Care Centres and it will be important to ensure that patients are clear on where to access the right services. Patients will be triaged on arrival and assessed or directed to an alternative appropriate service. Several assessment/ treatment rooms and bays will be provided for the assessment and treatment of patients. The A&E Local Model will be supported by a Medical Emergency Team who will stabilise and arrange transfer of a patient to the ED at RSH if their condition deteriorates. The co-located SDEC is expected to see patients between 8:00am and 8:00pm, 7 days a week.

1.3.2.4 Women and Children

Maternity Inpatients: The clinical adjacencies essential for patients to access safe and high-quality care require the maternity inpatient services be co-located with Emergency Medical and Surgical Specialties and Critical Care. This requires maternity services to be located at the RSH, the site specialising in emergency care.

The maternity inpatient beds to be sited at RSH will provide:

- Antenatal care to women requiring admission for observations prior to delivery.
- Postnatal care to women and babies following delivery.

The overall bed base will be split between antenatal care, postnatal care and transitional care beds. This will be designed in a way that enables the Trust to flex the size of midwife sections to reflect demand during any given time.

Neonatal unit: As above, with the new clinical model, it will be necessary for the Neonatal Unit to be located at RSH, the site specialising in emergency care, ensuring clinical adjacencies with the necessary other services and co-located with a Parent and Baby Unit.

Birthing: The new model of care will see women with a high-risk birth or those needing medical assistance, either before or during labour, cared for within a new build Consultant-Led Unit (CLU) at RSH, with Midwifery-Led Units (MLU) available at both sites for women who are expected to have an uncomplicated birth with the requirement for little or no intervention. Antenatal care, such as appointments and scans, will continue to be provided at both sites. Women assessed as having a high-risk birth but who live closer to Telford, will be able to see their midwife and doctor at PRH for outpatient appointments, assessment and scans.

The Trust will continue to work towards delivering a fully funded continuity of care model (subject to achieving safe staffing levels as per national guidance) so that women receive dedicated support from the same team throughout their pregnancy. The ongoing relationship between women and their midwives enables the midwife to provide care with greater empathy, provides women with a greater sense of control, and reduces any stress and anxiety.

Children's Centre: New care pathways are currently being developed. The intention will be that a lot of care will be given as an outpatient, whereas in the past, a child may have had to stay in hospital overnight. For the small number of children who will need to be admitted into hospital, the new clinical model will have admission to RSH, the site specialising in emergency care, although the majority of children will still be able to receive care at their nearest hospital. The Children's Centre will have a Children's Assessment Unit as well as inpatient beds (including designated adolescent beds) and designated beds for children undergoing planned surgery or treatments. Children's outpatient services will be delivered on both sites and children who don't require hospital admission will be seen in the UTCs on both sites.

Gynaecology: The implementation of the new service model of Emergency Care at RSH and Planned Care and Rehabilitation at PRH will result in gynaecology services being provided as follows:

RSH	• Early Pregnancy Assessment Unit; • Gynaecology Assessment and Treatment Unit including emergency local anaesthetic procedures such as Manual Vacuum Aspiration of Pregnancy, drainage of abscess; • Inpatient beds for emergency cases referred from GATU, EPAS, CCC, UTC and Emergency Department • Complex planned care requiring ITU/HDU access (currently predicted circa 1 session per month); • Gynaecology Outpatients (to remain in current location).
PRH	• Gynaecology Outpatients • Gynaecology Ambulatory Care: Procedures or investigations which may require local anaesthetic such as Colposcopy (Cystoscopy), Hysteroscopy and Hysteroscopic procedures (Novasure / Myosure), Manual Vacuum Aspiration of Pregnancy Failure (MVA), minor vulval procedures, IUCD removal/insertion • Gynaecology day case • Planned care IP beds – these could be co-located with other female surgical beds e.g. breast

1.3.2.5 Trauma and Orthopaedics

The new clinical model will mean that future provision of Trauma and Orthopaedics will see all children's and adult emergency trauma services undertaken at the existing site at RSH. This will require provision of adult trauma beds and trauma theatres within the existing estate, with a new trauma unit provided at RSH (the site specialising in emergency care). This will be in close proximity to the ED, radiology, theatres and the Critical Care Unit. Stepdown of care for appropriate patients, to the PRH will take place when appropriate (normally after 72 hours). Orthopaedic planned care, including both day case and inpatient surgery, will take place at PRH. Ambulatory trauma procedures will also be carried out at PRH, following initial triage at RSH. However, any complex needs arising from these procedures would require transfer back to RSH. If there will be a requirement for access to Critical Care, patients will be treated at RSH.

1.3.2.6 Outpatient Services

Outpatient services are not part of the HTP, and it is envisaged that these services will continue to be delivered from both sites. The Trust is currently delivering a programme of improvement across the Outpatient Departments on both sites, including decorating, refurbishment and new equipment / furniture. A new staff room has been developed at the RSH site to improve facilities for staff, and the Trust are working with individual specialties to support improvements in their areas. To support this a working group has been set up with attendance from all relevant disciplines within the Outpatient Department.

The Trust is also a partner within the ICS MSK Transformation Programme which simplifies the referral process and enables improvement in patient experience and reduces the need for surgery.

1.3.2.7 Oncology and Haematology

The revised clinical model will see radiotherapy and inpatient cancer care continue to be delivered at RSH. However, after the HTP, inpatient care will be within the new build at RSH and provided through a specially designed ward with a greater number of single rooms. Day case chemotherapy will be delivered across both sites from 8:00-18:00, 5 days a week. The Children's Haematology and Oncology Centre (CHOC) will be provided within the Children's Centre at RSH and will have dedicated staff.

As part of the programme, day case chemotherapy will be delivered across both sites from 8:00-18:00, 5 days a week. A new satellite oncology and haematology self-contained day unit will be developed at PRH with third sector funding being explore for this. This will provide facilities for outpatient chemotherapy administration, supportive therapies, investigations, and procedures. Clinical accommodation within the day unit will include treatment chair bays and single rooms. This will result in an increase in day case chemotherapy at PRH, creating additional clinic capacity and allowing patients to be treated closer to home.

As above, further detail on the specific requirements for each service is outlined within the Functional Briefs [redacted]

1.3.3 Designing two hospitals in line with most recent guidance

Our designs have been developed with the consultation outcomes and clinical briefs in mind and are aligned to the most recent appropriate guidance and recommendations. More details of the design can be found in the Commercial Case as well as in the RIBA Stage 2 Report [Appendix C-02] and the Schedule of Accommodation [Appendix C10]. The Estates Strategy [Appendix S-11] also outlines the Development Control Plans for the proposed development. Our Estates Strategy is aligned to the current mandatory Government Construction Strategy, in line with the requirements of the P23 Framework.

The are a range of standards and principles that have been followed in the development of the design and layout of the scheme. Alignment to certain principles, including PLACE scores, is outlined in the Trust's completed Premises Assurance Model (PAM) [Appendix C-07]. The design of the HTP also complies with the latest HTM/ HBN standards in clinical areas and clinical engagement has taken place to ensure that the buildings are safe and optimise patient flow. Infection Prevention Control (IPC) have also joined various estates meetings to ensure compliance with HBN 00-09. [redacted]

The HTP has also been designed with patient, staff and visitor needs in mind. The access requirements for patients, staff and visitors, as well as details around provision of carer and parent accommodation are outlined in the RIBA Stage 2 Report [Appendix C-02].

The scheme aligns to the relevant Carter Efficiency Recommendations with further details in Section 2.4.1. As identified within the Estates Strategy, the non-clinical space across the Trust is below national targets (30.9%) and the peer median (32.5%). It is currently identified at 27.19%.

In addition, there is no land disposal as part of the HTP but the expected disposals as part of the Trust's longer-term plan are aligned to the requirements of the Naylor Review.

Lastly, the general principles of clinical quality in the specification, design and layout of the scheme have been taken into consideration throughout including the patient-led assessment of the care environment (PLACE scores). Further detail on how the design meets these principles is set out in the RIBA Stage 2 report (Appendix C-02).

1.3.4 Investment objectives

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

- **Effectiveness**: improve the quality of public services in terms of the delivery of agreed outcomes.
- **Efficiency**: delivery of public services in terms of outputs.
- **Replacement**: re-procure services to avert service failure.
- **Economy**: reduce the cost of public services.
- **Compliance**: meet statutory, regulatory or organisational requirements and accepted best practice.

The objectives of this investment and the HMT category they address are defined in Table 14. The Critical Success Factors, outlined in the Economic Case, are each aligned to one of these Investment Objectives.

Table 14: Investment objectives

#	Objective	Critical Success Factor	Definition / measures	HMT category / categories
1	**PRIORITY OBJECTIVE** **Consultation**: Deliver the core DMBC requirements and move towards the wider Future Fit ambitions by 2029	Clinical model	• Delivering the configuration and clinical model defined in the DMBC (i.e., defined in DMBC S9.3, and associated capacity), and moving towards the wider Future Fit ambitions by 2029. • Maintained access to services, as defined in DMBC.	***Effectiveness*** ***Compliance***
2	**Clinical Quality and Safety:** Deliver safe, effective, and quality healthcare services for patients by 2029	Clinical quality and patient experience	• Improved clinical outcomes – delivering improvements in clinical outcomes identified in clinical strategy and DMBC from current 2022 levels by 2029. (These include cancer 62-day wait from urgent GP referral, currently c. 44%, NHS cancer screening service referral, currently c. 39% and RTT – max 18 weeks incomplete wait, currently c. 58%). • Increase in patients treated in lower acuity settings – reflected in increased proportion of patients treated in UTC, via SDEC, as outpatients or as day cases (vs. ED, NELIP, day cases and ELIP respectively), including 50% increase in ZLOS pathways and 10% increase in day case rates (currently 80%) from current levels by 2029. • Improved infection control – reflected in reductions in HCAIs from current levels (c. 17 2019/20) towards target of c. 14 (20% reduction), reflecting impact of facilities by 2029.	***Effectiveness***
3	**Patient Experience:** Improve patient satisfaction and wellbeing in purpose-built accommodation by 2029		• Improve patient satisfaction and experience – reflected in improved National Patient Survey results from current levels (8.3 in 2020) by 2029. • Solution provides enhanced privacy and dignity – providing 72% single rooms in new build areas, eliminating mixed sex breaches (35 in Jan 2022, breach rate of 2.5), and increasing ratings for patient privacy, dignity and wellbeing from current levels by 2029. • Improving RTT from 76% (2019/20) towards target of 90% by 2029. • 4-hour waits from 68% (2019/20) towards target of 85% by 2029.	***Effectiveness***
4	**Workforce:** Support sustainable staffing and be an attractive place to work by 2029	Workforce	• Improved workforce sustainability – reflected in a reduction in critical rota gaps through consolidation of rotas, meeting staffing standards in all specialties, and reduced staff sickness absence (from c.4.3% (2019/20) towards upper quartile of comparator Trusts (c.4.2%) by 2029. • Improved workforce availability – reflected in improved recruitment and retention, reduced staff turnover and reduced agency spend (target £2.6m reduction p.a.) by 2029. • Improved staff satisfaction – reflected in staff morale, feedback and wellbeing, including an increase in staff recommending the Trust as a place to work (from c.38% (2019/20) towards national average (66%) by 2029.	***Effectiveness***
5	**Effectiveness:** Deliver improved adjacencies and enhanced patient flow, supporting the efficient operation of the hospital and reduce elective cancellations by 2029	Effectiveness / Access	• Improved flow – reflected in reduced lengths of stay (average 0.5-day reduction from current levels which are NEL 6.5 days and EL 3.5 days) by 2029. • Improved efficiency – reflected in increased theatre utilisation from c. 75% (2019/20) to 85% by 2029.	***Efficiency***

#	Objective	Critical Success Factor	Definition / measures	HMT category / categories
			• Improved elective capacity – reflected in reduced elective cancellations from c. 630 (2019/20) towards target of c. 315 (50% reduction) by 2029. • Improved bed occupancy – from c. 92% (2019/20) towards target of 89% by 2029. • Alignment to the Digital Strategy – enables innovation in technology and design to improve patient/ staff experience and facilitate out-of-hospital care/ care closer to home.	
6	**Estate:** Deliver a safer, modern, financially sustainable estate by 2029	Commercial Viability	• A more efficient estate, reflected in reduced maintenance costs per sqm (from c. £48.47/sqm (2021-22) to median of comparator Trusts (c.£44.11/sqm)) and reduced energy and utilities spend (from c.£45.01/sqm (2021-22) to median of comparator Trusts (c.£30.54/sqm)) by 2029. • Elimination of high/significant risk backlog maintenance (£22.6m 2021/22) by 2029. • Elimination of issues identified by CQC (2021) associated with the facilities from which healthcare is being delivered by 2029, including poor urgent and emergency care environments at RSH and PRH, maternity care, wards and end of life care. • The net zero carbon strategy will be implemented as part of the HTP and the existing development control plan will be amended to reflect the impact of the HTP on the existing site. • Delivery of a commercially viable solution by 2029.	***Replacement*** ***Compliance***
		Build deliverability	• Deliverable by 2029 – accelerating where possible by 2028. • Solution has the support of the local system – reflected in confirmed CCG/ICS support by 2029. • Solution makes best use of available NHS estate, eliminating condition C/D Trust estate by 2029. • Put in place the infrastructure and technologies that will enable the new models of care to operate safely and effectively by 2029.	
7	**Finance:** Contribute to overall financial sustainability by 2029 (revenue affordability)	Value for money	• Value for money – solution offers a positive NPSV/BCR and maximises the social value and benefit of the investment by 2029.	***Economy***
8	**Finance**: Meeting capital availability requirements (capital affordability)	Revenue affordability	• Affordable solution – annual revenue benefits from the investment measured against the annual revenue costs (PDC and depreciation) – determining the net contribution by 2029.	***Economy***
		Capital affordability	• Affordable solution – capital required is expected to be available to the HTP (c. £312m currently allocated) by 2029.	

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

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

Key governance groups and committees involved included the Trust Board of Directors, STW ICB, HTP Committee, and the HTP Programme Board (see HTP governance, Section 5.1.35.1.1).

Each of these groups agreed the investment objectives as an appropriate reflection of our aims. Satisfying the potential scope for this investment will deliver the high-level strategic benefits shown below. As these plans progress, these will move towards realisation (see Section 5.35.3). We have plans to undertake a series of post-project evaluation (PPE) activities following completion of the main build elements. These PPEs will be integral to the monitoring of benefits realisation and will follow best practise. Our proposed post project evaluation review process is outlined in Section 5.3.5 of the Management Case.

Table 15: Strategic Benefits

Benefit Category	Benefit	Investment Objective	Rationale	Benefit Type
Workforce	FTE reduction	Workforce / Finance / Delivering Consultation Outcomes	Consolidation onto sites specialising in emergency and planned care enables FTE reduction. Calculated through workforce modelling undertaken for HTP.	Cash releasing and non-cash releasing
	Reduction in turnover costs	Workforce / Finance	Improved recruitment and retention processes supported by an improved working environment, driven by improved physical environment, better staff facilities and the new model of care	Cash releasing and non-cash releasing
	Reduction in staff sickness	Workforce / Finance	Reduction in workplace injuries and absence due to poor mental health	Cash releasing and non-cash releasing
Estates	Reduction in maintenance costs	Estate / Finance	Improved facilities and layout	Cash releasing
	Improved waste management	Estate / Finance		Cash releasing
	Improved energy efficiency	Estate / Finance		Cash releasing
	Reduction in backlog maintenance	Estate / Effectiveness		Non-cash releasing
	Estate utilisation	Estate / Finance / Delivering Consultation Outcomes		Cash releasing
Patient Safety	Falls reduction	Effectiveness	Improved room layout and facilities	Cash releasing and societal
	Improved infection control	Clinical Quality and Safety	Single patient rooms reduce spread of HCAIs	Cash releasing and societal

Benefit Category	Benefit	Investment Objective	Rationale	Benefit Type
	Reduction in adverse drug events	Clinical Quality and Safety	Improved patient rooms, acuity adaptable rooms, medication task area lighting, noise reduction measures and closed-loop prescribing.	Cash releasing and societal
Clinical	Non-Elective length of stay improvement	Clinical Quality and Safety	A modernised estate has potential to deliver a reduced length of stay through measures including: • Increased provision of single rooms • Improved natural light • Noise reducing measures • More efficient layout • Increased integration with community care and improved discharge to community settings • Improved patient flow	Cash releasing, non-cash releasing and societal
	Elective length of stay improvement	Clinical Quality and Safety		Cash releasing, non-cash releasing and societal
	Improved theatres utilisation	Effectiveness	Splitting into sites specialising in planned and emergency care will reduce inefficiency in theatres	Cash releasing, non-cash releasing and societal
	Reduced theatres cancellation	Patient experience	More appropriate models of care at each site will reduce controllable cancellations	Cash releasing, non-cash releasing and societal
	Reduced 4+ hour waits in A&E	Clinical Quality and Safety / Delivering Consultation Outcomes	Improved capacity will reduce 4+ hour waits	Societal benefit
	Integrated care (Option 4 only)	Clinical Quality and Safety	Investment into integrated care facilities will deliver wider benefits to the community as well as long term benefits to SaTH	Cash releasing, non-cash releasing and societal
Patient Experience	Improved patient experience	Patient Experience / Delivering Consultation Outcomes	Patient experience will improve at RSH and PRH through: • Modern environment and facilities at RSH • Reduced waiting times at both sites • Fewer cancelled operations at both sites • Increased single rooms, improving privacy and dignity at RSH • Effective wayfinding and accessibility at both sites	Qualitative
	Treating patients in a lower acuity setting	Patient Experience / Delivering Consultation Outcomes	Enablement of: • Avoidance of UTC referrals to the ED • Same day emergency care • Integrated care	Qualitative

Benefit Category	Benefit	Investment Objective	Rationale	Benefit Type
Reputation	Improved performance indicators	Effectiveness	Clinical outcome improvements through compliance with key targets, including: • ED waiting time • Referral to Treatment times • Delivery of cancer targets • Improved access to multi-disciplinary teams • Delivery of care in an environment suitable for specialist care	Qualitative
Local economic impacts	Job creation	Workforce	The investment will lead to the creation of local jobs through the construction period of the scheme	Qualitative (as per DHSC guidance)

1.3.5 Risks, constraints, and dependencies

The main business and service risks associated with the complex delivery of the programme as services move are summarised in Table 16 together with their mitigations. Our approach to risk management is described in the Management Case (Section 5.4) [redacted]

Table 16: Strategic risks and counter measures

Risk	Description and impact	Mitigation(s)
Delays to the scheme lead to increase clinical and estates risk and increase capital cost	There is a risk of delays the scheme. Which may result in increased clinical and estates risks and additional capital and revenue costs associated with delay and inflation. [redacted] Delays to the scheme was highlighted as the most significant risk to the programme by the national Gateway 2 review.	Ongoing engagement with key stakeholders (including political representatives), to secure their buy-in to the overall priority of the scheme and to get their support to urgently progress plans for the investment. Ongoing work to secure the resource and expertise for the FBC to maintain progress and momentum.
Inflation cost may increase as a result of approval delays and/or external economic factors	There is a risk that inflation costs may increase as a result of approval delays and/or external economic factors, which might result in: 1. Increase in the overall capital funding required to deliver the scheme 2. Reduction in the scope of the Programme	The scheme has been developed and costed using best practice benchmarks. Regular review and timely action to mitigate the impacts.
Insufficient impact of local care services (timing and scale)	There is a risk that the Trust goals for quantity of care will not be reached, which might result in an increase in patient quality of care incidents.	Develop plans for local care pathways during the OBC process that avoid the need for an additional 151 acute beds. The HTP team have developed and continue to refine activity and workforce models to support system scenario analysis. Local Care Programme established and led by Shropshire Community Health Trust. The ICB have now established an integrated Transformation Board (monthly) of which the HTP Directors have membership of.
Interdependent capital projects not fully aligned to the HTP	There is a risk that this would increase the cost and time to deliver results to the intended Trust's standards, which might result in overall increasing costs and inability to meet deadlines.	Clear development control plan in place to compliment the HTP. Development of the estate strategy to include the HTP. Strategic estates business partner to feedback on any potential impacts to the HTP from Capital Planning Group to ensure alignment of existing and future projects. Alignment of projects to ensure transparency and visibility of interdependencies between new build projects and the future HTP build.

Risk	Description and impact	Mitigation(s)
Other initiatives are perceived to have higher national priority which could cause approval delays	As a result of the HTP competing with other initiatives which may be of higher national priority there is a risk that this could delay the approval process/implementation or see funding re-prioritised for other investments. Which might result in the hindrance of progress and material delays will adversely impact the sustainability of our workforce, clinical services and our reputation.	Ongoing engagement with stakeholders, regional and national NSHE representatives to ensure that the priority of this proposal is clearly understood.
Some stakeholders may fail to engage and fully support the Preferred Option and could delay the approval process	There is a risk that some stakeholders may fail to fully engage in the process and continue to promote alternative options, creating further pressure on the project and programme teams that delays progress. This might result in the inability to quickly and efficiently progress the agreed way forward.	Development of a comprehensive communications plan that outlines how we will engage a wider variety of stakeholders. Expand our engagement with key stakeholders to ensure they fully understand the case for change, benefits and implications of the clinical reconfiguration so that they do not object to (or preferably are able to support) the Preferred Option.
There is a risk that our bed capacity assumptions are incorrect	There is a risk that our bed capacity assumptions are insufficient to deal with future demand. Which might result in a large increase to patient safety incidents and provide a possible compromise to the Trust's reputation.	Further testing of demand and capacity modelling at OBC stage and further development of out of hospital strategy suggests projected bed numbers are above what is necessary. 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.
The system financial plan is not signed off and/or assumptions change	There is a risk that the system does not agree a financial plan with aligned assumptions. Which might result in a delay to the submission of this OBC and future works.	Regular engagement with the system financial plan development, and accountability of those delivering it through the Programme Board and STW Board.
Inability to adopt clinical model and realise benefits due to competing priorities	There is a risk that the scheme will not fully realise the clinical model due to competing priorities or changes in national requirements, and therefore deliver the benefits planned within the business case.	Extensive clinical engagement throughout the the development of the clinical model. Programme demonstrates that the model is achievable, with a supporting workforce plan in place. Ongoing clinical engagement is led by Executive Medical Director and the HTP Medical Director.
Appointed contractor is unable to complete the works	There is a risk that the appointed contractor is unable to deliver on the contractual requirements and complete the works. Which may result in a delay to completion and additional cost to complete the scheme.	The process for selection of contractors will ensure that a capable contractor is appointed. Due diligence via the P23 framework will ensure credit checks are in place prior to appointment. This pre-selected framework reduces risk for the Trust.

Risk	Description and impact	Mitigation(s)
Workforce Retention	The Clinical Model moves services across the two sites and therefore staff may be asked to move to an alternative site to the one they choose to work at currently. Staff may not want to move sites and not take on alternative roles at their existing site and therefore choose to leave the Trust following HTP delivery. Unable to safely staff both hospital sites which could affect care delivery.	Workforce Steering Group established with all Divisional Triumvirates to define models of care. Communication early with all staff to establish potential impact and timeframes on changes in working practice and location. Engagement with staff early could help provide alternative opportunities for those staff who do not want to move location (link with training and development plans).
Negative staff impacts caused by lack of progress with the HTP	As a result of lack of progress and delays with the HTP there is a risk that our stakeholders (patients, staff, members of the public, local MPs etc.) may express concern and raise questions. This might result in the HTP being perceived as unlikely to progress which would result in reputational damage to both SATH and the ICS.	Updated comms and engagement strategy setting out active approach and a phased plan for comms and engagement with a wide range of stakeholders Engagement with external organisation to support with comms and engagement activities due to lack of Trust resource.
Workforce Transformation Development does not deliver sufficient workforce	Due to delays in initiating alternative role development training programmes. There is a risk that the future workforce requirements are not defined in a timely manner to ensure training, development, and recruitment of roles.	Unable to safely staff both hospital sites. Workforce Steering Group established with all Divisional Triumvirates to define models of care, associated roles and 3-5 year training programme. Consider ensuring initial staff models reflect the new ways of working. Learning from other areas suggests over-staffing in some areas initially, giving greater reassurance for practitioners and patients.
Potential for insufficient theatre capacity at the RSH site	Amalgamation of Trauma and Emergency Surgery at the RSH site will require four theatres, the remaining 5 theatres will need to accommodate high risk planned surgery and paediatric surgery. There is a risk of insufficient theatre capacity at the RSH site following reconfiguration of services for all our high risk planned activity.	Discussion with clinical colleagues regarding requirements for surgery at RSH as opposed to this being undertaken at PRH – cultural change amongst our practitioners Meeting with other Trusts who have implemented such models to determine requirements and share learning Alternative ways of working eg, LA procedures moved out of main theatres into a Procedure Suite resulting in great capacity within main theatres, extended operating hours eg weekends Demand and capacity review of theatre capacity (pre and post cultural change discussions) Effective staffing model at PRH to gain confidence in teams to undertake surgery at PRH Effective stabilisation and transfer model in place at PRH to ensure clinicians are confident to undertake surgery at PRH Provision of a Post-Anaesthetic Care Unit (PACU)

Constraints are the external conditions and agreed parameters within which the programme must be delivered, over which the project has little or no control. The project is subject to the constraints in Table 17.

Table 17: Main constraints

Constraint		Description
C1	**Capital availability**	Capital within the NHS is significantly constrained. While the scheme has had previous allocations, these have excluded the impact of external factors/changes such as inflation, single room requirements, Net Zero carbon and addressing the impact of COVID-19. Following the HTP SOC approval at the Joint Investment Committee, condition #14 states that the capital costs for the FBC should not exceed £312m. If costs exceed this, the Trust should work with the ICB to agree any additional CDEL cover, within operational capital envelopes. Given this situation, the scheme has sought to demonstrate what can be delivered within capital availability, and the incremental impact and value realised by further investment, to demonstrate an optimum return on capital – this is demonstrated in the Economic Case.
C2	**Workforce**	We must design, build, and operate the development within the capacity of the staff available at each point. This constraint is derived from the national and local shortage of clinical staff.
C3	**Service configuration**	The OBC must move towards the delivery of the configuration of services set out by commissioners and agreed to within the DMBC. As this has been consulted on, any changes to this will require further review by commissioners.

The project is subject to **dependencies** in Table 18 that will be carefully monitored and managed throughout the lifespan of the scheme. These can be interdependencies between other programmes and projects or external dependencies outside of the project environment. It is expected that the delivery of the dependencies will be managed by the relevant project, programme or operational management structures and resources. The HTP will work closely with each to confirm they are delivering to plan and will highlight potential risks as they emerge. These will be reviewed and updated at the next stage of the business case process.

Table 18: Main dependencies

Dependency		How dependency is managed
D1	**System financial position and regulatory requirements relating to system control totals**	As a key stakeholder within the system, the Trust is working closely with the System to ensure consistent and appropriate financial planning.
D2	**Alignment with system and STW strategies**	The Trust is working alongside STW to ensure both strategies and Demand and Capacity modelling is aligned. Capital and Financial plans are co-ordinated across the ICS through dedicated groups and roles.
D3	**National clinical policy changes**	Through the Trust's existing clinical teams we are continually monitoring and acting upon NHS policy changes. Should a change occur that impacts the clinical model or design of the proposed investment, this will be fed through the programme governance and a change control implemented where possible. However, through modern design standards, and embedded flexibility, it is anticipated that any policy changes can be accommodated through the options presented in the economic case.
D4	**Prompt approval of business cases by regulators and Government**	The programme is working regularly and closely with NHS regulators to set out a timeline for the review and approval of the business case. NHSE regional and national teams are part of the HTP Programme Board and so are kept informed of progress of the programme and key milestones.
D5	**Continued availability of capital throughout the programme**	The Joint Investment Committee provided clear direction on the capital available for this programme. As a result, the programme will seek to remain within this capital envelope, while also considering incrementally larger investments within the economic case to compare value for money.
D6	**Capacity of suppliers to develop the reconfiguration within the required timeline**	The Trust is progressing the business case at pace to ensure early engagement with suppliers is possible. The phasing of the development is considered to ensure early enabling works can commence as soon as reasonably possible.
D7	**Delivery of day case capacity via TIF2 funded programme**	The Planned Care Hub will ensure future protected day case capacity, and this will be delivered by March 2024. Phase 1 is underway and funding for Phase 2 has been approved.
D8	**Delivery of energy centre at RSH**	The Trust is dependent on the Energy Centre being completed to achieve the net zero carbon within the new site. There are a number of sources of funding being considered for this, with outcomes expected in Q1 2023.
D9	**Trust digital delivery programme**	The Trust Digital strategy has been extensively developed and iterated to ensure it is fit-for-purpose. The digital requirements of the HTP have been specified by the programme and will form a key part of the design requirements within this scheme. Further detail on the digital requirements are outlined throughout this case [Appendix S-05].
D10	**Delivery of local care services transformation**	The Trust is working with the LCTP to understand key interventions, including size and area of impact, timelines of delivery and associated risks.
D11	**Car Parking**	Required to ensure there is appropriate parking to support staff and visitors at the new build. The Technical Oversight Group will regularly discusses car parking and reports on progress / risks / issues associated with this programme where appropriate.
D12	**Human Resources and Organisational Development**	HR and OD will be critical to support the workforce changes that will be ongoing throughout the programme. HR and OD have been engaged in the programme from an early stage to ensure collaborative planning with them.

1.4 Conclusion

In Shropshire, Telford & Wrekin, we face some of the biggest acute care challenges in the NHS and fundamental changes are required to the configuration of services across both hospital sites. We cannot continue to operate safely and effectively as we are, and this has been highlighted by recent challenges.

Following the approval of our SOC by the JIC, this OBC considers the ways we can invest in our hospitals to move towards the delivery of the agreed clinical model.

The proposals will improve quality and safety, enhance patient experience, become an employer of choice, improve patient flow and efficiency, deliver a sustainable estate, and

contribute to the financial sustainability of our healthcare system. The options for delivering this are discussed in detail within the Economic Case and recognise the balance between these competing priorities.

This investment will implement the agreed models of care following the public consultation and commissioning decision on the future configuration of our services. This case is a key part of the Trust and System's strategic plans for addressing the challenges we face and delivering improvements to patient's experience and outcomes and the programme has full partner support.

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

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

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

Our proposals were supported by the Independent Reconfiguration Panel (IRP) and the Secretary of State for Health and Social Care who highlighted in 2019 that ***"…the proposal to establish a single emergency centre at RSH with a full range of complementary services at PRH, Telford, is in the interests of health services in Shropshire, Telford & Wrekin and should proceed without further delay…".*** Since then, the need for this change has increased as a result of the growing demand for services, compounded by the impact of the COVID-19 pandemic.

If this reconfiguration does not progress, there is an increasing risk to the ability to provide continuous, sustainable core services at both sites.

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

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NHS Trust

2 Economic case

2 Economic case

Building on the outputs of the extensive consultation completed in 2018–2019, we have considered the appropriate way to implement the agreed clinical model and address the case for change set out in the Strategic case.

We have appraised the costs, benefits and risks of the strategic options to identify the option that meets our investment objectives and delivers the highest net value for our local population and the UK public. Each of the options is appraised in relation to the BAU scenario.

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

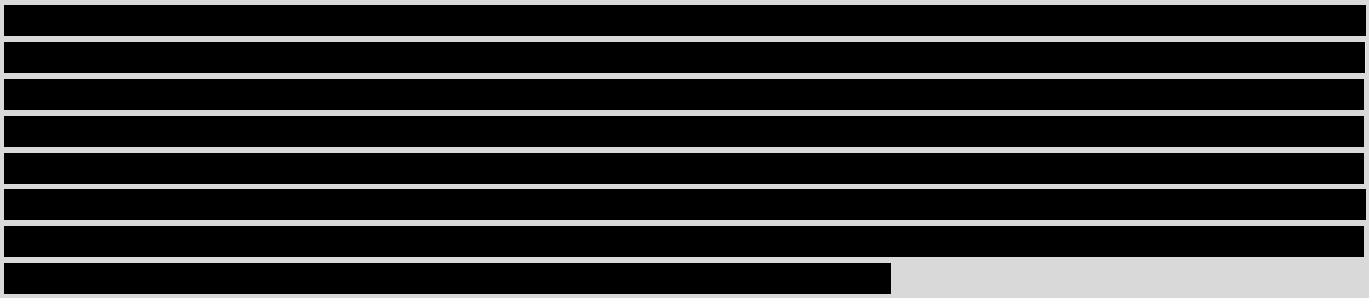
- delivering the full ambition behind the extensive public consultation (Future Fit),
- implementing new national standards (e.g. Net-Zero readiness),
- establishing a sustainable infrastructure to support the delivery of excellent healthcare through the move towards split site working,
- improving staff retention, attracting new staff and reducing our reliance on agency staff,
- futureproofing our estate, clinical and workforce model,
- the funding available to achieve those changes - the current allocation of funding (£312m) for this scheme is based on costings, inflation assumptions and national standards from 2016.

The short-list options we have considered in detail below, build on the appraisal completed during the SOC, and the feedback received from JIC. The short-list options are:

0. **Business As Usual (minimal capex – system capital, negative revenue impact)**: Continuation of current arrangements, with no additional capital expenditure beyond the existing backlog plans. This option does not deliver the consultation outcome and does not provide sufficient capacity for future demand. As a result, the Trust will need to meet demand through longer working hours and outsourcing activity, both of which incur additional costs. [redacted] Additionally, it will see the condition of the estate and clinical environment deteriorate without additional investment in the estate, with significant continued workforce challenges. This option is not a clinically safe and sustainable approach and will not solve performance and quality issues. The current market situation is unlikely to be able to absorb outsourced capacity, resulting in a significant number of patients experiencing prolonged waiting times. This option has been added since SOC [redacted]
1. **Additional Comparator (c. £72m):** Continuation of current arrangements, with additional investment in the estate to provide increased capacity to meet some increases in demand. This option does not deliver the consultation outcome. While it allows for some increase in capacity and will address statutory and essential elements of backlog, key estates risks will remain and the Trust will continue to operate inefficient services, with significant workforce challenges. This option would require capital above SaTH / ICS allocated funding but would still fail to solve the major quality, workforce, financial and performance issues associated with operating the two sites as they stand.
2. **Core DMBC ('Do Minimum') (c. £312m):** The minimum capital investment required to deliver the "priority Investment Objective" (DHSC/HMT guidance) – i.e. deliver the core DMBC requirements and move towards wider 'Future Fit' ambitions. This delivers a new, clinical model, significantly increasing the efficiency of services and addressing the significant workforce challenges the Trust faces.

3. **Core DMBC + key estates risks (c. £481m):** Investment 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, refurb of old ward accommodation for other uses and substantially reducing the estates risk. As a result, this option delivers further estates, clinical and workforce benefits over and above option 2, however is not within the capital envelope currently set for the programme.
4. **Core DMBC + key estates risks + integration (c. £534m):** This option seeks to maximise the opportunity for redevelopment and improvements to overall sustainability. The option delivers the core DMBC requirements and most of the wider Future Fit ambitions – including additional new wards, theatre refurbishment, outpatient transformation, improving the physical environment, substantially reducing the estates risk, optimising estate layout across both sites and providing integrated health and wellbeing services. This will enable greater integration with the wider system for physical and mental health pathways. As a result, this option delivers the most clinical, workforce and estate benefits, significantly greater than options 2 and 3, however is not within the capital envelope currently set for the programme.

The three do-something options (options 2 – 4) are designed to be incremental to each other and delivered through a phased approach.



The appraisal of the short list options provides a thorough consideration of the relative costs, benefits and risks of the options, as well as their sensitivities to changes in assumptions. **The detailed options appraisal undertaken within the Economic Case identifies that:**

- Options 2 to 4 offer significant clinical benefits, include patient safety and patient quality benefits, with option 4 delivering the most benefit.
- Options 2 to 4 offers further workforce and operational benefits vs. BAU and help address the issues we are facing, also with option 4 delivering the most benefit.
- Option 4 offers greatest clinical, workforce and operational benefit and for this reason; it is preferred across multiple qualitative CSFs (inc. clinical model, quality, workforce and effectiveness).
- When considering the costs and benefits that can be quantified, Option 4 offers the greatest value for money to the UK, marginally better than Options 2 and 3. However, both options 2 and 3 offer excellent value for money, and wider significant qualitative benefits and options 3 and 4 should be explored if future funding were to be available.
- Options 2 to 4 are all affordable from revenue perspective – as they offer financial benefits greater than the cost of capital.
- However, Option 3 and Option 4 require more capital than is currently available and therefore fail the capital affordability CSF. However, these options would continue to provide additional benefits and reduce risks to the Trust and System as a whole. Given their relative benefits and opportunity for integration, these should be explored more, if further capital became available. Options 3 and 4 are incremental phases to Option 2 and should more capital become available at a later date the trust would seek to complete these works.

[redacted]

- As Option 2 passes all CSFs (including capital availability), and offers a positive NPSV and BCR, it has been selected as the Preferred Option at this stage – maximising the benefits with the capital available.

As a result of the findings above, Option 2 has been selected as the Preferred Option at this stage. If further capital were to become available, the detailed appraisal highlights that Options 3 and 4 would deliver significant incremental benefit and value for money and should be explored.

Option 2 will provide improved facilities that will better meet the needs of our patients. It will put in place the core elements of the service reconfiguration described in the Future Fit consultation, help us to address our most pressing clinical challenges, and establish solid and sustainable foundations upon which to make further improvements. In particular, this option will:

- be delivered in full by December 2026 as per the programme plan set out in the Management case,
- deliver improvements in quality, safety & experience driven by a consulted clinical model as well as workforce availability and sustainability,
- improve workforce availability and sustainability driven by enhanced build environment,
- reduce waiting times and travel times for hospital services delivered through clinical model and improved access to appropriate specialists,
- meet future capacity needs (new wards) - avoids potentially significant and additional unnecessary costs associated with temporary measures required to address service capacity issues,
- better supports the integration of emergency and planned care pathways, enabling coordinated and seamless patient experience across the pathways,
- offer excellent value for money, with a net present social value of £1,318m and a benefit to cost ratio of 4.43,
- be affordable to the Trust and is within the £312m capital envelope. Demonstration of affordability is set out in more detail within the Financial case.

Our Preferred Option involves investing £312m in Royal Shrewsbury Hospital and Princess Royal Hospital to provide improved facilities that will better meet the needs of our patients. It will put in place the core elements of the service reconfiguration described in the Future Fit consultation, help us to address our most pressing clinical challenges, and establish solid and sustainable foundations upon which to make further improvements. A number of significant challenges will remain, particularly in relation to the standard and viability of patient accommodation at the RSH site and the RSH theatre complex. Whilst these can be managed with some risk of failure over the medium term, these risks will need to be addressed in the long term. This is reflected in the qualitative appraisal and the risk appraisal where options 3 and 4 deliver further benefit.

The Preferred Option is also fully aligned with local health system objectives and the Shropshire Telford & Wrekin JFP. It is one of the ICP's key strategic initiatives that will transform the health and wellbeing of the population of Shropshire, Telford & Wrekin, and Powys.

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

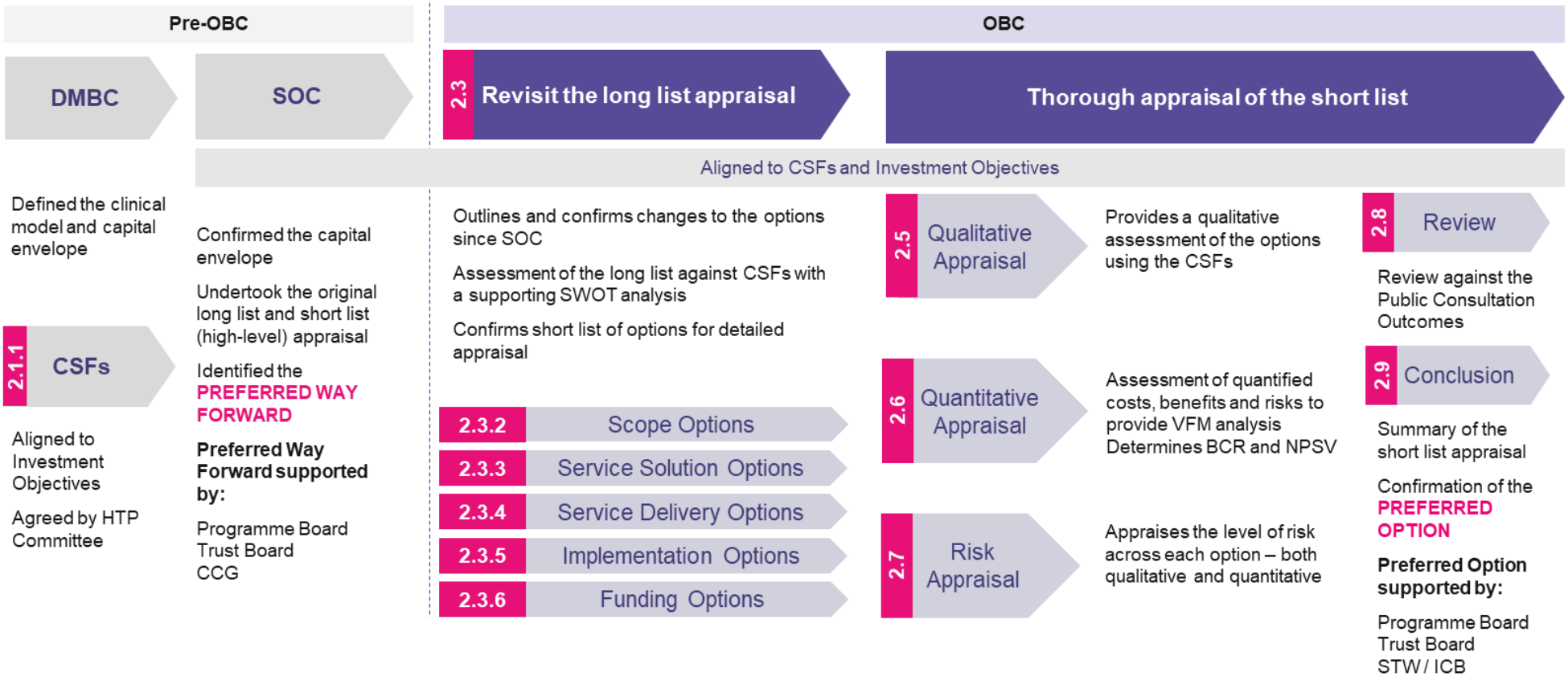
2.1 Approach to the options appraisal

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

Figure 16 outlines the options appraisal process that is detailed in this Economic Case. This appraisal is based on the available evidence when this OBC was developed. If additional options become apparent as the scheme progresses, we will remain open to considering them.

The process of developing and appraising options is based on the standard HMT Green Book approach. It has been informed by a series of workshops and best available evidence (dates and attendees of the key workshops are outlined in Appendix E-07). Where appropriate, outputs and conclusions have been tested more widely, including with the ICS and regulators. The outputs at each stage have been agreed by, as relevant, the Programme Board and the Trust Board of Directors [redacted]

Figure 16: Economic Case development and appraisal process



2.2 Critical Success Factors (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.

Based on our investment objectives, we defined a range of CSFs for assessing the options at SOC. These remain consistent at OBC. They are all the factors an option must pass for us to give them further consideration within the short-list appraisal. Where possible and appropriate, we have also identified where an option is preferred (most favourable) against each of the Critical Success Factors.

2.2.1 Agreed Critical Success Factors

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

Table 19: Critical Success Factors, mapped to investment objectives (Section 1.3.2)

Investment Objective	Critical success factor	Description	HMT Category
1. PRIORITY OBJECTIVE Consultation	Clinical model	Delivering the core DMBC requirements (defined in DMBC S9.3 [Appendix S-02], and associated capacity) and moving towards the wider 'Future Fit' ambitions that are outlined in the DMBC [Appendix S-02].	Strategic fit and business needs
2.Clinical Quality and Safety	Clinical quality and patient experience	Supports required improvement in service and clinical quality and safety	
3. Patient Experience		Supports required improvement in patient experience	
4. Workforce	Workforce	Supports required improvement in workforce availability and sustainability	
5. Effectiveness	Effectiveness / Access	Services must be located to maintain or improve access for local population (patients and staff) and to improve adjacencies and enhance patient flow	
6. Estate	Commercial viability	Procurement route facilitates access to suppliers with capacity and appropriate capability	Supplier capacity and capability
	Build deliverability	Makes an appropriate use of existing NHS estate Deliverable by target year of opening Site locations must be able to deliver the required footprint and capacity Supported by commissioners and the system	Potential achievability
7. Finance	Value for money	Net present social value and benefit-cost ratio[34]	Potential value for money
8. Finance	Revenue affordability	Net contribution to the system's income and expenditure position	Potential affordability
	Capital affordability	Relative capital affordability of the option versus the original allocated capital of c. £312m	

2.3 Long-list and options framework

Building on the extensive consultation completed in 2018–2019, and the supporting options appraisal for the future configuration of our services and subsequent appraisal of the options to deliver the consultation outcome in the SOC completed in 2022, we have further considered the

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

options to best implement the agreed clinical model. We have appraised the costs and benefits of these options to understand an appropriate value option for our local population and the UK public.

The options framework is provided by HM Treasury to help schemes systematically work through the options available to them, covering the choices for what, how, who, when and the associated funding arrangements. These five dimensions of the Options Framework are shown in Table 20.

This OBC considers each of the five dimensions of the options framework and builds on the Future Fit DMBC [Appendix S-02] and the SOC [Appendix S-03], which both defined the scope and configuration of hospital services in Shropshire, Telford & Wrekin. The OBC also addresses the JIC conditions that we were required to meet in order to progress to the next stage of the HTP timeline.

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

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

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

The SOC focussed primarily on how to deliver the scope (solution options) and how best to phase the project and accelerate the benefit. The OBC explores further funding and implementation options as well as an additional service solution option, as requested by JIC.

Table 20: Summary of Green Book options framework[35]

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

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

The long-list considers the potential variations in scope, while still delivering the core DMBC decision, the service solution options, and the arrangements to deliver the scope and service solutions outlined, aligned to the HMT Green Book options framework. This OBC includes additional consideration of implementation routes and alternative funding options.

These options have been developed within an overall Development Control Plan (DCP) for RSH and PRH available in Appendix S-11.

In line with the JIC conditions, we have appraised the following long-list identified by the programme:

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

Table 21: Dimensions of options framework and long-list

#	Domains and options
Scope	
i.	Continue Current Arrangements (comparators)
ii.	Delivering the core DMBC requirements
iii.	Delivering the wider Future Fit ambitions
Service solution	
0.	Business As Usual (minimal capex – system capital)
1.	Additional Comparator (c.72m capex)
2.	Core DMBC ('Do Minimum')
3.	Core DMBC + key estates risks
4.	Core DMBC + key estates risks + integration (delivers the majority of the Future Fit ambitions)
Service delivery	
i.	Procurement Framework
ii.	Single-stage tender
iii.	Two-stage tender
[redacted]	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
Funding	
i.	Internal financing
ii.	Charitable financing
iii.	Government PDC via the HTP
iv.	Private financing

Notes:

1. Options deliver the outcome of consultation and associated clinical model, scope and solution – comparators do not, but are included to meet regulatory requirements.
2. BAU does not deliver the agreed clinical model, scope of solution, but is required by HMT Green Book and is included as a comparator.
3. The Additional Comparator does not deliver the agreed clinical model, scope of solution, but was requested by JIC and is included as a comparator.
4. The additional implementation options from the SOC Long List appraisal reflect the SOC conditions for approval from the JIC.

This creates 122 potential permutations including the BAU comparator and the Additional Comparator at the long-list stage. These are detailed in the Long-list appraisal [Appendix E-01].

The following sections provide the appraisal of the options within each dimension of the options framework. The appraisal has focused on the CSFs that are relevant to each dimension at the long-list stage. The short-listed options will be appraised against all the qualitative and quantitative CSFs.

The scope options are largely defined by the Future Fit public consultation. The service delivery, implementation and funding options have been appraised in more detail at OBC stage.

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

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

2.3.1 Long-list Appraisal: Process

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

Table 22: Appraisal definitions

Appraisal	Definition
Fail	Fail a Critical Success Factor – not expected to meet a Critical Success Factor Not taken forward, with the exception of the BAU / comparator options
Pass	Pass a Critical Success Factor – are expected to meet a Critical Success Factor Taken forward
Preferred	Preferred against a Critical Success Factor – is expected to be most favourable against a Critical Success Factor Taken forward and offer material advantages vs. other options that have passed

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

Once completed for each domain, this provides us with a short-list of options to undertake a further quantitative and qualitative appraisal. The conclusions of the long-list appraisal are summarised in sections below, with the further quantitative and qualitative appraisal undertaken in Section 2.5 and 2.6, respectively.

This long-list appraisal [Appendix E-01] has been based on broad engagement and consideration of the evidence, including:

- Extensive evidence collected through the development of the SOC, where the long-list was first identified and appraised.
- Engagement throughout the winter of 2021/22 in the development of the first draft to review the long-list of options and evidence for the appraisal.
- Further engagement and appraisal of options in late 2022 and early 2023.
- A Long-list and Qualitative appraisal workshop on 9th December 2022, attended by representatives of the Hospitals HTP (outlined in Appendix E-07) Trust, clinicians and the wider system.

The supporting evidence for these appraisals including a SWOT analysis is included in Appendix E-01 and E-03.

2.3.2 Long-list Appraisal: Scope

This section considers the scope of the scheme. Scope was extensively considered as part of the Future Fit consultation, including as part of the PCBC, public consultation and DMBC. During the Future Fit process, a long-list of scope options, including different sites, and configurations of services across sites was considered. Through this process, we agreed the shape of the reconfiguration of acute services across Shropshire, Telford & Wrekin.

The agreed configuration of services was for RSH to specialise in emergency care and for PRH to specialise in planned care, with the scope of the services to be provided on each site defined in the Future Fit decision-making business case.[36]

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

This OBC reflects the JIC conditions and therefore looks at a wider scope option of 'Continue Current Arrangements' compared to just BAU at SOC, to account for the Additional Comparator option.

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

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

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

i. **Continue Current Arrangements.** This option does not deliver any of the requirements of the DMBC and is included for comparative purposes. It maintains the risk of service and estate failure. As demand on the Trust increases, activity will have to be increasingly outsourced or met through working late initiatives in order to maintain services.

ii. **Delivering the core DMBC requirements.**

iii. **Delivering the wider Future Fit ambition.**

As a result of the clear direction provided by the consultation, and the wider strategic plans, the scope of this investment is targeted towards delivering the core DMBC requirements and delivering the wider Future Fit ambitions. As outlined in the Strategic Case (Section 1.2.6), there are areas of the Trust's wider strategic plan, such as the development of a planned care hub at PRH (with Phase 1 completing in July 2023 and Phase 2 completing in Q4 2023/24) and the off-site renal dialysis unit (expected move date Q3 2023/24) that are out of scope as they are being delivered as separate projects to this investment. However, these projects are aligned to the HTP and are being developed in line with this project. The Management Case (Section 5.1.4) outlines how progress of these other projects is monitored to ensure that the HTP is delivered on time.

A detailed SWOT analysis of the options along with the appraisal against the relevant CSFs is included in Appendix E-01. Continuing current arrangements, delivering the core DMBC requirements, and delivering the wider Future Fit ambition were assessed against the relevant Critical Success Factors. **Delivering the core DMBC requirements** and the **wider Future Fit ambition** were both shortlisted to carry forward for appraisal. Continuing current arrangements was also assessed against the Critical Success Factors but failed against some of them and is therefore carried forward for comparative purposes only.

2.3.3 Long-list Appraisal: Service Solution

This section considers the solution options for the programme and the estates solutions that have potential to deliver the proposed scope. At OBC, there is an additional service solution option which considers the situation with no/ minimal capital expenditure – this option was requested by JIC and is now considered as the BAU option. The previous BAU option is now referred to as the Additional Comparator option as it includes the potential for expansion in capacity and therefore doesn't meet the definition of BAU.

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

2.3.3.2 Summary of the long-listed service solution options

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

0. BAU (new BAU per JIC condition, no/ minimal capex)
1. Additional Comparator (previous BAU)
2. Core DMBC ('Do Minimum')
3. Core DMBC + key estates risks
4. Core DMBC + key estates risks + integration

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

Based on the long-list appraisal of service solution options, our Preferred Option is **(Option 4) Core DMBC + key estates risks + integration**. However, it is noted that although it passes all of the qualitative CSFs which will be looked at in more detail as part of the qualitative appraisal, there are likely to be affordability constraints when appraised quantitatively. All the service solution options are carried forward to the short-list, either as comparators or because they pass all relevant CSFs at this stage.

2.3.4 Long-list Appraisal: Service Delivery

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

i. Framework procurement
ii. Single-stage tender
iii. Two-stage tender

The procurement options have been explored in more detail as part of the OBC process. The advantages and disadvantages of each option are outlined in the Long-list Appraisal [Appendix E-01]. Since SOC stage, we have also further analysed the alternative procurement frameworks. These are considered for the Preferred Option in Section 3.2.

Based on the appraisal of the available procurement options against the relevant CSFs, **our Preferred Option is the Framework Procurement** route to market for the provision of design and construction services.

2.3.5 Long-list Appraisal: Implementation (phasing)

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

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

- **Core DMBC ('Do Minimum'):** Delivered through a single, core, phase of works (Phase 1)
- Delivering the core DMBC requirements and addressing key estates risks: Delivered through two phases, the first delivering the works outlined in the 'Do Minimum' option (Phase 1), and the second phase delivering the additional works of this option (Phase 2)
- **Delivering the core DMBC requirements, addressing key estates risks and improving health service integration:** Delivered through three phases, the first two phases are consistent with the option above (Phases 1 and 2), and the third phase will deliver the additional works of this option (Phase 3)

[redacted]

[redacted]

- [redacted] [redacted]
- [redacted] [redacted]
- [redacted] [redacted]
- [redacted] [redacted]

[redacted]

[redacted]

2.3.6 Long-list Appraisal: Funding

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

Now at OBC stage, as per current business case guidance, it is also important to explore opportunities for alternative funding sources, especially given the specific allocation of funding for this scheme from the Government. These known alternative sources of funding were assessed against the relevant CSFs.

The funding options considered were:

i. Internal financing
ii. Charitable financing
iii. Government PDC via the HTP
iv. Private financing

The Preferred Option will deliver the core DMBC requirements within the allocated funds of £312m and is planned to be funded through PDC as this is the Preferred Option against the other funding options. Internal, private, and charitable financing pass all the CSFs and there is potential to explore contributions during FBC and implementation, however, at this stage these funding options are unlikely to be available and would not be sufficient to finance the scheme.

The Trust has explored and reviewed prioritisation of in-year capital plans. There is circa £18m of internally generated capital per year. The Trust has a significant need to address backlog maintenance and estates risks, and diagnostic replacement over the next few years, which limits the flexibility within the capital plans. The Trust is also planning for £5m per year from 2024/25 to be made available to find a solution for energy provision at the site, which is outside the scope of HTP, but will support its delivery. The above results in there being no opportunity to part-fund HTP through internal initiatives.

2.3.7 Long-list Appraisal: Conclusion

The long-list appraisal identified the options within the options framework to carry forward to the short list appraisal. This is summarised below in Table 23.

Table 23: Summary of appraisal

#	Domains and options	Summary of Assessment
	Scope	
i.	Continue Current Arrangements (comparator)	Carried Forward – Comparators
ii.	Delivering the core DMBC requirements	Short-listed
iii.	Delivering the wider Future Fit ambitions	Short-listed
	Service Solution	
0.	Business As Usual (new BAU per JIC condition, no/minimal capex)	Carried Forward – BAU
1.	Additional Comparator (previous BAU, c.72m capex)	Carried Forward – Additional Comparator
2.	Core DMBC requirements ('Do Minimum')	Short-listed
3.	Core DMBC + key estates risks	Short-listed
4.	Core DMBC + key estates risks + integration	Short-listed
	Service Delivery	
i.	Procurement Framework	Short-listed
ii.	Single-stage tender	Discounted
iii.	Two-stage tender	Discounted
[redacted]		
	Funding	
i.	Internal financing	Explore if available at FBC
ii.	Charitable financing	Explore if available at FBC
iii.	Government PDC via the HTP	Short-listed
iv.	Private financing	Discounted

Further detail on the rationale for the conclusions is outlined within the Long List appraisal, Appendix E-01.

2.4 Short-list

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

Optionality exists within the short-list in the scope, solution, procurement and funding dimensions. Further procurement options, including the selection of the preferred framework are explored in the Commercial Case. [redacted] Despite passing all relevant CSFs, the alternative funding options are unlikely to be available and therefore are not considered in the short-list appraisal. This creates 5 potential permutations for further consideration in the short-list.

This short-list was supported by the HTP Programme Board (25/05/23) and the Trust Board of Directors (13/06/23).

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

- **Option 0: Business As Usual (new BAU per JIC condition, c.£0m/ minimal)**: Continuation of current arrangements, with minimal capital expenditure.
- **Option 1: Additional Comparator (previous BAU, c.72m)**: Continuation of current arrangements, with investment in the estate to address estates risks and provide additional capacity to meet future demand. This option is in line with the BAU option outlined in the SOC.
- **Option 2: Core DMBC: ('Do Minimum') (c.£312m)**: "The minimum capital investment required to deliver only the priority Investment Objective" (DHSC/HMT guidance) – i.e. deliver the core DMBC requirements and move towards wider 'Future Fit' ambitions.
- **Option 3: Core DMBC + key estates risks (c.£481m)**: This allows us to progress beyond the core DMBC requirements towards some of the wider Future Fit ambitions. It seeks to maximise the opportunity for redevelopment whilst improving overall sustainability. This is a fuller development – including additional new wards, theatre refurbishment and addresses all key issues with physical environment and reduces estate risk.
- **Option 4: Core DMBC + key estates risks + integration (c.£534m):** Seeks to maximise the opportunity for redevelopment and improvements to overall sustainability. Delivers the core DMBC requirements and most of the wider Future Fit ambition – including additional wards, outpatient transformation, theatre refurbishment, integrated health and wellbeing services, and addresses all key issues with physical environment and reduces estate risk.

The do-something options (options 2, 3 and 4) are designed to be incremental to each other so that they can be delivered in a phased approach.

Table 24: High-level description of the short-listed options

Dimension	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
Scope	Continue Current Arrangements (comparator)	Continue Current Arrangements (comparator)	Core DMBC decision	Core DMBC decision, and wider Future Fit ambition	Core DMBC decision, and wider Future Fit ambition
Service solution	n/a	n/a	Delivery of clinical model	Delivery of clinical model and addressing key estates issues	Delivery of clinical model and addressing key estates issues and improving health service integration
Procurement*	n/a	n/a	Framework procurement	Framework procurement	Framework procurement
Implementation**	n/a	n/a	Phased implementation	Phased implementation	Phased implementation
Funding***	n/a	n/a	Public Dividend Capital	Public Dividend Capital	Public Dividend Capital

*The alternative procurement frameworks have been explored in more detail for this OBC and this is considered in the Commercial Case. It is not expected that any option will result in notable differences in capital cost or quantitative benefit, and as such they are not considered in the short-list appraisal within the Economic Case.

** The variation in the implementation options have been explored in more detail for this OBC, in line with the requested JIC conditions and is considered both as sensitivities in the quantitative appraisal and within the Financial Case (as affordability sensitivities).

*** Although the alternative funding sources pass all of the relevant CSFs, they are unlikely to be available and therefore are not considered in the short-list appraisal.

Note that BAU (Option 0) and the Additional Comparator Option (Option 1) failed Critical Success Factors in the long-list appraisal, but these are carried forward to the short-listed options for comparison purposes.

2.4.1 Short-list Options

A summary of the short list options is set out below:

*Option 0: Business As Usual (*new BAU per JIC condition)

Table 25: Business As Usual

Description	***As per JIC condition #6, a new BAU option with no / minimal capital investment is included in the options appraisal*** This includes any project 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. Within the BAU, the following will also be included: • RSH and PRH energy centre renewal, subject to securing funding (dependent project and outside core scope of this investment) • Critical works • As per guidance, RSH and 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
Advantages	No capital investment required.
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
Benefits	By definition, Business As Usual has no benefits, as other options are compared to this.
Risks	• Increased risk to patients due to increased demand and deteriorating clinical environment and service failure • Increased 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
Consequences	• Poor patient experience • 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

Conclusion	The option of continuing with Business As Usual is not a viable option, as the investment objective is to deliver the core DMBC requirements and move towards the wider Future Fit ambitions, which would not be met by this option. The Business As Usual option fails on several Critical Success Factors, as it does not deliver the changes to services that are critical for clinical and financial sustainability. This option was requested by JIC and is required as the economic comparator, so will be included in the appraisal process.

In the Business As Usual Option, the primary configuration of RSH and PRH will be the same (e.g. 2 EDs, 2 critical cares, 2 acute medical units) and therefore all main areas of operational risk remain.

Option 1: Additional Comparator (previous BAU)

Table 26: 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 and PRH energy centre renewal • Critical works • As per guidance, RSH and PRH annual essential backlog only will be addressed (that can be delivered through depreciation-funded capital) • Potential capital programme for winter bed pressures
Advantages	• Through increased capacity, it allows the Trust to avoid outsourcing activity. • Through investment in the estate, some estates risks will be mitigated.
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 and 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 poor patient experience, impacting on patient outcomes, and 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
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. • 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
Consequences	• De-scopes backlog maintenance including significant /high risk backlog, which will have to be addressed separately or at a later date when further funding is available. • 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
Conclusion	The Additional Comparator option is not a viable option, as the investment objective is to deliver the core DMBC requirements and move towards the wider Future Fit ambitions, which would not be met by this option. The Additional Comparator option fails on several Critical Success Factors, as it does not deliver the changes to services that are critical for clinical and financial sustainability.

	This option is included as an additional economic comparator to remain consistent with the SOC, so will be included in the appraisal process.

In the Additional Comparator Option, the primary configuration of RSH and PRH will be the same (e.g., 2 EDs, 2 critical cares, 2 acute medical units) and therefore all main areas of operational risk remain.

Option 2: Core DMBC ('Do Minimum')

Table 27: 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. There is approximately 5,800sqm of refurbishment within Option 2 with approximately 29,000sqm of new build. The only works identified for PRH within the £312m is for the refurbishment of A&E at approximately £1.5m. 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 2030.
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 %)
Disadvantage	• Requires the continued use of existing sub-optimal wards from a space utilisation and 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 support further consolidation of all Women and Children's services with some elements remaining in existing accommodation at RSH, which is not purpose designed • Provides limited increase in single room provision across the entirety of the ward estate (most of the site development activity associated with this option takes place at the RSH site and the works are focused primarily on implementing the clinical reconfiguration. As a result, the majority of the existing ward accommodation will continue to be utilised). • This solution would result in a significant contrast between buildings, with some new build elements compliant with modern standards and HBNs, and some buildings unaltered and remaining in poor condition

Benefits	•	Better patient outcomes (including improved morbidity and mortality) – urgent and emergency care
	•	Reduced 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
	•	Provides improved staff facilities, with staff welfare considered throughout the design. Each department has it's own staff rest room and kitchen areas, with new change male and female changing areas attached to the new build.
Risks	•	This option leads to continued use of the existing ward accommodation in the upper three floors of the ward block deemed as condition 'C(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
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 on ward condition)
	•	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

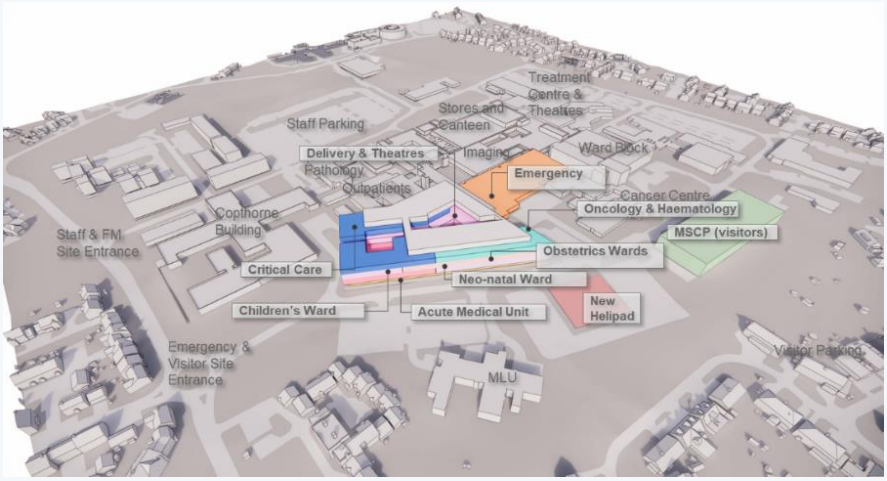
To note, the Hospital Transformation Programme (HTP) has considered the estate driven recommendations derived from the Lord Carter Efficiency Review within its current design proposals. The scheme complies with all the relevant Carter efficiency recommendations, as outlined below.

The latest Trust issued ERIC submission identifies approximately 43,960sqm (69.3%) of occupied clinical space at RSH, with 19,445sqm (30.7%) of non-clinical space, PRH has 38,067sqm (77.2%) of occupied clinical space with 11,197sqm (22.8%) of non-clinical space. The total non-clinical space identified across both Trust sites is 27.19%. The latest Model Hospital space utilisation data identifies the non-clinical space across the Trust as being below the national targets of 30.9% and below the peer meridian of 32.5%.

Empty space at the Trust, identified at the time of the six-facet survey, is 1.4% which is slightly over the benchmark target of 1.1% and the peer meridian of 0.9%. Empty space is mainly associated to plant and ancillary space because of ongoing backlog maintenance works

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

Figure 17: Summary representation Core DMBC ('Do Minimum')

RSH site option 2 (phase 1)		Option 2 RSH Scope: • New ED • New W&C Inc New Theatres, Obstetrics & Neo-natal Wards. • New Critical Care • New Acute Medicine Area • New Oncology & Haematology Wards • Relocation of Helipad (The enabling works are represented in orange)
PRH Site option 2 (phase 1)		Option 2 PRH Scope: • Planned Care Hub (funded via TIF2 and is expected to be completed by early 2024) • Admin Hub works (alternative funding from regional TIF 2 funding) • A&E Local Model (UTC)

Option 3: Core DMBC + key estates risks

Option 3 builds on option 2 with further investments in the facilities and estate, driving further benefit and mitigating risk.

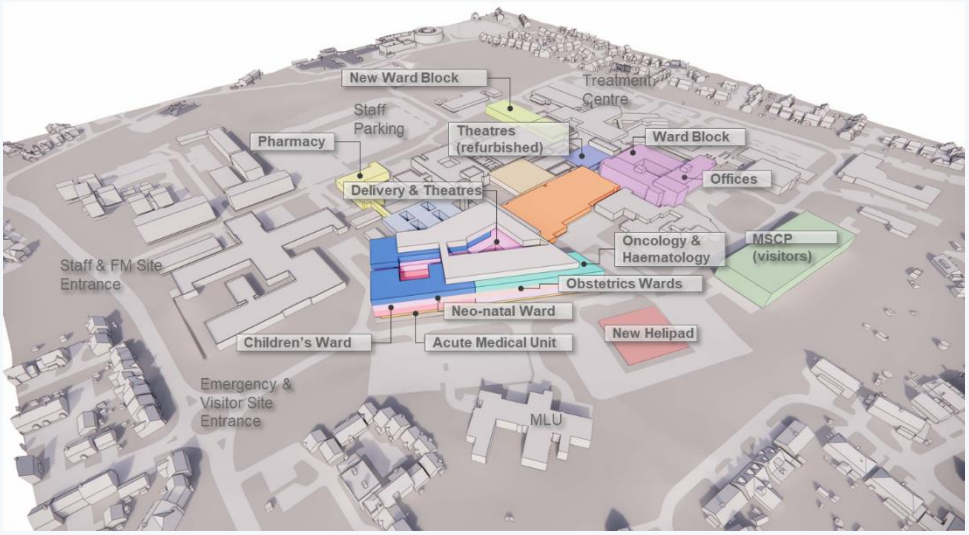
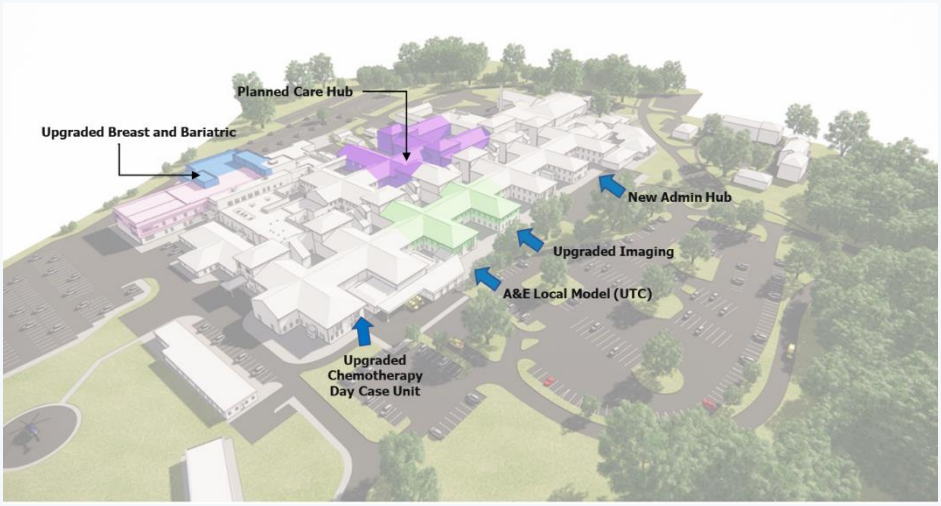
Table 28: Core DMBC + key estates risks

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 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

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) • The capacity we need for the future would be met within new ward accommodation at RSH that meets latest standards and address the latest CQC feedback on ward condition • Facilitates the colocation of Women and Children's services • Provides an increased footprint to repatriate off-site staff and deliver educational requirements • Refurbishes theatres
Disadvantages	• Lack of redevelopment of outpatient departments impacts on improvements to flows and efficiencies • Restricts ability to integrate acute and community services • When implemented through a phased approach, delivery timelines are extended (and overall costs increased)
Benefits	• Delivers the core DMBC requirements and some of the wider Future Fit ambition • Provides the bed capacity to vacate and repurpose the upper three floors of the ward block, an area with significant estates risks • Better patient outcomes (including improved morbidity and mortality) – urgent and emergency care • Reduced waiting times (including ambulance handovers) • Improved emergency department throughput, better emergency access target performance • Further improvements to patient and staff experience (over and above option 2) • Further improvements to clinical adjacencies and flow, better bed utilisation (over and above option 2) • Provides increased pandemic / infection control resilience on the RSH site (reduced risk of HCAIs) • Expanded range of elective services (increased efficiency and access / better outcomes) • Results in improved facilities and environment • Provides improved staff facilities, with staff welfare considered throughout the design.
Risks	• Interdependent on the progression of the day case hub
Consequences	• Will not improve patient quality and experience across the entirety of the estate • Will not support wider optimisation of activities on each site

The use of RSH and PRH are summarised below. Further information is included in Appendix S-11.

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

RSH site option 3		Option 3 RSH Scope: • 4 New Wards • Refurbishment of Theatres • Refurbishment of Ward Block • Upgrade of Pharmacy (The enabling works are represented in orange)
PRH Site option 3		Option 3 PRH Scope: Departmental Relocations • Breast & Bariatrics to W&C • Upgrade of Imaging • Chemotherapy to use Day case unit

Option 4: Core DMBC + key estates risks + integration

Option 4 builds on option 2 with further investments in the facilities and estate, driving further benefit and mitigating risk.

Table 29: 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: • Consolidate planned care at PRH (particularly, when considered alongside day case hub investments) • 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 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 • Refurbishment of wards at PRH
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 met within new ward accommodation at RSH that meets latest standards and address the latest CQC feedback on ward condition • Facilitates the colocation of all Women and Children's services • Provides an increased, consolidated footprint to deliver educational requirements • Fit for purpose and sustainable estate and infrastructure to deliver clinical services
Disadvantages	When implemented through a phased approach, delivery timelines are extended (and overall costs increased)

Benefits	• Delivers the agreed clinical model, reconfiguration and associated clinical benefits (quality, safety, and workforce)
	• Optimises site layouts and facilities, with additional improvements in adjacencies and patient flow leading to enhanced quality, performance, and experience (more efficiency and improved utilisation)
	• Better patient outcomes for (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
	• Improved planned care waiting times with reduced cancellations
	• Further improvements to patient and staff experience
	• Further improvements to clinical adjacencies and flow, better bed utilisation
	• Provides increased pandemic / infection control resilience on the RSH site (reduced risk of HCAIs)
	• Further expansion of range of elective services (above option 3, increased efficiency and access / better outcomes)
	• Enhanced access to rehabilitation services
	• Enhanced support for LTCs through enhance integrated models of care
	• Improved and seamless integration of services with system partners – Health and Wellbeing services, and broader benefits of the Integrated Care Hub including
	  • Facilities to support uptake of virtual outpatient appointments
	  • Triaging services that shift towards planned urgent care appointments
	  • Provision of mental health support / services
	  • Support for patients age 65+ to reduce frailty admissions
	• Enables the repurposing of significant areas of the ward block
	• Provide workforce sustainability

Risks	Interdependent on the progression of the day case hub

Consequences	Limited adverse consequences as this option delivers the core DMBC requirements and most of the wider Future Fit ambition

The use of RSH and PRH are summarised below.

Further information is included in Appendix S-11.

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

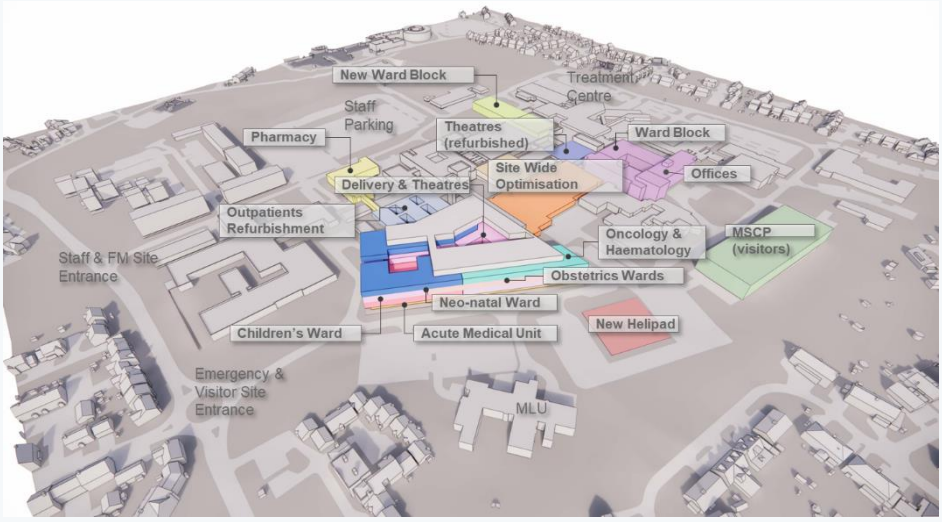
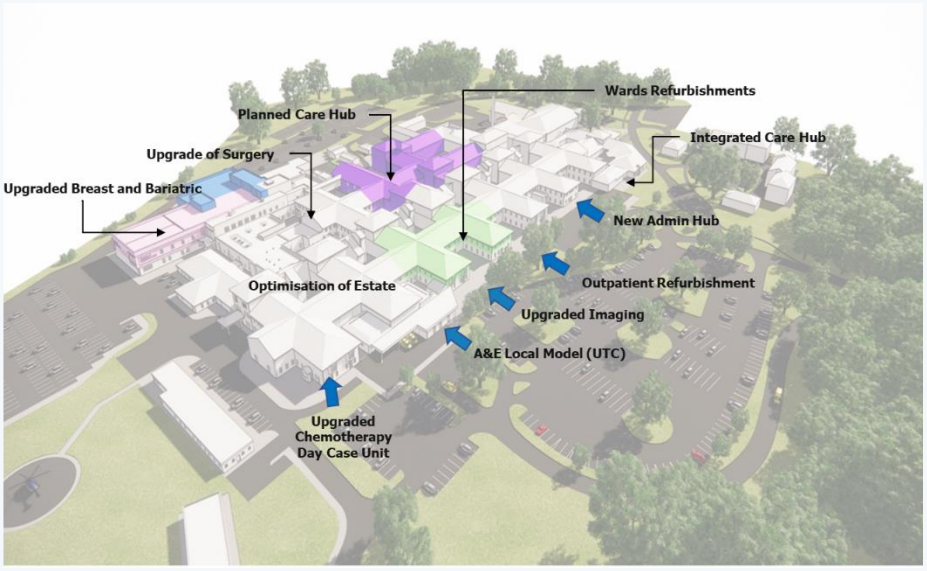
RSH site option 4		Option 4 RSH Scope: • Refurbishment of OPD • Site wide Optimisation (The enabling works are represented in orange)
PRH Site option 4		Option 4 PRH Scope: • Ward Refurbishments • Outpatient Refurbishment • New Integrated Care Hub

Table 30: Integrated Care Hub Description

The integrated care hub will deliver
The investment into Integrated Care Hub would provide resources to enable the following: 1. Facilities to support uptake of virtual outpatient appointments 2. Triaging services that shift towards planned urgent care appointments 3. Provision of mental health support services 4. Support for frail patients to reduce hospital admissions patients This will deliver benefits to both the Trust and System, as well as to the wider population. [redacted] This is supported by our partners within the system including ShropComm and MPUFT who we will work closely with on the delivery of the Integrated Care Hub in this option. At present, we have made the prudent assumption the floor area will be c. 1100 sqm at PRH made up of Ward 37 and16.

2.5 Qualitative Appraisal

A qualitative appraisal of the short-listed options was carried out to support the identification of the Preferred Option and assess the options characteristics that could not be quantified. This involved assessing each of the short-listed options against the qualitative CSFs.

The summary qualitative appraisal against the Critical Success Factors for each short-listed solution option is shown below. The evidence underpinning this appraisal is provided in the Appendix E-03.

2.5.1 CSF1: Clinical model (aligned to priority Investment Objective)

Options 0 and 1 will not only fail to deliver the DMBC decision, but they will also lead to deterioration of the current clinical state with risk of service and estate failure. Options 2 to 4 deliver the core configuration of our services and achieve the priority investment objective (delivery of core DMBC requirements and move towards the wider Future Fit ambitions before 2029). Options 3 and 4 deliver more of the wider Future Fit ambition and provide further improvement in adjacencies and service experience.

Table 31: Clinical Model appraisal

	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 as demand beings to exceed capacity.**	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

2.5.2 CSF2: Clinical quality and patient experience

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

Table 32: Overall single room provision (new build areas at 70%)

		RSH	PRH
0	Business As Usual	<5%	16%
1	Additional Comparator	<5%	16%
2	Core DMBC ('Do Minimum')	19%	16%
3	Core DMBC + key estates risks	36%	16%
4	Core DMBC + key estates risks + integration	36%	>16%

In the Core DMBC ('Do Minimum') option, the limited allocated investment funds have been focussed almost entirely on delivering the pathway changes described in the consultation documents. As a result, very little funding has been allocated to wider estate improvements. This is highlighted by the lower increase in the ratio of single rooms and the reduced amount of estates backlog that is addressed by Option 2.

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

As part of the service reconfiguration on the RSH site, four new wards are being added (with 72% single room provision), which means that the proportion of single rooms (adult beds) at the RSH site will increase from 14% to 19%.

No additional ward capacity is being added at the PRH site, however, ward refurbishment will be completed in Option 4 which will seek to increase the proportion of single rooms with a long term aspiration to align to Government standards.

Table 33: Quality and Experience appraisal

	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	• Substantial issues with quality and safety not addressed • Risk of further deterioration and threat to patient safety	• Poor	Fail
1	Additional Comparator	• Substantial issues with quality and safety not addressed • Risk of further deterioration and threat to patient safety	• Poor	Fail
2	Core DMBC ('Do Minimum')	• Improvements in quality and safety driven by consulted clinical model which better integrates care, enabling coordinated and seamless patient experience across the pathway (clinical outcomes, waiting times, safety) • Provides improvements to some pathways • Lack of redevelopment of OPD impacts on improvements to capacity and patient experience • Continued use of the existing ward accommodation in the tower block	• Improvements in experience driven by consulted clinical model (waiting times, coordination of care) • Provides improved facilities, but only in the new build areas of the development • Continued use of the existing ward accommodation in the tower block (poor environment)	Pass
3	Core DMBC + key estates risks	As Option 2, plus: • Improvements in quality and safety driven by enhanced build environment (pandemic / infection control, resilience) • Provides improvements to most pathways • Allows mitigation of all significant clinical risks • Upgrades of Breast, Bariatrics and Surgical services • Lack of redevelopment of OPD impacts on improvements to capacity and patient experience • Provides enough new bed capacity to vacate the ward block (mitigates IPC risk)	As Option 2, plus: • Improvements in experience driven by enhanced build environment (design, privacy, dignity) • Increased single room provision (privacy, dignity) • Provides enough new bed capacity to vacate the ward block (mitigating poor experience)	Pass

	Options	Supports improvement in service and clinical quality and safety from current levels	Supports improvement in patient experience from current levels	
4	Core DMBC + key estates risks + integration	As Option 3, plus: • Further improvements driven by estate optimisation, additional upgrades (OPD, wards) and Health and Wellbeing services	As option 3, plus: • The Integrated Health and Wellbeing Hub which will enable a number of initiatives including: - Virtual outpatient clinics - Mental health support services - Frailty support services - Improved triaging into planned urgent care These services will generate a substantial benefit to the population of STW as outlined in the quantitative appraisal, and in Appendix E-09.	Preferred

Option 4 delivers the greatest qualitative benefits to clinical quality and safety and patient experience. While options 2 and 3 both pass the clinical quality and patient experience CSF, Option 4 delivers notably greater benefits through the additional investment in clinical services at both the RSH and PRH sites.

2.5.3 CSF3: Workforce

Options 0 and 1 have a high reliance on agency staff due to recruitment and retention issues. These issues are likely to have an impact on the quality of care and the health and wellbeing of staff. These options also maintain the risks of service failure in key clinical services. Options 2 to 4 offer improvements for the workforce driven by the clinical model, however, Option 4 also offers additional benefits associated with further optimisation and upgrades across the sites support staff morale, recruitment and retention and increased staff engagement. Role attractiveness is also improved through better integration with partners and enhanced Health and Wellbeing services.

Table 34: Workforce appraisal

	Option	Supports improvement in workforce availability and sustainability from current levels	
0	Business As Usual	• Worsening of current recruitment and retention issues. • Increased agency usage to back-fill resignations.	Fail
1	Additional Comparator	• Worsening of current recruitment and retention issues. • Increased agency usage to back-fill resignations.	Fail
2	Core DMBC ('Do Minimum')	• Improvements in workforce availability and sustainability driven by clinical model (rotas, recruitment, retention) • Improvements in workforce availability and sustainability driven by enhanced physical environment and staff facilities (morale, wellbeing), limited to redeveloped areas only	Pass
3	Core DMBC + key estates risks	As option 3, with: • Further improvements in workforce availability and sustainability driven by enhanced physical environment and staff facilities (morale, wellbeing), limited to key estates risks	Pass
4	Core DMBC + key estates risks + integration	As option 4, with: • Further improvements in workforce availability and sustainability driven by enhanced physical environment and staff facilities and optimisation across both sites • Increased staff engagement and role attractiveness through better integration with partners to deliver enhanced Health and Wellbeing services	Preferred

2.5.4 CSF4: Access/Effectiveness

Options 0 and 1 do not result in reconfiguration of services and therefore are likely to lead to deterioration in access and effectiveness. Options 2 to 4 result in the reconfiguration of services.

Table 35: Access/effectiveness appraisal

	Option	Services must be located to maintain or improve access for local population (patients and staff)	
0	Business As Usual	• Increase in travel time • Deterioration in waiting times • Onward management of patients is likely to deteriorate	Fail
1	Additional Comparator	• Increase in travel time • Deterioration in waiting times • Onward management of patients is likely to deteriorate	Fail
2	Core DMBC ('Do Minimum')	• Some increased travel time mitigated through DMBC actions • Reductions in waiting times for hospital services delivered through clinical model • Improved access to all appropriate specialists	Pass
3	Core DMBC + key estates risks	• Some increased travel time mitigated through DMBC actions • Reductions in waiting times for hospital services delivered through clinical model • Improved access to all appropriate specialists • Improved staff access to patients	Pass
4	Core DMBC + key estates risks + integration	• Some increased travel time mitigated through DMBC actions • Reductions in waiting times for hospital services delivered through clinical model • Improved access to all appropriate specialists • Improved staff access to patients • Health and wellbeing hub (Integrated) Care improves access further	Preferred

2.5.5 CSF5: Commercial viability

Options 0 and 1 are likely to require outsourcing which has the potential to impact ICS sustainability. Options 2 to 4 have viable procurement routes.

Table 36: Commercial viability appraisal

	Option	Procurement route facilitates access to suppliers with capacity and appropriate capability	
	Business As Usual (new BAU per JIC condition,)	• BAU Trust procurement can apply • Potential to impact ICS sustainability	Fail
	Additional Comparator (previous BAU)	• BAU Trust procurement can apply	Pass
2	Core DMBC ('Do Minimum')	• Several procurement routes are available all of which have potential to find a contractor who can deliver the required services • 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

2.5.6 CSF6: Build deliverability capacity and support

Options 2 to 4 pass all the components of this CSF including making good use of the existing NHS estate, being deliverable by 2029, delivering the footprint and capacity required and are supported by commissioners and the system. As outlined in the table below, Options 2, 3 and 4 pass all the components of this CSF.

Table 37: Build deliverability appraisal

	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	Unlikely to be supported – does not deliver system aims	Fail
1	Additional Comparator	Does not address backlog and estates issues Limited additional capacity will be unable to make services more efficient	Ongoing programme	Existing site footprint cannot accommodate capacity	Unlikely to be supported – does not deliver system aims	Fail
0	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

2.5.7 Other Qualitative Impacts

As well as an assessment against the qualitative CSFs, as part of the qualitative appraisal, it is important to consider the wider societal impacts of the options. The societal benefits for each option are defined within Section 2.6.1 and highlight the QALY impacts of each option.

Notably, the BAU and Additional Comparator options do not deliver adequate ED capacity or emergency specialist functionality. The resultant impact of this, combined with the demographic of STW, is an increase in patient mortality as the Trust exceeds its 4+ hour target as demand continues to outstrip capacity.

There are additional population benefits derived in each option, as a result of an expansion in provision of services. The 'do-something' options will also improve job prospects for the local population due to better health outcomes for patients resulting in people returning to work earlier and also remaining in their jobs for longer.

The 'do-something' options will allow the hospital to move towards the goal of achieving net-zero emissions by 2032. Despite increasing space resulting in more energy being used, the new areas of the hospital will be more efficient. Achieving net-zero emissions is dependent on the successful delivery of the new energy centre.

2.5.8 Qualitative appraisal summary

Based on the qualitative evidence provided in above, the Programme Board endorsed the appraisal of the Solution options shown below on 25th May 2023.

Table 38: Qualitative appraisal of short list options against CSFs

	Option	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

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

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

The BAU and Additional Comparator options are carried forward as comparators, however it should be noted they are not viable options as they fail several CSFs.

Table 39: Benefits against investment objectives

Investment Objective	Description	Option (2)	Option (3)	Option (4)
Clinical Quality and Safety	Improve **cancer waiting times** as a result of ringfenced elective capacity/facilities and more effective pathways (improve cancer waiting times against peer trusts from lowest quartile 1 to highest quartile 4)	●	●	●
	Support **elective restoration and recovery** in medium-term with additional, pandemic resilient, ringfenced elective capacity (helping to deliver 130% of pre-pandemic elective activity by 2024/25)	●	●	●
	Reduce average **elective LoS** by 0.5 days as a result of improved adjacencies and separation of emergency flows	◑	◕	●
	Eliminate **delayed transfers (longer than 2 hours) from critical care**	◑	◕	●
	Increase **weekend discharges** from 35% of the average weekday discharges to 75%	●	●	●
	Increase adoption of **zero length of stay pathways** (meeting Directory of Ambulatory Emergency Care upper recommended levels for patients deemed suitable for AEC treatment)	●	●	●
	Eliminate mixed-sex breaches	◑	◕	●
	Reduction in **hospital acquired infections (HCAIs)**	◑	◕	◕
	Reduction in emergency transfers between sites as a result of emergency depatment and speciality consolidation	◕	◕	◕
	Increased single room provision	◕	●	●
	Dedicated Therapy Led Ward provision	◑	◑	◑
Patient Experience	Eliminate **'day before' and 'on day' elective cancellations** resulting from emergency escalation	●	●	●
	Increased single room provision for improved privacy and dignity	◑	●	●
	Improved environment with access to outside space and natural light for our most vulnerable patients	●	●	●
	Increasing overall provision of day case chemotherapy	◕	◕	◕
	Provision of a dedicated Procedure Suite	◑	◑	◑
	Reduced waiting and over-crowding in the emergency department within purpose designed facilities	◕	◕	◕
	Improve patient experience (increase Friends and Family uptake from 13% to 20% and maintain 99% positive outcomes)	◑	◕	●
Effectiveness	Improve **referral-to-treatment performance** (exceeding national target of 90%)	◕	●	●
	Eliminate **12-hour breaches**	●	●	●
	Reduce **4-hour emergency wait breaches** (exceeding NHSE/I A&E target of 85%, upper quartile performance vs peer NHS Trusts)	◕	●	●
	Improve **general and acute bed occupancy** (from an average of 92%, peaking at 98% during winter escalation, to a target of 89% across the year)	●	●	●
	Ensure 95% of patients are admitted to ward within 45 minutes of decision to admit time (including resus)	◕	●	●
	Improved utilisation of a planned care pathway for patients	●	●	●
	Improved adjacencies between the Emergency Department and the Acute Medical Service to support better patient flow	●	●	●
	Improved MDT working with consolidation of emergency specialities	●	●	●
	Reduce **ambulance handover times** (95% of handovers within 30 mins)	●	●	●
Workforce	Positive impact on **staff experience** leading to improvements in recruitment and retention (increase staff recommending SaTH as a place to work into the upper quartile of peer NHS Trusts, reduce staff turnover by 5%)	◑	◕	●
Estate	Improve the standard of the hospital estate, **reducing overall estate risk and improving experience** (for patients, familiies and staff)	◑	●	●

Key

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

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

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

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

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

The Trust's longer-term strategy is to deliver the core DMBC outcome and progress the wider Future Fit ambition, which would be delivered if option 4 were selected, increasing the qualitative benefits (as described above) but exceeding the allocated funding.

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

2.6 Quantitative Appraisal

2.6.1 Benefits

2.6.1.2 Analytical framework, approach to benefits beyond SOC

As outlined in the Strategic case, our current configuration and layout of acute services will not support future population needs and presents an increasing risk to the staffing, quality and continuity of services**.** Services are duplicated and fragmented, leading to complex patient pathways that increase the risk to patient outcomes. Emergency, medicine and critical care services with significant workforce challenges require urgent change and consolidation.

Whilst a proportion of the benefits delivered by the options are quantifiable, it is important to note that a significant driver of the case for change are the unquantifiable benefits to patients, staff and services from our current estate and clinical models. The risk appraisal in Section 2.7 highlights the possible significant cost of business risk, should these benefits not be realised under the Preferred Option.

At SOC stage, benefits were quantified at a high level (appropriate for this stage of the business case development process) and based on the information available at the time. Since submission, a detailed review has been undertaken to ensure that the benefits quantified at SOC remained relevant and appropriate to progress to OBC. The process that was followed is outlined below.

1. Refreshing benefits

The programme had identified a longlist of benefits associated with individual sites, within the SOC. This work has been collated and formed based on this benefits longlist, alongside ongoing work, and precedent from other programmes. At OBC these have been refined based on discussions with leads, and assumptions have been updated.

2. Additional Benefits

Further work has been done to quantify additional benefits. An initial hurdle criterion based on feasibility was then applied and a benefits prioritisation exercise was undertaken to reach the final shortlist of benefits for quantification. We focused on those benefits with the greatest materiality, strategic alignment, and differentiation across options.

3. Master Schedule

A master schedule of agreed benefits was produced, with support from clinicians, leads, etc. Detailed logic models with an outlined methodology, the assumptions and their assumptions were collated and shared with the UHD team to ensure they were deliverable and they fit the case's aspirations.

4. Option split and phasing

A set of drivers and assumptions were then produced which set out how each benefit would likely be applied to different options within the OBC. This was then phased across the years to ensure effective input into the CIA model.

The detailed long-list of benefits that have been reviewed, including those tested and deemed non-viable [redacted]

Benefits with a high degree of double-counting risk with each other, or with ongoing scheme were also ruled out at this stage.

The master benefits schedule has been derived by members of the HTP team, with support from various members of staff at SaTH. The relevant owners have tested logic models, rationales, and assumptions, as well looking at similar interventions and schemes. The final list of benefits to progress to OBC has an allocated lead for each line with whom the detailed calculation has been derived. This has then been tested with a wide range of stakeholders from the Trust including finance, estates, clinical and executive colleagues. The master schedule of benefits includes the following areas:

1. Estates benefits
2. Patient safety benefits
3. Clinical benefits
4. Workforce benefits

These fall under the following categories:

Table 40: Main benefit categories

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

The detailed rationale and calculations for each of these benefits are outlined below, [redacted] All benefits have been calculated at 22/23 prices. The benefits are all fully realised by 31/32, a detailed breakdown of the phasing of each benefit is shown in the CIA model [Appendix E-04].

2.6.1.2 Estates benefits

In each option, the estate undergoes differed levels of refurbishment or rebuild. As a result, there is a net benefit of improved efficiency and savings from furloughed estate, which is offset by the increased size of the site. Where the estates benefits are offset by an increased floor area, this has been reflected in the CIA model appropriately. [redacted]

Table 41: Estates Benefits

Description	Rationale	Calculation Methodology	Benefit type
Maintenance	Areas which are either new or refurbished accrue a lower level of maintenance cost per GIA versus current levels. The benefit is the net impact of the more efficient refurbished area, less the additional cost from any new build.	Refurbished area improves to maintenance cost / GIA as peer upper quartile. New build area improved to cost / GIA as peer upper decile. Savings from furloughed area offset.	CR
Energy	Areas which are either new or refurbished accrue a lower level of energy cost per GIA versus current levels. The benefit is the net impact of the more efficient refurbished area, less the additional cost from any new build.	Refurbished area improves to energy cost / GIA as peer upper quartile. New build area improved to cost / GIA as peer upper decile. Savings from furloughed area offset.	CR
Waste	New or refurbished areas will generate lower waste costs (confidential, domestic, other waste etc) due to improved layout and waste / recycling facilities The benefit is the net impact of the more efficient refurbished area, less the additional cost from any new build.	Categories of waste include domestic waste (recycling and incineration), confidential waste and other waste. Refurbished area improves to waste cost / GIA as peer upper quartile. New build area improved to waste cost / GIA as peer upper decile. Savings from furloughed area offset.	CR
Backlog maintenance	A level of backlog maintenance will be addressed upon completion of each option.	Overall backlog less asbestos allowance is decreased by the value addressed in the option. The Trust is assumed to pay 10% of their backlog costs each year.	NCR
Estates utilisation	Following the new build, there is opportunity to better utilise the existing estate, reducing usage of offsite spaces.	Released costs for offsite estate including leases, service charge, maintenance, energy, waste and backlog costs	CR

2.6.1.3 Patient Safety Benefits

Improved patient safety is a primary driver of the HTP, however, not all of the patient safety benefits are quantifiable. Those which are quantifiable are expected to have a cash-releasing impact from reduced length of stay, reduced litigation costs etc, a non-cash releasing impact from improving staff productivity, and a societal benefit from the associated QALY. [redacted]

Table 42: Patient Safety Benefits

Description	Rationale	Calculation Methodology	Benefit type
Patient falls	Improved facilities reduce likelihood and severity of patient falls. This reduces patient length of stay and associated ligation costs. There is a productivity gain to staff from the inefficiencies associated with falls, as well as a QALY accrued to patients who avoid falls.	Total patient falls reduced to target level. Associated cost, productivity and QALY value applied to expected reduction in falls.	CR / NCR / SB
Adverse Drug Events (ADEs)	Improved facilities reduce likelihood of adverse drug events. The digital strategy that is in development will further improve this benefit. This reduces patient length of stay and associated ligation costs. There is a productivity gain to staff from the inefficiencies associated with falls, as well as a QALY accrued to patients who avoid falls	Total ADEs reduced to target level. Associated cost, productivity and QALY value applied to expected reduction in ADEs.	CR / NCR / SB
Hospital acquired infections (HCAIs)	Improved facilities reduce likelihood of HCAI This reduces patient length of stay and associated ligation costs. There is a productivity gain to staff from the inefficiencies associated with falls, as well as a QALY accrued to patients who avoid falls	Peer benchmarking performed. Areas which are refurbished, or new build are assumed to improve HCAIs to peer level.	CR / NCR / SB

2.6.1.4 Clinical Benefits

A large amount of detailed modelling underpins the OBC clinical benefits, including the refreshed demand and capacity modelling, as well as the modelling for the new BAU scenario. Additionally, prudent assumptions have been made to ensure there is no double count with other schemes underway, in particular the Planned Care Hub Business Case. [redacted]

Table 43: Clinical Benefits

Description	Rationale	Calculation Methodology	Benefit type
Length of Stay	Improved patient facilities including more natural light, better air filtration, reduced noise, single rooms etc, contribute to a reduced length of stay.	As part of the demand and capacity modelling the Trust has reflected a reduction in LOS to peer upper quartile level for certain services will deliver reduced demand for beds. The non-pay element of this is a cash releasing / non-cash releasing benefit, whilst the pay element is captured through the workforce modelling. There is an additional societal benefit of reducing patient time in hospital.	CR / NCR / SB
Increased Capacity	The Trust is currently operating at around 98% capacity, at times exceeding 100% capacity. Without investment, every additional unit of activity will need to be delivered at premium cost. In all of the options, additional capacity is delivered which enables these premium costs to be released.	Modelling has been undertaken to show where elective demand (inpatient and day case), will exceed capacity. The Trust is assumed to service a proportion of this activity though WLIs, with the remainder being outsourced. The marginal cost of WLIs or outsourcing is applied to each unit of activity. There is an assumption that the Trust will continue to service all the activity through these initiatives, as opposed to increasing the backlog in the system. This benefit is therefore fully cash releasing.	CR

Description	Rationale	Calculation Methodology	Benefit type
Theatre cancellations	HTP will enable the new theatre model, splitting emergency and elective care. The more appropriate models of care, as well as availability of staff and facilities / beds, will further be able to reduce controllable cancellations.	Cancellations controllable by SaTH have been identified, along with the time at which they were cancelled. The HTP is assumed to decrease cancellations to different levels depending on the reason for cancellation. The corresponding bed day impact from controllable cancellations is then calculated and a productivity / cash releasing benefit is attributed.	CR / NCR
Theatres Utilisation	The Planned care hub case will enable 4 theatres at PRH to achieve 85% utilisation. The HTP will further enable 85% utilisation in the remaining theatres once the new clinical model is in place.	Quantification of additional hours used effectively from moving to 85% utilisation vs baseline for both the planned care hub and the HTP changes. The cost per hour of running a theatre has been applied to hours saved.	NCR
Integrated care	In Option 4 only, funding is allocated for an integrated care hub. Treating patients in this setting can reduce A&E attendances and unnecessary admissions. It will also facilitate a virtual outpatient service.	Reduction in A&E attendances from mental health patients to peer benchmarked levels. Savings associated with moving towards virtual outpatient target levels. Movement towards planned urgent care reduces time for nurses ensuring patients are at the correct location.	CR / NCR / SB
A&E QALY	The Trust is currently delivering more than 50% of its A&E activity over 4 hours. The forecast growth rate of A&E activity, aligned with system assumptions, will put a significant amount more pressure on this. Unlike with elective activity, the Trust does not have viable options to service this additional volume of activity and the result is therefore a worsening in patient outcomes.	Increase in patient mortality from Type 1 attendance delays has been calculated, with the corresponding QALY value should additional capacity not be created. In Options 2, 3 and 4, this large societal impact will be avoided. [redacted]	SB

2.6.1.5 Workforce benefits

Detailed workforce modelling has been undertaken at OBC, triangulated with the finance and demand and capacity modelling. [redacted] Bottom-up workforce models have been detailed for the areas that are expecting to see major changes from the HTP, and they have been tested and refined through a number of sessions with stakeholders from Finance, Workforce, Executive and Clinical teams. [redacted]

Table 44: Workforce Benefits

Description	Rationale	Calculation Methodology	Benefit type
Substantive staffing	Three key areas have been identified as those which will see material reconfiguration upon completion of the HTP. These areas are Urgent and Emergency care, Medical beds at the site specialising in planned care and Critical Care. The new clinical model will remove duplication in these areas and implement new, modern ways of working. This will allow FTEs to be released. It is noted that these are expected to be released through offsetting growth as opposed to redundancies being made.	For each focus area the schedule of accommodation pre and post the HTP is identified. The staffing ratios that will be required to deliver the new clinical model have been agreed with key stakeholders across a series of workshops, and applied to the schedule of accommodation. This is compared to the baseline staffing plus growth and the incremental change in FTEs is recognised as a net benefit or cost.	CR
Agency staff	The Trust has a large opportunity to reduce its agency pay cost as a % of total pay costs to the same level as its peers. Upon completion of existing schemes (e.g. BTIs, efficiency plans), there is still an opportunity to bring both the agency premium, and the number of agency FTEs down. A proportion of this is assumed to be delivered by the HTP.	Review forecast agency % of total pay costs. Allocation of existing schemes underway to achieve 3.7% agency cap and amount attributed to HTP.	CR
Staff sickness	Peer benchmarking shows that the Trust has a higher sickness rate than the average. Further evidence from the People Pulse report (July 2022) shows that mental health is considered one of the key areas for improvement. Additionally, the updated facilities will provide a safer working environment for staff.	Sickness report provides costs associated with sickness. Mental health and musculoskeletal illnesses are assumed to be reduced to target levels based on literature reviews and discussions with the Trusts workforce teams	CR / NCR
Turnover rate	There is a high turnover in SaTH for a number of reasons. The People Pulse report highlights that in particular, staff feel negative about the current workforce model and that it is unsustainable. The reconfiguration enabled by the HTP will remove duplication of services, reduce inefficiencies, create a sustainable clinical model and enable a number of productivity gains for staff. Additionally, an improved physical environment with better staff facilities will help improve staff experience and support retention. The resultant impact is that the turnover rate will decrease.	Turnover costs are calculation as a proportion of staff salary. For those staff groups which are expected to be impacted for the HTP, a decrease in turnover, and the corresponding costs is realised. Additionally, there is a productivity gain to staff from more consistent staffing models.	CR / NCR
Agency cost avoidance	If HTP does not go ahead to deliver the core DMBC requirements there will be an increase in resignation and a worsening of the existing fragile workforce position. This will require additional agency spend to backfill vacancies.	Increased % of existing agency spend	CR

2.6.1.6 Options split and phasing

Details of the phasing of each benefit is outlined in the benefits realisation section of the Management case. Benefits have been split across the options as outlined below:

Table 45: Options split and phasing

Benefit Category	Benefit Description	Options split methodology
Estates	Maintenance	Total floor area refurbished or new build
	Energy	Total floor area refurbished or new build
	Waste	Total floor area refurbished or new build
	Backlog maintenance	Total backlog addressed in each option
	Estates Utilisation	Floor area furloughed
Patient Safety	Patient falls	Apportioned based on floor area refurbished or new build
	Adverse Drug Events	Target varies with level of service change
	Hospital acquired infections	Target varies with level of service change
Clinical	Elective length of stay	Assumed consistent across all options as service changes impacting elective work are all enabled by the £312m option.
	Non-Elective length of stay	Options 3 and 4 improve NEL length of stay for specific service lines to peer upper decile level. This is apportioned by floor area impacted to reflect that not all wards will see benefits.
	Theatres cancellations	Assumed consistent across all options as the works enabling the change in theatre model are enabled by the £312m option
	Theatres Utilisation	The clinical model changes enabling 85% utilisation will occur in all options
	Integrated care	The full benefit is realised by Option 4, no other options realise a benefit from this.
	A&E QALY	Assumed consistent across all options as service changes impacting A&E are all enabled by the £312m option.
Workforce	Substantive staffing	Assumed consistent across all options as service changes impacting the focus areas are delivered by the £312m option
	Agency staffing	The agency benefit is assumed to consistent across all the options as the reconfiguration and new workforce model will enable the trust to achieve the 3.7% target, however due to constraints (including market supply of substantive staff) agency costs will not be reduced beyond this.
	Staff sickness	Option 4 is assumed to realise the maximum value of the benefit. A review has been undertaken to reflect the proportion of FTEs that would be impacted in options 2 and 3 compared to Option 4. This has been used to scale the benefit.
	Turnover rate	Option 4 is assumed to realise the maximum value of the benefit. A review has been undertaken to reflect the proportion of FTEs that would be impacted in options 2 and 3 compared to Option 4. This has been used to scale the benefit.
	Agency cost avoided	This cost will be avoided in all options that fulfil the core DMBC requirements. In BAU and Option 1, the Trust will still see an increase in resignations and therefore the cost will be accrued.

2.6.1.7 Summary of benefits

A summary of the cash releasing benefits in 2022/23 prices for each short list option is shown below. The benefits shown in Option 2 reconcile to those in the Financial Case.

Table 46: Summary of cash releasing benefits in 22/23 prices in £m

Benefit Category	Benefit Description	1. Additional Comparator	2. Core DMBC ('Do Minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Estates benefits	Maintenance	[redacted]	[redacted]	[redacted]	[redacted]
Estates benefits	Waste management	[redacted]	[redacted]	[redacted]	[redacted]
Estates benefits	Energy and utilities	[redacted]	[redacted]	[redacted]	[redacted]
Estates benefits	Car Parking income	[redacted]	[redacted]	[redacted]	[redacted]
Estates benefits	Estates utilisation	[redacted]	[redacted]	[redacted]	[redacted]
Patient Safety	Falls reductions	[redacted]	[redacted]	[redacted]	[redacted]
Patient Safety	Infection control	[redacted]	[redacted]	[redacted]	[redacted]
Patient Safety	ADE's and electronic dispensing	[redacted]	[redacted]	[redacted]	[redacted]
Clinical Benefits	Integrated care	[redacted]	[redacted]	[redacted]	[redacted]
Clinical Benefits	LOS improvement	[redacted]	[redacted]	[redacted]	[redacted]
Clinical Benefits	Additional NEL LOS Improvement	[redacted]	[redacted]	[redacted]	[redacted]
Clinical Benefits	Theatres utilisation	[redacted]	[redacted]	[redacted]	[redacted]
Clinical Benefits	Additional capacity	[redacted]	[redacted]	[redacted]	[redacted]
Workforce benefits	Workforce	[redacted]	[redacted]	[redacted]	[redacted]
Workforce benefits	Agency saving	[redacted]	[redacted]	[redacted]	[redacted]
Workforce benefits	Staff sickness	[redacted]	[redacted]	[redacted]	[redacted]
Workforce benefits	Reductions in turnover costs	[redacted]	[redacted]	[redacted]	[redacted]
Workforce benefits	Agency cost avoided	[redacted]	[redacted]	[redacted]	[redacted]
CR Benefits Total		[redacted]	[redacted]	[redacted]	[redacted]

The table below shows a summary of the non-cash releasing benefits in 2023/23 prices.

Table 47: Non-Cash Releasing Benefits 22/23 Prices in £m

Benefit Category	Benefit Description	1. Additional Comparator	2. Core DMBC ('Do Minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Clinical Benefits	Theatre cancellations and utilisation	[redacted]	[redacted]	[redacted]	[redacted]
Clinical Benefits	A&E Avoided FTEs	[redacted]	[redacted]	[redacted]	[redacted]
Clinical Benefits	Additional NEL LOS	[redacted]	[redacted]	[redacted]	[redacted]
Patient Safety	ADEs	[redacted]	[redacted]	[redacted]	[redacted]
Workforce benefits	Staff sickness / satisfaction	[redacted]	[redacted]	[redacted]	[redacted]
Workforce benefits	Turnover	[redacted]	[redacted]	[redacted]	[redacted]
Estates benefits	Reduction in backlog	[redacted]	[redacted]	[redacted]	[redacted]
NCR Benefits Total		[redacted]	[redacted]	[redacted]	[redacted]

A number of the cash releasing and non-cash releasing benefits quantified have additional societal benefits associated with them. [redacted] The most material societal benefit is the QALY associated with the substantial improvements to ED, which is currently operating at maximum capacity. This has been quantified through the detailed BAU modelling [redacted]

Table 48: Societal Benefits

Benefit Category	Benefit Description	1. Additional Comparator (previous BAU)	2. Core DMBC ('Do Minimum')	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Patient Safety	HCAI QALY	[redacted]	[redacted]	[redacted]	[redacted]
Patient Safety	Falls QALY	[redacted]	[redacted]	[redacted]	[redacted]
Patient Safety	ADE QALY	[redacted]	[redacted]	[redacted]	[redacted]
Clinical benefits	Theatre Cancellation QALY	[redacted]	[redacted]	[redacted]	[redacted]
Clinical benefits	LOS QALY	[redacted]	[redacted]	[redacted]	[redacted]
Clinical benefits	Integrated Care QALY	[redacted]	[redacted]	[redacted]	[redacted]
Clinical benefits	A&E QALY	[redacted]	[redacted]	[redacted]	[redacted]
Societal Benefits Total		[redacted]	[redacted]	[redacted]	[redacted]

The benefits quantified for Option 2 are also used in Options 5 and 6, aligned to the delay. The benefits identified differentiate the options and these are summarised below which shows the discounted whole life benefits for each option, including both non-cash releasing and societal benefits. [redacted] This is reconciled to the CIA model which is provided in Appendix E-04.

Table 49: Summary of discounted benefits over 60 years

Option	Total Incremental Benefits (Discounted)
1. Additional Comparator (previous BAU)	[redacted]
2. Core DMBC ('Do Minimum')	[redacted]
3. Core DMBC + key estates risks	[redacted]
4. Core DMBC + key estates risks + integration	[redacted]

BAU is used as the economic comparator and therefore delivers no additional incremental benefit.

The full solution (Option 4) will deliver the most financial benefits, [redacted]

Over the life of the investment, Option 4 delivers the most economic benefits, due to the maximum reconfiguration and the Integrated Care investment.

The benefits realisation plan including current and target levels are included within the Management Case.

2.6.2 Costs

Costs of each option were estimated by our external cost consultants. We reviewed all options for value engineering opportunities to minimise the capital requirement. The outline designs, and associated costs, include:

- inflation to midpoint of construction (varies by option), based on latest PUBSEC indices at the time of calculation,
- impact of MMC, including opportunities for standardised and repeatable design, and
- uplifts for optimism bias and planning contingency.

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

The capital costs of the options are summarised below. Further information is included in Appendix E-05, alongside cost advisors' commentary. These OB forms demonstrate that this proposal is compliant with NHS costing requirements.

An allowance for project fees of c.15% of works cost (for the Preferred Option) is included in the capital cost of the scheme, to which location factor, inflation, optimism bias and other allowances are applied.[37]

Based on similar completed schemes, this is expected to be a sufficient budget to develop the scheme and manage it to successful delivery. The decision to include a fees allowance based on similar schemes, reflects a prudent approach to make the scheme budget resilient to unforeseen requirements during later stages of the programme.

Table 50: Capital costs of short-list options

£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	-	46	218	299	327
Optimism Bias and Contingency	Line 10C	-	8	35	63	69
Sub-total (aligns with OB forms)		**-**	**54**	**253**	**362**	**397**
Sunk cost	NA		-3	-3	-3	-3
Sub-total (aligns with CIA model)			**51**	**249**	**358**	**393**
Inflation	Line 11	-	8	12	51	58
Net Value Added Tax	Line 12	-	10	48	69	78
Total Capital Cost (aligned to financial model and case)		**-**	**72**	**312**	**481**	**534**

*For the purposes of the economic appraisal, as per NHSE and HMT guidance, sunk costs were removed from the total capital costs within the CIA model. In this case, sunk costs were identified as £3.4m (before VAT and inflation) reflecting the costs incurred during the OBC process, which are within the cost estimates above.

For the economic appraisal, by excluding inflation, the costs are stated in real terms at constant (uninflated) prices with the base year set as 2022/23. As per the CIA model, costs have been discounted at 3.5% for Years 0-30 and 3% for years 31-70. The project life for the appraisal is set at 60 whole years, reflecting the useful life of the asset. A further breakdown of the assets created and their useful lives is set out in the finance model, which impacts the PDC and depreciation charges on the assets created through this investment.

For the economic appraisal, the following costs have been removed:

[37] This value is an allocated and typical design team percentage at this stage on a project, calculated using industry standard framework rates. This is a lump sum allocation at the SOC stage (a typical project manager or quantity surveyor cost within this overall allowance would typically be about 1–1.5% of the total allocation).

- Sunk costs – as per above
- Transfer payments
- VAT
- Capital charges
- Depreciation

The total capital cost in the table above is aligned to the financial model and case for this OBC.

As outlined above, options 1 and 2 meet the capital affordability CSF (Relative capital affordability of the option versus the original allocated capital of c. £312m), however, options 3 and 4 do not meet the capital affordability CSF.

Options 2 – 4 include a £25m package of enabling works to be completed in tandem with the FBC. This is a critical package of works that enables the programme to maintain pace and momentum, ensuring the full build can commence in early 2024. The enabling works will provide expansion and refurbishment of the Emergency Department (ED) that will enable more appropriate and safe patient and ambulance access to the ED before the main works commence on site. In addition to the significant patient safety requirements, this approach will also mitigate further inflationary costs associated with a delay to the programme.

The HTP enabling works comprises of the build of a new 8 bedded resuscitation room and fit for purpose majors facility for ED (adjacent to the existing department); and refurbishment of part of the existing outpatient and Executive office accommodation into clinical space to accommodate the Same Day Emergency Care unit (SDEC).

Currently the ED resuscitation room is sub optimal in terms of size, facility, and bed numbers. SDEC currently sits on the ED forecourt in a modular build which is too small and ill placed. The enabling works will provide a suitable estate for ED majors, resus and brings the SDEC into the main body of the hospital adjacent to ED.

Phase 1 delivers an increase footprint to ED and SDEC.

This phase will run concurrently with the completion of the FBC and onward to the end of the 23/24 financial year. Phases 2 and 3 will run through to August 2024, with phase 4 is designed to run concurrently with the new build.

[redacted]

Lifecycle costs

In addition to the core capital cost of the scheme, lifecycle costs have been estimated for each option as follows:

Table 51: Lifecycle costs

£m, nominal capital cost	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
Lifecycle costs	-	80	349	480	527

The approach to calculating lifecycle costs is as follows:

- Option 2: These have been provided by the QS based on the level of design of option 2 – see attached Appendix E-08.
- Option 1, 3 and 4: To ensure a consistent comparison of options ad given there is not the detailed level of design for options 1, 3 and 4 to support detailed lifecycle costing, the lifecycle costs worked up for Option 2 have been scaled in line with the capital costs (excluding VAT, OB and contingency and inflation) for the other options.

Transition and double running costs

Transition and double running costs have been estimated at this stage as 1% of the build costs incurred in the year of opening. It is expected that these will be managed and funded by the Trust and will be refined through the FBC and implementation as the detailed plans for the transition and commissioning of the new hospital facilities are finalised.

Other running costs

Where appropriate, we have identified additional running costs, over and above the BAU (which includes the cost of growth). These are minimal, given one of the key objectives of this investment is to drive value for money, and be affordable to the Trust by delivering financial efficiencies (cash releasing benefits). However, recognising the additional estate that is created through this investment, a maintenance and energy and utilities cost has been identified for the do-something options. This is largely offset by the estates benefits outlined above through better utilisation of the estate.

Note, this is consistent to the SOC, where this cost was captured as an estates disbenefit. For this OBC, it has been categorised as a cost within the CIA model following feedback on the SOC.

2.6.3 Economic appraisal (BCR / NPSV)

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

The BCR is defined by the Green Book as the ratio of the present value of benefits to the present value of costs. It provides a measure of the benefits relative to costs.

The differential costs and benefits of the options, along with their detailed phasing, VAT treatment, inflation etc. are used to support the calculation of NPSVs. This analysis is presented in the CIA model, provided in Appendix E-04. These have been triangulated across the workforce, financial, demand and capacity workstreams [redacted]

Table 52: Short list value for money assessment

Metric	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 (m)	n/a	(£100)	(£385)	(£518)	(£548)
Incremental benefits (m)	n/a	£99	£1,703	£1,981	£2,479
Risk-adjusted Net present social value (NPSV) (m)	n/a	(£1)	£1,318	1,463	£1,931
Benefit Cost Ratio	n/a	0.99	4.43	3.83	4.52

*(60 years) excl. PDC vs. BAU (£m)

As outlined above, based on measures that can be quantified, Option 4 delivers the greatest NPSV and BCR to the UK.

2.6.4 Sensitivity analysis

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

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

The results of the NPSV sensitivity analysis are shown below. Note, the reference to base case in Table 53 and Table 54 below is the level of capital and benefits associated with the option before any sensitives are applied. Each option has a different level of capital and benefits.

Table 53: Sensitivities on NPSV

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	-£1	£1,318	£1,463	£1,931
Capital +10%, Benefits Basecase	£0	-£11	£1,280	£1,412	£1,876
Capital -10%, Benefits Basecase	£0	£9	£1,357	£1,515	£1,985
Capital Basecase, Benefits +20%	£0	£18	£1,659	£1,860	£2,426
Capital +10%, Benefits +20%	£0	£8	£1,620	£1,808	£2,371
Capital -10%, Benefits +20%	£0	£28	£1,697	£1,912	£2,481
Capital Basecase, Benefits -20%	£0	-£21	£978	£1,067	£1,435
Capital +10%, Benefits -20%	£0	-£31	£939	£1,015	£1,380
Capital -10%, Benefits -20%	£0	-£11	£1,016	£1,119	£1,490
Capital Basecase, Benefits excluding avoided agency costs	£0	-£1	£1,122	£1,267	£1,734

In all sensitivities, the rank ordering of NPSVs remains consistent, with Option 4 delivering the greatest net present social value. Even in the worse case scenario (capital +10% and benefits -20%) the NPSVs of all the do-something options remain high. [redacted]

Table 54: Sensitivities on BCR

BCR	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	0.99	4.43	3.83	4.52
Capital +10%, Benefits Basecase	0.00	0.90	4.02	3.48	4.11
Capital -10%, Benefits Basecase	0.00	1.10	4.92	4.25	5.02
Capital Basecase, Benefits +20%	0.00	1.18	5.31	4.59	5.42
Capital +10%, Benefits +20%	0.00	1.08	4.83	4.17	4.93
Capital -10%, Benefits +20%	0.00	1.32	5.90	5.10	6.03
Capital Basecase, Benefits -20%	0.00	0.79	3.54	3.06	3.62
Capital +10%, Benefits -20%	0.00	0.72	3.22	2.78	3.29
Capital -10%, Benefits -20%	0.00	0.88	3.94	3.40	4.02
Capital Basecase, Benefits excluding avoided agency costs	£0	0.99	3.92	3.45	4.16

In all sensitivities, the rank ordering of BCRs remains consistent, with Option 4 delivering the greatest benefit to cost ratio. Even in the worse case scenario (capital +10% and benefits -20% the BCRs of all the do-something options remain high (>3 for options 2 and 4). This demonstrates

that the options are robust to changes in costs and benefits, and that all the do-something options will continue to deliver strong value for money. Additionally, if the £8.1m avoided agency costs are not realised, all of the do-something options deliver consistent, high BCRs.

Table 55: Switching analysis

	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	**£0**	**-£100**	**-£385**	**-£518**	**-£548**
Incremental Benefits	**£0**	**£99**	**£1,703**	**£1,981**	**£2,479**
BCR	**£0**	**0.99**	**4.43**	**3.83**	**4.52**
Ranking	5	4	2	3	1
Change in costs to match Preferred Option BCR	N/A	-£78	£0	-£70	£12
Total Required Costs	N/A	£22	£385	£448	£560
Change in cost as a %	N/A	-78%	0%	-14%	2%
Change in benefits to match Preferred Option BCR	N/A	£343	£0	£312	-£51
Total Required Benefits	N/A	£442	£1,703	£2,293	£2,428
Change in benefits as a %	N/A	349%	0%	16%	-2%

The switching analysis reflects the change in the costs or benefits required in each option to match the BCR of the preferred option. This demonstrates that it would require a significant change in costs and benefits for the Additional Comparator to deliver the optimal value for money. A small change of 2% in the costs or benefits in Option 4 would reduce the BCR to match that of Option 2.

2.6.5 Quantitative Appraisal Summary

Table 56: Appraisal of short list options against quantitative CSFs

Appraisal Section	CSF	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
Quantitative	Value for money	Fail	Fail	Pass	Pass	Preferred
	Revenue affordability	Fail	Pass	Pass	Pass	Preferred
	Capital affordability	Pass	Fail	Preferred	Fail	Fail

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

The rationale for the assessments above is outlined in the Quantitative Appraisal [Appendix E-09]. The Business As Usual and Additional Comparator both fail the value for money assessment as their costs are greater than their benefits. The Additional Comparator fails the capital affordability CSF as it requires external capital, which is not available, as the £312m allocation is specifically to deliver the outcome of the Future Fit consultation and new clinical model.

2.7 Risk appraisal of short-listed options

A detailed risk appraisal has been completed as part of the OBC. The evidence underpinning this appraisal is provided in the Appendix E-02.

2.7.1 Risk appraisal methodology

The diagram below outlines the approach followed:

Figure 20: Risk appraisal process

Risks were identified by each workstream across the programme. Where possible, the risks have been quantified in monetary terms, and where not possible they have been appraised qualitatively using a consistent methodology to ensure objectiveness across the appraisal. Quantitative risks were assigned a risk probability and a calculated estimated cost if the risk were to occur. Qualitative risks were assigned a risk probability and a qualitative impact score. Both approaches give an indication of the expected risk of each option across the three categories of risk set out in the HMT guidance (business, service and external – detailed below). However, neither represents an exact assessment of the risk due to challenges in estimating probabilities and impacts.

A full list of the risks identified for each option, as well as the risk owners and reviewers of each risk, is included in Appendix E-02.

Each risk was first categorised into one of the three main categories that are set out in the HM Treasury business case guidance. These are detailed in the below:

Table 57: Risk types

Risk Type	Description
Business	These risks remain with the organisation (internal risks) and cannot be transferred. They include capacity risks, patient care and safety risks.
Service	These risks fall within the design, build, financing, and operational phases of the project/investment and may be shared with the others from outside of the organisation. They are associated with the services that are being procured / provided as part of this investment.
External	These non-systemic risks affect all society and are not connected directly with the project. They are inherently unpredictable and random in nature. They include technological disruption, legislation, general inflation, and catastrophic risks.

After identification and categorisation, each risk was allocated to an owner. Each workstream was consulted with and provided input around potential risks to the programme that were associated with their workstream. These workstreams are also responsible for making sure that any new risks are reported to the PMO via through the fortnightly reports to the HTP Delivery Group, and this approach is aligned to the Trust's ongoing Risk Management Process that is outlined in more detail in Section 5.4 of the Management Case. Additionally, The PMO are responsible for managing risk and updating and maintaining the overall Programme Risk Register [redacted]

Table 58 shows the number of risks (that are included as part of the risk appraisal) allocated to each workstream:

Table 58: Risks associated with each workstream

Workstream	Qualitative risk count	Quantitative risk count
Clinical	5	1
Workforce	1	3
Estates	5	4
Finance	2	1
Commercial	NA	1
PMO	4	1
Digital	5	NA
Business Intelligence	NA	1
Total	**22**	**12**

Sessions with all the owners took place to agree probability and impact scores as well as costs for quantified risks. Throughout the process, probability and impact scores were updated based on changes to the programme and regular discussions with key stakeholders.

The methodology to calculate the overall impact score of each **qualitative risk** is outlined in the table below. This includes the categorisations used to determine the severity of each qualitative risk. The qualitative risks are also accompanied with a qualitative rational, which is explained in more detail in the risk log [Appendix E-02].

Table 59: Qualitative Probability and Impact Scoring

Scale	Probability of occurrence			Impact on project			Total Risk Score
	Probability	Probability score	Qualitative scale used	Qualitative impact	Qualitative score used	Impact	
Very low	<10%	0.1	1	Temporary defects, causing minor short term consequences	1	Score*Probability Score	Impact
Low	10%-<30%	0.3	2	Performance shortfall in area of tertiary or minor importance	2		Impact Score*Probability Score
Medium	30%-<50%	0.5	3	Performance shortfall in area of secondary importance	3		Impact Score*Probability Score
High	50%-<70%	0.7	4	Moderate performance shortfall in area of critical or primary importance			Impact Score*Probability Score
Very High	70%+	0.9	5	Significant performance shortfall against a critical or primary purpose.	4	Score*Probability Score	Impact

The methodology to calculate the overall impact score of each **quantitative risk** is outlined in the table below. This includes the categorisations used to determine the severity of each quantitative risk. The calculations used to quantify each risk are included in the risk log [Appendix E-02].

Table 60: Quantitative Probability and Impact Scoring

Scale	Probability of occurrence		Impact on project	Total risk score
	Probability	Probability score	Quantified impact: cost of risk occurring	
Very low	<10%	0.1	£ (calculated estimate)	Cost of risk occurring * probability score
Low	10%-<30%	0.3	£ (calculated estimate)	Cost of risk occurring * probability score
Medium	30%-<50%	0.5	£ (calculated estimate)	Cost of risk occurring * probability score
High	50%-<70%	0.7	£ (calculated estimate)	Cost of risk occurring * probability score
Very High	70%+	0.9	£ (calculated estimate)	Cost of risk occurring * probability score

2.7.2 Qualitative risk profiles across options

The conclusions of the appraisal of the qualitative risks are outlined in the table below. The table shows the total qualitative risk score of each option, according to risk type.

Table 61: Qualitative Risk Scores

Risk Type	0. BAU	1. Additional Comparator	2. Core DMBC	3. Core DMBC + key estates risks	4. Core DMBC + key estates risks + integration
Business	124	108	35	28	28
Service	5	20	86	100	100
External	10	12	9	9	9
Rank	4	5	1	2	2

Qualitative risk profiles for each option are included below. These outline the different ways in which the options present risks that cannot be quantified in monetary terms. This risk assessment is most appropriately viewed by the HMT risk type across the options. Option 2 has the least qualitative risks as many of the risks associated with the BAU are mitigated by the investment and the risks associated with the 'Do-something' options increase as more money is spent.

Business Risks

BAU (new BAU per JIC condition) – The most severe qualitative risks for BAU are related to a deteriorating working environment. This is because, without intervention, not only will the benefits associated with the HTP not be realised, but the current environment will only worsen. We will continue to have problems with workforce, performance and quality of care. Clinical adjacencies cannot be sustained, and a shortage of workforce capacity will lead to problems with the working environment. This also means that the Trust is unlikely to be able to meet the required regulatory healthcare and emergency standards as the strategic solution will not be implemented which is essential for safe delivery of care.

Additional Comparator (previous BAU) – Similarly to BAU, the most severe qualitative risks for the Additional Comparator are related to a deteriorating working environment. This is because, with minimal intervention, not only will the benefits associated with the HTP not be realised, but the current environment will begin to deteriorate as additional capacity will still be required.

'Do-something' Options – Business risks for 'Do-something' options reduce, as the Trust has an increased ability to mitigate these risks with the new clinical model and capacity provided in each of these.

Note, this assessment is in addition to the forecast benefits associated with the do-something options.

Service Risks

BAU (new BAU per JIC condition) – BAU has the least service (being the procured service as part of this investment) risks given there is a minimal investment to apply risk to. This is typical for business case appraisals of risk.

Additional Comparator (previous BAU) – The Additional Comparator has few service (being the procured service as part of this investment) risks given there is a minimal intervention to apply risk to. This is typical for business case appraisals of risk. Service risks for the Additional Comparator are higher than BAU because there is some intervention and therefore risks that come with this intervention (often associated with potential for disruption / delay).

'Do-something' Options – The service risk score for the 'Do-something' options is higher than the 'do-nothing' options because doing something is inevitably risky. These risks relate to the implementation of the investment itself. The most severe risks for the 'Do-something' options are related to affordability and key dependencies. There is a high likelihood of higher-than-expected inflation if there are any delays to the programme and this has the potential to impact the design plans for the hospital sites due to an increase in costs. As well as this, there is a risk that funding from the government is no longer available; the risk of funding no longer being available is higher in options 3 and 4 due to the allocated budget from the government meaning that additional funding would need to be sought for these options. With regards to key dependencies, whilst HTP no longer requires an energy centre, the Trust is still working to secure funding for this, which will enable net zero delivery within the new build.

Note, service risks are typically larger in the 'Do-something' options because they are associated with delivering the investment.

External Risks

The external risk captures the impact of external political and/or economic events.

BAU (new BAU per JIC condition) – These are larger as the impact of external environmental events is larger when buildings are not set up for these events, despite there being minimal change / investment within this option for external political / economic factors to impact.

Additional Comparator (previous BAU) – These are larger as the impact of external environmental events is larger when buildings are not set up for these events. External risks are higher in the Additional Comparator option compared to BAU.

'Do-something' Options – These are reduced, as even though the impact of external political / economic events will be larger with more significant investment, external environmental events will have a lower impact.

2.7.3 Quantitative risk profiles across options

The conclusions of the appraisal of the quantitative risks are outlined in the table below. The table shows the total quantitative risk score of each option, according to risk type.

Table 62: Quantitative risk scores (undiscounted)

Risk Type	0.BAU (minimal capex) (£'000)	1. Additional Comparator (c.72m capex) (£'000)	4. Core DMBC (£'000)	3.Core DMBC + key estates risks (£'000)	4.Core DMBC + key estates risks + integration (£'000)
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
Rank	1	3	2	4	5

Quantitative risk profiles for each option are included below. These outline the different ways in which the options present risks that can be quantified in monetary terms. As with the qualitative risks, these are compared within each HMT risk type.

This demonstrates that the 'Do-something' options have significantly lower business risks, highlighting how the investments mitigate the Trust's existing risks. However, the 'Do-something' options have greater service risks (risks associated with implementation). This is because there is no implementation within the BAU option. These should be considered in tandem with the qualitative risks, where the BAU option has much greater risk.

The total quantitative risk score for Option 2 is lower than options 1, 3 and 4. The total quantitative risk score for the BAU is lower than for Option 2 due to the nature of the risks that could be quantified. The Business risks are larger in the 'Do-nothing' options because the investment mitigates the impact of many of these business risks (namely those associated with the potential for increased demand above what is forecast). Service risks are typically larger in the 'Do-something' options because they are associated with delivering the investment. External risks only apply to options 1-4 here because the only identified quantitative external risk is related to a change in government approach that would affect delivery of the HTP and therefore doesn't apply to the BAU option.

Business Risks

BAU / Additional Comparator – The most severe quantitative risks relate to demand, recruitment and retention and backlog. In relation to demand, there is a risk that increased demand (above that forecast) results in increased pressure on clinical services. This has a greater impact in the BAU scenario there is already insufficient capacity for forecast demand, meaning activity is already outsourced and therefore there is an inability to expand further. As well as this, in the Additional Comparator scenario, where the working environment is not addressed and only likely to worsen, the Trust is likely to continue to experience recruitment and retention issues which will lead to use of more agency staff. There is also the potential for backlog to deteriorate more than expected in the comparator options as it will not be addressed, and this would increase estates costs.

'Do-something' options – In the 'Do-something' options, similar risks may occur, however, with the investment in additional capacity and the new clinical model, the Trust will have a greater ability to mitigate the impacts of these risks (e.g. greater demand than forecast). Business risks are therefore reduced within the do-something options.

Service Risks

BAU (new BAU per JIC condition) – There are not service risks for the BAU option, as there is not investment taking place.

Additional Comparator (previous BAU) – There is a small service risk for the Additional Comparator, which is related to the potential increase in construction costs as part of the investment.

'Do-something' options – Service risks are greatest for the 'Do-something' option, reflecting the quantified risk associated with the investments. The most severe risks for the 'Do-something' options primarily relate to delays and costs. There are many factors related to the HTP that could lead to delay such as delays to the approval process and non-delivery of community schemes. The risk of this delay is associated with increased costs for the programme team as they must work for a longer period. These delays relate to delays in the approval process, as well as potential issues with the supply chain and the potential for failure to engage clinical or operational teams. There is also uncertainty around capacity in the construction sector to deliver the scheme. This has the potential to increase the cost of delivery by 5% due to an increase in time frame for delivery or a required premium to access construction services.

Note, service risks are typically larger in the 'Do-something' options because they are associated with delivering the investment.

External Risks

The external risks relate to delays to the approval process for the scheme.

BAU (new BAU per JIC condition) – The external risk relates to the investment options, and therefore does not apply to BAU.

Additional Comparator (previous BAU) – The external risk is related to delays to approval and therefore also applies to the Additional Comparator as some intervention is taking place in this option.

'Do-something' options – All 'Do-something' options have a consistent quantified risk associated with delay which equates to a 3-month delay.

2.7.4 Risk Appraisal Conclusion

The risk appraisal highlights that the BAU and Additional Comparator options carry the most **business risk**, as with the investments within the do-something options, the impacts of the risk occurring are mitigated or removed. This highlights the positive impact on the Trust's ability to manage and mitigate risks through this investment.

The **service risks** (those associated with the design, build, financing and operational (DBFO) stages) are naturally higher for the 'Do-something' options, reflecting greater risk as the scale of the intervention increases. These are not applicable to the BAU option as there is no DBFO as part of the BAU.

External risks are fairly consistent across the options.

As shown in Table 62, the risk appraisal concludes that when qualitative and quantitative risks are looked at collectively, Option 2 is the least risky as it consistently ranks highly when compared to the other options. This is because many of the risks associated with the BAU are mitigated by the investment and the risks associated with the 'Do-something' options increase as more money is spent. When the risks associated with the options are compared to the potential benefits of the HTP (outlined in Section 3.6.1), the potential benefits outweigh the potential risks. This analysis therefore supports the implementation of the HTP.

Table 63: Qualitative and quantitative risks ranking

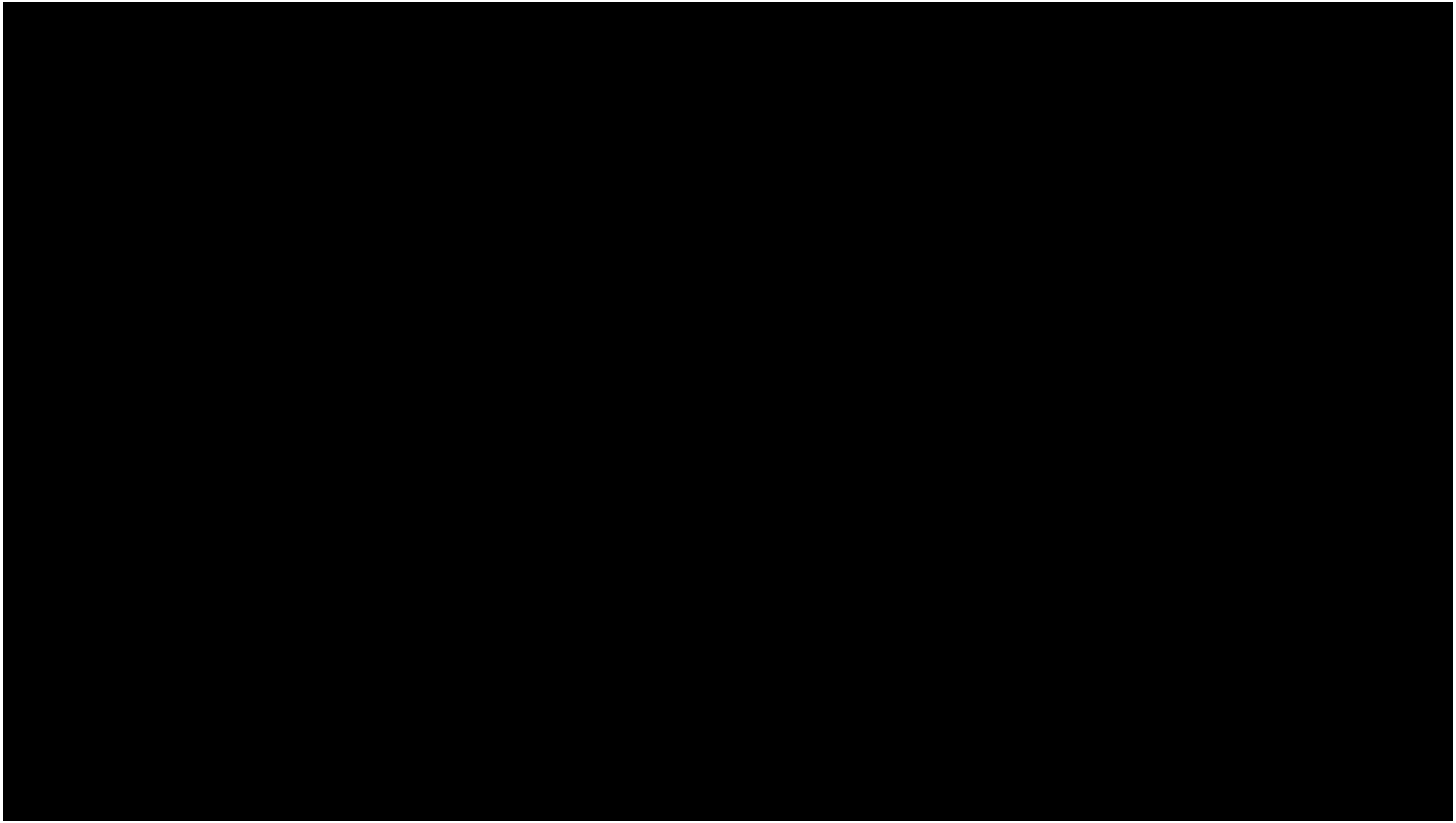
	0.BAU (minimal capex) (£'000)	1. Additional Comparator (c.72m capex) (£'000)	2. Core DMBC (£'000)	3.Core DMBC + key estates risks (£'000)	4.Core DMBC + key estates risks + integration (£'000)
Qualitative Rank	4	5	1	2	2
Quantitative Rank	1	3	2	4	5

[redacted]

Table 64: Capital costs for phasing sensitivities

£m, nominal capital cost	OB form reference	2. Core DMBC ('Do Minimum')	5. Core DMBC ('Do Minimum') – 12 month delay	6. Core DMBC ('Do Minimum') – 24 month delay
Works, Fees and Equipment	[redacted]	[redacted]	[redacted]	[redacted]
Optimism Bias and Contingency	[redacted]	[redacted]	[redacted]	[redacted]
Economic case total (included in CIA model*)		[redacted]	[redacted]	[redacted]
Inflation	[redacted]	[redacted]	[redacted]	[redacted]
Net Value Added Tax	[redacted]	[redacted]	[redacted]	[redacted]
Total Capital Cost (aligned to financial model and case)		[redacted]	[redacted]	[redacted]

[redacted]



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	[redacted]				[redacted]				[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

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[redacted]

2.9 Public consultation

A public consultation was completed through Future Fit with a decision by our commissioners on the proposed clinical model and service configuration. This outcome was endorsed by the Independent Reconfiguration Panel and the Secretary of State for Health and Social Care. It is now our responsibility to deliver this outcome.

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

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

Both comparator options do not deliver the outcome of consultation and we would not be fulfilling the previous commitments made to our population.

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

2.10 Conclusion and Preferred Option

We have undertaken a comprehensive and robust appraisal of all the options that could deliver the consultation outcomes, consistent to NHS and Government guidance for OBCs. Our appraisal against the CSFs identifies the option that achieves the most appropriate balance between delivering the commitment we made as a system during consultation, addressing our urgent clinical and operational risks, protecting the continuity of our services and providing value for money for taxpayers. Table 67 summarises the appraisal results against all 9 CSFs:

Table 67: Summary of appraisal against CSFs

Appraisal Section	CSF	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
Qualitative	Clinical Quality and Patient Experience	Fail	Fail	Pass	Pass	Preferred
	Workforce	Fail	Fail	Pass	Pass	Preferred
	Effectiveness	Fail	Fail	Pass	Pass	Preferred
	Clinical Model	Fail	Fail	Pass	Pass	Preferred
	Commercial Viability	Fail	Pass	Pass	Pass	Pass
	Build Deliverability	Fail	Fail	Pass	Pass	Pass
Quantitative	Value for money	Fail	Fail	Pass	Pass	Preferred
	Revenue affordability	Pass	Fail	Pass	Pass	Pass
	Capital affordability	Pass	Fail	Preferred	Fail	Fail
CONCLUSION		Fail	Fail	Preferred Option	Explore if further capital became available	Preferred Option Explore if further capital became available

To achieve an appropriate balance between overall net benefits and affordability, Option 2 is the Preferred Option.

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

This is also reflected in the quantitative appraisal, where Option 4 delivers the greatest value for money to the UK with the highest benefit to cost ratio and net present social value, reflecting the additional incremental benefit that is delivered from the incremental investment within Option 4. Options 2 to 4 are also affordable in revenue terms, with cash releasing / financial benefits offsetting the costs of capital upon year of completion. With no capital constraints, the options appraisal suggests that Option 4 should therefore be taken forward as the Preferred Option.

However, Options 3 and 4 fail the capital affordability CSF, with a capital requirement greater than the allocated capital envelope of £312m.

As a result, the options appraisal identifies Option 2 as the Preferred Option for this OBC. This option will:

- be delivered in full by December 2026 as per the programme plan set out in the management case,
- deliver improvements in quality, safety and experience driven by consulted clinical model as well as workforce availability and sustainability,
- improve workforce availability and sustainability driven by enhanced build environment and delivery of the clinical model,
- provide better accommodation in new areas. In particular emergency medicine, paediatric zoning, acute medicine, oncology and haematology, critical care and emergency services,
- reduce waiting times and travel times for hospital services delivered through clinical model and improved access to appropriate specialists,
- meet future capacity needs (new wards) – avoids potentially significant and additional unnecessary costs associated with temporary measures required to address service capacity issues,
- better supports the integration of emergency and planned care pathways, enabling coordinated and seamless patient experience across the pathways,
- offer excellent value for money, with a net present social value of £1,319m and a benefit to cost ratio of 4.43,
- be affordable to the Trust and is within the £312m capital envelope,
- demonstration of affordability is set out in more detail within the Financial case.

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

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

Our Preferred Option involves investing £312m in RSH and PRH to provide improved facilities that will better meet the needs of our patients. It will put in place the core elements of the service reconfiguration described in the Future Fit consultation, help us to address our most pressing clinical challenges, and establish solid and sustainable foundations upon which to make further improvements. A number of significant challenges will remain, particularly in relation to the

standard of patient accommodation at the RSH site, and whilst these can be managed over the medium term, these risks will need to be addressed in the long term.

As part of this option we plan to deliver a c.£25m package of enabling works. Further detail on this is set out in commercial and management cases below.

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

The Commercial, Finance and Management cases below reflect our approach to securing a deal to implement the Preferred Option, demonstrating the affordability of the option and outlines the delivery arrangements we have in place to successfully implement the option.

Partnering
Ambitious
Caring
Trusted

NHS
The Shrewsbury and Telford Hospital
NHS Trust

3 Commercial case

3 Commercial case

The Commercial Case determines the procurement strategy for the **Preferred Option** identified within the Economic Case, focusing on how the required services, suppliers or works can best be procured and should be considered from the outset. This OBC builds on the assumptions made within the SOC and clearly outlines the identified benefits of the chosen route.

The Preferred Option described in the Economic Case is Option 2 (Core DMBC), phased as per the SOC and financed through Government PDC via the HTP.

The alternative procurement (service delivery) options were evaluated as part of the Long-list Appraisal [Appendix E-01].

The alternative procurement options investigated were:

- Framework procurement
- Single-stage tender
- Two-stage tender

Framework procurement was selected as the Preferred Option as it was preferred against the other options in relation to all the relevant CSFs. The NHSE checklist also provides a clear default position for Framework procurement.

As part of OBC development, we have investigated the potential procurement frameworks in the Commercial Case.

The different frameworks that we evaluated against our selected criteria (outlined in Section 3.2.1) were:

- Crown Commercial Services (CCS) / NHS England – ProCure23 (P23)
- ProCure Partnerships
- Pagabo
- Construction Framework South East (SCAPE)
- NHS Shared Business Services (SBS) – Public Sector Construction Works Framework

The **P23 framework** is expected to offer best value for money and help us move quickly to implementation and build, while also aligning with guidance from NHSE and the wider public sector. Based on the analysis of alternative procurement frameworks, P23 has been selected as the procurement approach for this scheme. This ensures that the delivery of the scheme is fulfilled, as per the JIC conditions.

Through the development of this OBC, the Trust has defined clear procurement objectives and services required to deliver these objectives. This ensures that the Trust's commercial approach is in line with the Government's NZC priorities and considers social value and utilises Modern Methods of Construction (MMC). The precise commercial and contractual arrangements will be set out at FBC stage.

The Trust expects to appoint a Principal Supply Chain Partner (PSCP) in Q1 2023/24. The process to formally appoint a contractor began at the end of the RIBA Stage 2 design process. This ensures that the design has reached a level of maturity to allow the contractor to meaningfully engage with enough information to allow them to begin market testing and reduces costs associated with additional support from the contractor. The Trust will then work collaboratively with the contractor to develop the design.

Once appointed, the PSCP will carry out the enabling works. These works will begin in September 2023 and run in parallel to the completion of the FBC. The PSCP will then begin implementation of the main works for the Preferred Option in August 2024. The arrangements for how the PSCP will be managed are outlined in the Management Case.

3.1 Required services to implement the project

To implement the Preferred Option and a new model of care, several goods and services need to be provided.

These include:

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

To deliver the new clinical model of care and provide the above goods and services, the Trust is looking to appoint a suitably qualified main contractor. The Trust aims to secure the full design and construction services of a Tier 1 contractor, utilising Lot 3 of the P23 framework. The decision to use the P23 framework is discussed in Section 3.2.1. The Trust requires these services from RIBA Stage 3 spatial co-ordination and design through to Stage 7 operational use of the new build and refurbished elements of the scheme. This contractor will work alongside the Trust's existing Hospitals Transformation Team (outlined in Section 5.1.1 of the Management Case) to deliver the HTP within the allocated budget and time constraints.

The professional services required by the appointed contractor will include architectural, financial, mechanical, electrical, structural, and civil in both pre-construction and construction phases of the programme. We intend to novate the existing design team (including architects, structural, civil, mechanical, and electrical engineers) to the PSCP when there is formal regulatory approval to engage the PSCP beyond RIBA Stage 3 (as per the JIC condition). This has been communicated to the PSCPs throughout the process and will provide the Trust with continuity of design and allow the Trust to utilise and build on existing relationships, minimising time associated with handover. It will also help to shorten timescales in overall design delivery, ensuring greater cost efficiency.

The Trust intends to maintain the appointed cost consultants / quantity surveyors after the PSCP is appointed and will also retain its incumbent construction professional technical advisors for project management. The team will be supplemented with other professional technical advisors to quality check any PSCP design changes from OBC appointment through to FBC and delivery of the enabling works. This will include architects, fire consultants, environmental advisors, mechanical and electrical engineers, structural and civil engineers, and a clerk of works. These advisors will be appointed separately, in addition to the PSCP appointment, ensuring no loss of technical services once the PSCP is on board.

The technical advisors mentioned above and our proposed approach for each technical advisor once the PSCP is appointed are outlined in Table 68. Section 5.1.5 of the Management Case provides a full list of specialist advisors used for this OBC.

Table 68: Technical advisors used for the HTP

Area	Advisor	Proposed approach
Architects	AHR	Novated to the PSCP
Mechanical and Electrical Engineering	DSSR	Novated to the PSCP
Structural and Civil Engineering	Ramboll	Novated to the PSCP
Quantity Surveyors	Edmond Shipway	Retained by the Trust
Healthcare Planners	Strategic Healthcare Planners (SHP)	Retained by the Trust
Planning Consultants	Nexus	Retained by the Trust

In the areas where we do novate existing teams, additional specialist advice will be procured as required to ensure compliance with all regulatory and statutory requirements. This includes compliance with HBN/HTM, HMT Green Book, building regulations and local authority planning requirements. This appointment will also help to ensure that the Trust's aspirations to meet its Net Zero Carbon and MMC targets are achieved. These additional specialist advisors will be direct Trust appointments to ensure a level of independent oversight and assurance to the PSCP.

Further detail on the procurement approach is provided in the Sections (3.2 and 3.5) below.

3.2 Procurement of design and build services

3.2.1 Key procurement considerations

The key considerations when deciding the approach to procurement for the scheme involved the evaluation of service delivery options as well as the potential alternative procurement frameworks.

Evaluation of the alternative service delivery options is explained in further detail in the Long-list appraisal [Appendix E-01]. The outcome of this appraisal was that Framework Procurement was selected as the Preferred Option. This is because it provides an established governance-assured process and certainty over the interest, evidence, and timescales for delivering a value for money route to market. This decision is endorsed by the 2023 NHSE business case core checklist and the Government Construction Strategy (2016-2020) (and the related Common Minimum Standards for Construction (CMS)). The NHSE checklist suggests that Framework Procurement is the default procurement option:

"Where NHSE Procure or equivalent framework is not used, sufficient robust justification must be provided as to why and how this alternative approach contributes to the aims and outcomes of the Government Construction Strategy?" NHSE Business Case Checklist (2023)[38]

It was noted that a local tender process, under Public Contracts Regulation would have longer procurement timescales and could not guarantee competition and cost certainty. For a scheme of this size, the use of frameworks is well established within the market.

Once Framework Procurement was selected, it was important to evaluate the potential alternative procurement frameworks. The key criterion for our procurement strategy was that the contractor must take single-point design responsibility for the works once they begin.

We identified the following critical factors for providing the best value procurement solution for the HTP scheme:

- early engagement of the market
- contractor ability
- ability to adhere to allocated funding constraints
- ability to deliver according to the proposed timelines
- management of risk
- resources and expertise we require to deliver a project of this type, size and complexity
- the level of Trust influence required during pre-construction and construction phases of the scheme
- the routes to market (framework agreements) available to us
- the use of the Social Value Model award criteria and evaluation questions

These critical factors informed the selected success criteria for the scheme that are outlined in Table 69.

[38] https://www.england.nhs.uk/publication/capital-investment-and-property-business-case-approval-guidance-for-nhs-trusts-and-foundation-trusts/

Table 69: Evaluation Criteria

Evaluation criteria	Description
Support	The proposed framework can be easily implemented by the Trust team / support from the framework is available.
Process Timescales	The procurement framework allows services to be delivered at pace, according to delivery timelines.
Market capability	The framework gives access to contractors who can demonstrate a strong track record.
Market appetite	The proposed approach will meet market expectations and be appropriate for the required skillsets within the market. The scheme can be shown as being an attractive proposition to bidders in the market.
Competition	The proposed framework will challenge the market to deliver value for money solutions whilst adhering to allocated funding constraints.
Governance	There is precedent for the approach to be used (e.g., recommended by NHSE / DHSC).
NHS alignment	The solution is a recognised and promoted approach (by DHSC / NHSE), or there is precedent for the approach to have been approved by regulators in the past for equivalent sized schemes.

The PMO, estates and procurement workstreams evaluated the relative benefits of five frameworks against the above criteria. These frameworks were:

- CCS Construction Works and Associated Services (RM6267) / NHS England – ProCure23 (P23)
- Procure Partnerships
- Pagabo
- Construction Framework South East (SCAPE)
- NHS Shared Business Services (SBS) – Public Sector Construction Works Framework

The CCS Construction Works and Associated Services framework contract (RM6088) was also identified. However, for new requirements over £80 million contract authorities are instructed to use the RM6267 Construction Works and Associated Services 2 (CWAS2) and the lots within it are specifically for NHSE managed ProCure23 lots.

The following assessment was used for the assessment of the frameworks for each evaluation criteria.

Table 70: Evaluation definitions

Key	Meaning
	Preferred against the other frameworks in relation to the criterion
	Meets the criterion but is not preferred
	Does not meet the criterion

Table 71 outlines the comparison of these alternative frameworks against the selected criteria.

Table 71: Framework evaluation

Criteria	*Framework*				
	Pagabo	**SCAPE**	**ProCure Partnerships**	**NHS SBS**	**P23**
Support					
Process Timescales					
Market Capability					
Market Appetite					
Competition					
Support from Framework					
Governance					
NHS alignment					
SUMMARY					**Preferred Option**

The evaluation of alternative procurement frameworks concluded that P23 should be the chosen route to market for the HTP as it was the only framework that met all the criteria. P23 clearly and most explicitly provides contractors who have past and recent experience working in the healthcare sector. It is managed by NHSE and hosted by Crown Commercial Services. The alternative procurement routes provide similar pre-vetted construction contractors to P23 for design and build of large and complex public sector projects such as schools, sports centres, libraries, and primary healthcare facilities. However, P23 is the dedicated healthcare framework of choice by the NHS. The pre-vetted contractors are experienced healthcare construction professionals who have the expertise to deliver large, complex healthcare schemes in acute clinical settings. The framework also provides a unique clinical repeatable room process that provides the Trust with increased cost certainty for design as well as reducing risk in delivery. The decision to use P23 also means that there is a dedicated team of healthcare design, procurement, and construction specialists available from within NHSE to advise and support the Trust throughout the duration of the works. P23 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 P23 framework meets all the delivery criteria for this scheme; it outlines the requirements for a single point of responsibility, and a guaranteed maximum price (GMP) / target price to manage risks associated with delivery. Alternative procurement routes do not provide this level of cost certainty, reduction in risk or robust criteria specifically aligned to healthcare schemes. P23 also 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. As part of the P23 framework, PSCPs also participate in a number of working groups which ensures that best practice and market trends are captured in the P23 framework processes and that the framework behaviours and culture can continuously improve.

P23 also best enables the HTP to achieve the aims set out in the Construction Playbook as it encourages collaboration and better strategic relationships between the public and private sector and drives improvement and innovation within the construction industry. The Construction Playbook sets out 14 key policies for how the government should assess, procure, and deliver

public works projects. CCS were integral to the development of the Construction Playbook and continue to play a role as part of the steering group supporting and overseeing the implementation of the Construction Playbook which ensures P23 alignment.

P23 has shorter timescales in going to market than some other frameworks which means that financial spend targets are met quicker with increased efficiency. These shorter timescales also reduce exposure to inflation and allow for the ability to act on GMP prices quickly. There are also many economies of scale that result from using the P23 Framework. The Trust will benefit from better prices from PSCPs as more work is let through P23 and the PSCPs will have access to benchmarking data through a £ / m^2 style intelligence database which is more relevant and real time than Healthcare Premises Cost Guides (HPCGs). P23 also benefits from a growing database providing better opportunity to understand how much construction costs. NHSE collaborative input from workstreams such as Future standards, Cavell, Net Zero, Digital will also improve the ability of PSCPs to positively influence the design and implementation.

In terms of post award contract considerations, P23 is also preferred. Whilst all the framework routes enable selection of appropriate forms of contract, including the preferred NEC4 suite of contract documents that best aligns with public sector contracting, P23 explicitly promotes the use of the NEC4 suite of contracts based on sound project management principles (namely time, cost, quality, and risk). The use of NEC4 provides increased cost certainty for the Trust and there are specific schedules and additional clauses embedded into the P23 call-off process that are applicable to NHS schemes which PSCPs are used to working to and have therefore been developed and tested.

The Trust will formally appoint a PSCP in Q1 2023/24 (during RIBA Stage 3) , with the process to formally appoint a P23 contractor beginning at the end of the RIBA Stage 2 design process. It is necessary to wait until completion of RIBA Stage 2 before starting to appoint a contractor because it ensures that the design has reached a level of maturity to allow the contractor to meaningfully engage with enough information to permit them to commence their market testing. The decision to wait until completion of RIBA Stage 2 to appoint a contractor means that the PSCP has less time to evaluate the designs. However, there is more information available, and costs associated with additional support from the contractor are lower. This favours commercially driven decisions and provides the best value for money for a scheme the size of the HTP.

3.2.2 Engagement with the framework

The Trust project team (including Procurement and Strategic Capital Estates leads) conducted early engagement with the NHSE P23 framework from the outset of the HTP planning to ensure the suitability of this framework for this investment. 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.

The latest P23 iteration went live in July 2022. The framework call-off contract guidance has been reviewed following the SOC stage; workshops have been undertaken with the NHSE P23 Implementation Advisors (IA). These workshops provided a clear understanding of key differences between this and previous ProCure framework iterations. Additional considerations identified during this review are as follows:

- CCS owns P23, although operational management continues to be delivered by NHSE.
- There is now the ability to allow for a private open day for PSCP tender engagement.

- The free-of-charge 'VAT Recovery Service' provided via the framework is no longer available. Our understanding is that we as a Trust need to ensure appropriate management of VAT (including external advice) is factored into PSCP-related activities. P23 still provides VAT recovery guidance and the ability to take advantage of the processes and procedures developed and agreed with HMRC, ensuring compliance with latest guidance.
- The Trust will be required to calculate the price scores for their tenderers and will score quality submissions without being aware of their price scores. A Price Computing Tool will be provided to clients by NHSE (this activity will be managed appropriately by the Trust to ensure an effective evaluation process is undertaken, with support from the P23 IA).
- Procurement Policy Notes relating to the Social Value Model, which effectively mandates the Contracting Authorities, must explicitly evaluate Social Value when this procurement value is built into the framework call-off tools / document suite.
- Economic and Financial checks must be undertaken in line with the Construction Playbook. Best financial practice ensures that P23 bidders are assessed at on-boarding (this was to be undertaken as part of the existing Trust procurement procedures, but it is acknowledged as being a more explicit activity within P23).

3.2.3 Procurement at FBC

The PSCP will be appointed on 26th May 2023. Once appointed, the PSCP will:

- Feed into the completion of the RIBA Stage 3 designs
- Complete the next stage of design for the scheme (RIBA Stage 4)
- Undertake package pricing – working with the supply chain to obtain costs for individual packages of work
- Collate package pricing to prove a Target Cost (formally known as Guaranteed Maximum Price (GMP))

The package pricing and Target Cost will form the basis of the FBC economic case, with the FBC seeking national approval to sign the contract with the PSCP for the delivery of the full works. The FBC will set out the negotiated deal in detail, the detailed plans / design for the scheme and the financial implications of this deal. The NZC and MMC plans will develop further as we progress to FBC stage. The FBC will also provide a detailed financial and technical analysis of the equipment requirements and a detailed project plan will be developed. The portfolio of existing commercial contracts held by the Trust (and ICS partners) will be reviewed during the FBC process. This review will inform the outturn cost for the project and will benefit from the market testing of work packages by the PSCP. The Z clauses of the NEC4 construction contract Option C will be defined upon completion of the FBC.

The P23 framework has robust processes in place to ensure all due diligence, governance and administrative processes are followed to deliver the scheme. The Trust's Hospitals Transformation Team have the necessary experience to administer the contract under the NEC4 suite of construction documents, as required under the P23 process. The experienced team will further reduce delivery risk to the Trust by carefully monitoring and managing the P23 process and ensuring the scheme is completed on time and within budget.

Additionally, the PSCP will complete the delivery of the enabling works scheme run in parallel to the completion of the FBC. Further detail on this is outlined in the RIBA Stage 2 Report [Appendix C-02] and Section 5.2.2 of the Management Case.

3.2.4 Market engagement

An Invitation-to-Tender (ITT) document was issued by the Trust on 3rd March 2023 to appoint a preferred P23 Contractor, in line with the Master Programme, to bring the PSCP on board as

quickly as possible to maximise time and minimise design risk. The PSCP has been selected based on the evaluation criteria outlined in Section 3.2.5.

The HTP falls into P23 Lot 3 which is for works for NHSE schemes of above £70m. Within Lot 3, the contractors are:

- Integrated Health Projects (Vinci + Sir Robert McAlpine)
- Laing O'Rourke
- Galliford Try
- Kier
- Graham
- ISG
- MWD Healthcare (Mace + Willmott Dixon)
- Wates

Informal communication with the PSCPs began in November 2022 to get an understanding of PSCP interest, given the scale of the scheme. The following key stakeholders and subject matter experts have attended the P23 process workshops and follow-up activities:

- HTP SRO
- Programme Director
- Programme Nursing Lead (clinical representative)
- Programme Clinical Director (clinical representative)
- HTP Technical Advisor
- Senior Procurement Manager
- Director of Estates
- Estates Capital Programme Lead
- Programme Finance Leads
- Director of Finance
- Non-Executive Director Representative
- NHSE Strategic Estates Lead
- NHSE P23 Implementation Advisor

The initial 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 and background to the HTP (business case and approval status / NHSE + MP + ministerial support / our approach)
- Leadership and support for the HTP within SaTH (Board, Exec Team and Senior Leadership / Clinical and Medical Support
- Local system and the Integrated Care Board role (the HTP is a major programme of the ICS > SaTH are the lead organisation for delivery)
- The design and construction requirements (including the design baseline)
- Procurement process and next steps

The first session was held on 2nd November 2022, with a follow-up session on 15th February 2023. All 8 PSCPs within the applicable P23 framework lot attended both sessions. These sessions gave the PSCPs the opportunity to feedback their thoughts on our approach to the procurement. The feedback from PSCPs has been very positive so far. They liked how the phasing and structure of the programme for the Preferred Option had been developed and thought that the scheme was deliverable. The PSCPs were also given the explicit opportunity to comment against our proposed procurement timetable. There were no clear barriers as to why a PSCP would not consider submitting a bid, with discussions held around their procurement and delivery pipelines. The Trust also made our proposed approaches to invitation to tender decisions (such as quality /

price ratio, price scoring methodology and contract price option) known and invited comments from the PSCPs. The feedback was positive, and they agreed with the Trust. The PSCPs also appreciated the Trust's foresight and open book nature at this early stage of the process.

The PSCP Open Day took place on 8th March 2023 and Integrated Health Projects and Laing O'Rourke confirmed that they would be submitting a response to the Invitation-to-Tender. Moderation interviews took place on the 21st April and evaluation scoring concluded on the same day to enable a PSCP award recommendation.

When engaging with the PSCPs, the following success criteria were used to select an appropriate PSCP:

- Cost certainty.
- 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 withstand the highest levels of scrutiny.

3.2.5 Evaluation criteria

Quality Criteria

In respect of **quality** related evaluation criteria, we selected sub-criteria topics from the P23 framework set that are relevant and appropriate to a procurement of this scale and to the HTP specifically.

A series of workshops with the key stakeholders and subject matter experts listed above concluded that the criteria outlined below were to be used.

From these quality criteria, an appropriate series of quality related questions with sub-weightings was developed for the Invitation-to-Tender. This determined the respective sub-weightings applicable to each of these sub-criteria topics, together with an appropriate methodology applied to scoring bidder responses to each of the relevant questions. More details of these quality criteria are outlined in the Appendix C-01.

Table 72: Quality Criteria

Weighting (max 100)	Total Marks (out of 70)	Quality Criteria	Description
100	15.6%	Relevant experience	**Q1a** Evidence of a successful track record of delivering projects of a similar clinical functionality. **Q1b** Evidence that the proposed team have the relevant personnel experience required.
100	15.6%	Care, Quality and Productivity	Description of ways in which they intend to work alongside our people. Explanation of how they will successfully manage the ED refurbishment and acute floor adjacency. Provision of evidence of how they will drive a positive culture and professional attitude.
100	15.6%	Stakeholder engagement	**Q3a** Description of how they will work collaboratively with the Programme Director / PMO to ensure effective communication with local resident groups, Councils, and clinical teams. **Q3b** Description of how they will manage the Trust stakeholder engagement process to ensure the scheme manages risk, costs, and quality issues.
70	7.6%	Smart Infrastructure and Modern Methods of Construction	Provision of details of how they have successfully delivered projects that are NZC, included renewable energy sources and adopted MMC.
100	15.6%	Social Value and Net Zero Carbon	**Q5a (SV Theme 2: Tackling Economic Inequality)** Evidence of how they will create local employment opportunities for those who face barriers to entry and those located in deprived areas. Provision of a detailed plan of how they will ensure these opportunities arise within the first 24 months of the project. **Q5b (SV Theme 5: Wellbeing)** Description of the community initiatives and programmes that will be undertaken in delivery if this project. **Q5c (SV Theme 5: Fighting Climate Change)** Description of how they will reduce their negative environmental impact during delivery.

Price Criteria

In respect of **price** related criteria, this process assesses Supplier fees and rates.

Whilst PSCP fees / rates have already been capped and assessed by CCS / NHSE during the P23 framework appointment process as being sustainable, competitive and value-for-money, the Trust need to determine the scoring methodology to evaluate the Tendered Rates and Fees.

[redacted]

[redacted]

3.2.6 Procurement process

With the P23 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. As the procurement process has been carried out in line with the P23 Framework, which is part of Crown Commercial Services, there are no legal issues to report as the contract is not bespoke.

Competitive procurement

The mini-competition process considers both qualitative and price tenders from PSCPs.

Under the framework, with the HTP using the competitive procurement method (mini-competition), the process stages are outlined in Table 73.

Table 73: 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 utilised the P23 Call-Off and Price Tools provided by our NHSE P23 Implementation Advisor (IA). The P23 IA acted 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 74: Timeline of procurement activity

Task	Date/time
Register schemes	14th Sept 2022
Initial Informal Pre-Tender Engagement session: 8 x PSCPs and Trust Leads Follow-up Pre-Tender Engagement session	2nd November 2022 15th February 2023
Issue Client Invitation-to-Tender Brief (CITTB)	3rd March 2023
PSCP Open day: i) Introductions and Designer Forum ii) RSH site walk iii) PRH Telford site walk	8th March 2023
PSCPs to confirm to the Client and IA whether they will be bidding for the scheme	14th March 2023
PSCPs submit Initial Tenders	6th April 2023
Client to assess Initial Tenders	11th – 14th April 2023
Moderation Interviews	21st April 2023
PSCP evaluation concluded recommendation confirmed	21st April 2023
Down-selection and further negotiation with short-listed PSCP	w/c 24th April 2023
Evaluation Decision Trust Approvals Cycle	From 28th April
PSCP appointment	26th May 2023
P23 Launch workshop	w/c 29th May 2023
P23 pre-construction training for project team	w/c 5th June 2023

This timeline was shared with the PSCPs throughout the engagement process, and they have confirmed that the key milestones and delivery dates are realistic and achievable. [redacted]

3.2.7 Scope of services

The Trust will work collaboratively with the PSCP to deliver the HTP. The Invitation-to-Tender (ITT) document issued to the PSCP outlines the design and construction services that are required. The scope of the PSCPs design and construction services for the HTP is to deliver the Preferred Option. This consists of 28,611m^2 of new build at RSH which includes a new Acute floor, Oncology and Haematology wards, Women's and Children's services, a new 32 bed general ward and a new Critical Care Unit. The services required also include refurbishment at RSH (5,128m^2) and PRH (660m^2) which incorporates the enabling works that involve refurbishment of the ED at RSH.

As per Section 3.1, we aim to novate the existing architectural, financial, mechanical, electrical, structural, and civil design services and use them during the RIBA Stage 2 and RIBA Stage 3 elements of the pre-construction phase of the works. This will happen when there is the necessary formal regulatory approval to engage the PSCP beyond RIBA Stage 3 (as per SOC JIC conditions). Whereas we will retain our appointed cost consultants. Additional specialist advice will also be procured as required to ensure that the design complies with all regulatory and statutory requirements. These designs can be found in Appendix C-02. The Trust will also expect the PSCP to buy into the existing Common Data Environment (CDE) to ensure that all materials are shared and stored in an agreed format that is clearly auditable to demonstrate a clear governance process throughout the scheme.

The Technical Oversight Group has been established to facilitate engagement with the PSCP (outlined in more detail in Section 5.1.1 of the Management Case). The PSCP will engage with

the Technical Oversight Group daily and attend the HTP Delivery Group to ensure that the HTP Team are aware of potential issues that arise and risks to the delivery of the HTP.

3.2.8 PSCP appointment

The Trust expects to appoint a PSCP by the 26th May 2023. The services acquired are outlined in the Procurement Documentation [Appendix C-05]. The proposed approach to novation of existing services and appointment of supplementary team members is outlined at the beginning of Section 3.1. This approach will ensure that the PSCP is able to market test construction material packages of work on behalf of the Trust. This means that essential elements can be market tested to demonstrate value, providing cost certainty for FBC completion. The PSCP will be able to immediately feed into the RIBA Stage 3 design process as a result.

The scope of the procurement is outlined in detail in the RIBA Stage 2 Report [Appendix C-02]. This report includes details relating to the design of the HTP. The Preferred Option has total capital costs of £312 million based on the latest PUBSEC indices. The GIA of the new build areas as part of the HTP at RSH in the Preferred Option is 28,611m^2. The GIA of the refurbished areas in this option is 5,128m^2 at RSH and 660m^2 at PRH. Total GIA for the Preferred Option as part of the HTP is 34,399m^2. Since SOC, the design has been changed to accommodate for budget constraints. This has involved the relocation of major building work from the northwest to the southeast of the RSH site. The Preferred Option is expected to be completed by 2026/27 and relies on multiple inter-dependent projects such as the Energy Centre to deliver as planned. The Preferred Option doesn't involve the disposal of any land and therefore this does not need to be considered as part of this scheme.

The proposal is deemed to be commercially feasible and deliverable by the Trust and relevant project advisors. Engagement with PSCPs has confirmed that the programme timelines are achievable and appropriate. The capital cost of the scheme is also in line with the original allocated funding and is broken down in further detail in the OB Forms [Appendix E-05]. The Trust also has robust Governance arrangements in place (explained in Section 5.1.1 of the Management Case) to ensure that decisions are overseen and approved by relevant stakeholders.

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).

3.2.9 Key contractual issues

Principal Supply Chain Partner contract

In terms of PSCP appointment, the P23 framework call-off mandates the use of the NEC4 construction contract Option C suite of documents. There are no expected special clauses or derogations in the procurement contract. The Z clauses will be defined upon completion of the FBC. The use of NEC4 by P23 promotes collaborative relationships, and the decision to use the NEC4 Contract Option C (Target Price) over Option A (Lump Sum) for the HTP is because it is appropriate for the design development requirements of the HTP. [redacted] The NEC is a tried and tested contractual vehicle of delivery for projects and programmes of this size. It ensures a high degree of collaboration and means that risk mitigation is captured throughout. The NEC suite of documents require specialist administration to deliver; the Trust has a team of internal and external professional consultants who have experience in the successful delivery of

healthcare programmes of this size using the NEC and the P23 framework processes and procedures.

The P23 process has pre-existing templates to be followed which will assist the Trust in understanding the complex processes involved. The process is specifically designed for the healthcare industry and helps to reduce risk and provide cost certainty as a result.

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

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

Table 75 below outlines the anticipated allocation of risk at this stage, now that P23 has been chosen as the procurement framework for this scheme.

Table 75: Risk Transfer Matrix

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

For the HTP, we are using the Procure framework under the Design and Build approach as we are appointing the PSCP during the design process to assist with the completion of pre-construction activities. This approach ensures that all construction and development risks are allocated to the contractor which reduces risk to the Trust as it allocates all construction and development risks to the contractor. The diagram below demonstrates the indicative construction and development risk allocation for the differing approaches available under P23. It highlights the lack of risk for the client when selecting the Design and Build approach to the ProCure framework compared to the alternative approaches.

Figure 21: Indicative risk allocation for the different procurement routes

The decision to use the P23 framework and the NEC4 Option C contract documents mitigates the risk of a delay in completion through the inclusion of Liquidated Ascertained Damages (LADs) and the management of contractor performance.

All risks are effectively managed using a fully developed and detailed Costed Risk Register [redacted] This is systematically and regularly updated and maintained as the design and development of the programme progresses. The Costed Risk Register will be shared with our prospective partner at an appropriate time within the P23 tender cycle and risks will be allocated to the PSCP according to the above risk allocation matrix. After this point, the Costed Risk Register will be jointly owned and developed with the PSCP. The Technical Oversight Group will meet regularly with the PSCP, and the costed risk register will be an agenda item at all meetings to ensure that risks are appropriately evaluated and managed. The tender cycle will progress after the Bidder's Day on the 7th March 2023. Our approach to costed risks is outlined in more detail in Section 5.4 of the Management Case.

3.3 Planning and Design

We are currently undertaking the detailed design process for the HTP and our 1:200 plans are included in the RIBA Stage 2 Report [Appendix C-02]. This report also provides detail around our NZC and BREEAM Strategies as well as the incorporation of MMC and BIM into the design. This is outlined in more detail in Section 3.3.1 and 3.3.2. The proposal is also aligned with the principles and requirements of the Naylor review and the Carter Review. The Preferred Option doesn't involve the disposal of any land but the expected disposals as part of the Trust's longer-term plan are aligned to the requirements of the Naylor Review. The Trust's non-clinical space is below the peer median and national average. Details of the Carter Metrics for the Trust are outlined in more detail in Section 2.4 of the Economic Case. In addition, we have also undertaken design principles and reviews that are included within the RIBA Stage 2 Report. The design also considers how the estate will be maintained in the long term and ensures that there are adjacencies to public transport. This is described in more detail in the completed NHSE Premises Assurance Model (PAM) [Appendix C-07].

We have begun consultation with both local planning authorities (Shropshire, and Telford & Wrekin) as part of this process. Initial meetings with these local planning authorities confirmed that they were verbally supportive of the scheme with the main consideration being to ensure appropriate car parking solutions on the site. We have also received pre-application advice from Shropshire Council that we are responding to ahead of our application for full planning permission. The letter from the local authorities is included in Appendix C-03. We have ongoing engagement with the Air Ambulance, West Midlands and Welsh Ambulance Services and Shropshire Fire and Rescue. This will continue throughout the remainder of the process. Site visits have taken place and we plan to submit a full planning application was submitted on 30th March 2023 and the full planning permission process is being progressed. PRH consists of internal reconfiguration and therefore doesn't require planning permission but building regulations will be adhered to within the detailed design.

All our designs demonstrate that we can deliver the scheme on land that we have the ability to occupy.

3.3.1 Modern Methods of Construction and BIM

Modern Methods of Construction (MMC) are integral to the HTP design process. Our MMC Solution is outlined in more detail in our RIBA Stage 2 Report [Appendix C-02]. Early engagement with the PSCP will ensure the design parameters and metrics are targeted to achieve a compliant MMC % outcome of 70%. The core objectives and key requirements have remained consistent since SOC, despite the changes to the overall design, and this approach is expected to be used when engaging with the PSCP to assist in finalising the FBC. The current design will provide a renewal of the SaTH estate and create a sustainable healthcare infrastructure. This solution can be delivered with a high degree of certainty and speed and will provide an extensive range of clinical spaces which are able to adapt to a rapidly changing clinical landscape, whilst delivering the project within the allocated cost envelope.

The MMC solution should therefore be:

- able to be implemented without significant developmental costs
- highly repeatable
- low maintenance
- sufficiently flexible to allow for change

Building Information Management (BIM) is also a key component of our strategy, creating an information rich model which can be utilised by the contractor for design, development, and manufacture by the Facilities Management Team to assist in the maintenance and operation of the infrastructure and can be built upon for future projects. The Project will fully utilise the NHS 3D BIM Model Principle across all its design packages to ensure continuity and efficiency in its design process and beyond. The initial design phase will be coordinated to ensure future PSCP contractor appointments can smoothly transition into the already established BIM design model with a recognised industry standard of practice. Our BIM Strategy is also included within our RIBA Stage 2 Report [Appendix C-02].

We will continue to develop and assess available options throughout FBC to maximise the use and benefits of MMC. A ‘Shell and Core’ model has been utilised to allow for ongoing development of the clinical brief without impacting the construction methodology. This model is supported by a simple 7.8m x 7.8m grid which provides the optimal span for the framed solution. This grid outlines an efficient plan 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 for customisation of room types for adult inpatient, maternity inpatient, short-stay, oncology, and paediatric use. This approach supports prefabrication and MMC and will be extended as the design develops to reduce the number of alternative room types required for the project.

In addition to this, and explained in more detail in the Management Case, the appointed design team will consider all options to accelerate delivery and reduce the carbon impact of the scheme.

3.3.2 BREEAM and NZC Strategies

The project is currently undergoing a BREEAM V6 review and in line with NHS Guidance, we will achieve BREEAM ‘Excellent’ for all new buildings. Our BREEAM Strategy (included in Appendix C-02) clearly defines our approach to achieving BREEAM ‘Excellent’ by incorporating the BREEAM credits where possible and subject to the completion of the new energy centre. In line with the latest BRE guidance, the HTP Team will work with the PSCP to achieve this target.

Our Net Zero Carbon Strategy (included within our RIBA Stage 2 Report) [Appendix C-02] outlines our approach to achieving net zero in detail and is in line with the latest NHSE guidance. It incorporates the NHS Strategy to achieve net zero emissions by 2040 and reach an 80% reduction by 2032. The project aims to achieve Net Zero Operational Energy (assuming a

decarbonised grid where all electricity provided by the network is generated from non-fossil fuel sources). No specific target has been set for Net Zero Carbon Construction, but we will work with the appointed PSCP to maximise the reduction in the utilisation of carbon throughout the construction process. The design team will also identify opportunities to utilise low carbon solutions where possible.

Materials will also be responsibly sourced, and this will be monitored by maintaining close control of the materials supply chain. The HTP will also utilise industry standards to reduce waste and improve flexibility. The changes to the design of the HTP since SOC have reduced the need for new construction by approximately 2000m^2, further improving the sustainability of the programme.

To achieve our target of net zero operational energy use, we have adopted a 3-stage plan:

1. **Reduce the need for energy in the building**
    - By making appropriate provision for ventilation and utilising waste heat during the colder months.
    - By considering the importance of adjacencies to minimise the reliance on artificial lighting.
    - By ensuring enhanced fabric performance with high levels of insulation.

2. **Use energy more efficiently**
    - By using the TM54 calculation methodology.
    - By being electric where possible.
    - By replacing the existing site-wide hospital distribution with a low carbon alternative.
    - By applying hybrid energy strategies.

3. **Supply energy from renewable sources**
    - By carefully considering the availability of on-site renewables – opportunities to use photovoltaic panels are currently being explored by the design team.

The HTP also aims to promote a sustainable travel policy. SaTH has a well-developed Travel and Transport Plan [Appendix C-06] and the HTP is aligned to this. The development will provide electric vehicle charging facilities for at least 10% of total car parking capacity and improved staff changing facilities will also support increased bicycle use. Water consumption will also be carefully monitored throughout the programme and the HTP will feature low flow rate fittings.

Achieving Net Zero Carbon in this proposal is dependent on the successful delivery of a new zero carbon energy centre. The scope of this project excludes the energy centre. We are currently investigating alternative avenues of funding for this, such as the Green Network Heating Fund (GNHF). Included within the scope of this project are all elements of the building fabric and the engineering infrastructure leading into and within the envelope of the various elements of the project but excluding the energy centre itself.

Appropriate measures for monitoring and variation are in place to ensure that the HTP meets the targets set out in our Sustainability Strategy. These will be detailed within the Stage 3 RIBA Report. The Trust will coordinate with our contractor to set up a process for monitoring of energy and water use once the HTP is complete. The use of energy for the HTP will be measured and reported on an annual basis to ensure appropriate consideration of seasonal variations. These plans will be developed further as we progress to FBC stage.

3.4 Reduction in backlog maintenance

The HTP addresses some of the high and significant backlog. This is identified as a benefit of the HTP and is explored in further detail in Section 3.6.1 of the Economic Case. The RIBA Stage 2 Report [Appendix C-02] provides further detail of backlog to be addressed. Most of the works in Option 2 involve new buildings rather than refurbishment. However, in Options 3 and 4, more backlog is addressed due to increased refurbishment. Table 76 outlines the levels of predicted backlog addressed by each phase of the HTP.

Table 76: Backlog

	Backlog before works (ERIC 21/ 22)				Backlog Addressed by option				Remaining backlog
	Low	Moderate/ High	Significant	Total	Low	Moderate/ High	Significant	Total	
Option 2 c.£312m	£0.9m	£20.1m	£18.1m	**£39.1m**	£0.08m	£2.4m	£3.7m	**£6.1m**	**£33m**
Option 3 c.481m	£0.9m	£20.1m	£18.1m	£39.1m	£ -	£6m	£2.6m	£8.7m	£30.4m
Option 4 c.534m	£0.9m	£20.1m	£18.1m	£39.1m	£ -	£6.5m	£7.4m	£20.2m	£18.9m

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

We operate in-house hard and soft facilities management (FM) services. At this stage, we continue to assume that this will be the case upon completion of the HTP, and we will work with our in-house estates team on the appropriate change control arrangements during the lifecycle of the project and after implementation.

Our Change Control Process [Appendix S-13] outlines our procedure for appropriately addressing change. If a change is proposed, it will be reviewed by the Estates Workstream Lead and the Technical Oversight Group. The change will be recorded on the Change Control Register and discussed with the Change Control Group to decide whether the change is to be accepted or rejected. The Change Control Group will meet fortnightly to review proposed changes and the PMO will maintain the Master Change Control Register to capture changes across all workstreams. This process is important because it ensures that everyone is aware of proposed changes and key stakeholders inform the decisions made.

In addition to our in-house estates team, we have contractors for services such as laundry and waste. We aim to review these contracts annually throughout the lifecycle of the project and after its completion. As explained above, we expect that the areas of new build will help to eliminate some of the significant backlog issues. These new build areas will also be more efficient than the existing site and therefore result in some efficiency savings, however, these will be offset by the overall increase in footprint across the two sites. The cost impacts of this are factored into both the Economic Case and Financial Case.

The new build elements of the HTP will also provide the Trust with greater influence in relation to building maintenance management and performance through the latest versions of MICAD and software updates, enabling a 24/7 response to building control issues as a result of the environment. These software updates will also improve functionality and lead to better KPI dashboards, helping to measure performance of assets. The building will be built smarter and leaner with reductions in solar gain and thermal efficiencies requiring less daily maintenance and less requirement for reporting of issues, as the building will be designed to the latest HTM / HBN standards in clinical areas. This is quantified as a benefit and outlined in further detail in Section 3.6.1 of the Economic Case. External areas, landscaping and natural light for staff, patients and visitors has also been a consideration within the design of the building which incorporates NZC and MMC. These external areas are important for staff and patient wellbeing. This was considered further as part of our Social Value Model [Appendix S-08]. This also applies to the design and maintenance of the building during its operational life.

3.6 Procurement routes for professional services, equipment and temporary facilities

3.6.1 Professional services

As set out in the Management Case, we have an experienced and capable in-house team for the HTP. The HTP team ensures clear ownership and co-ordination of the project at both a strategic and a detailed level within the local health system. The team can lead on business case production, clinical planning and workforce development. They will be supported by additional procured professional services where necessary and appropriate.

Our internal service improvement team will also provide support to the HTP team as the project progresses towards implementation, as detailed in the Management Case. The team have strong service change / improvement experience and the Trust was selected as one of five hospital Trusts nationally to partner with the Virginia Mason Institute in Seattle. Using the knowledge and skills gained from this partnership and other recognised NHS improvement practice, we have developed the SaTH Improvement method. This methodology will be valuable in supporting the clinical service changes required to underpin the physical reconfiguration within the HTP.

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

To support our in-house HTP Team, additional external specialty support has been sought. This 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 an appropriate framework.

Any further specialist advice required throughout the completion of the HTP process will be purchased an appropriate framework, or via local appointment in line with our Standing Financial Instructions.

3.6.2 Equipping

The Trusts Medical Devices and Equipment strategy [redacted] had been developed during OBC and 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.

[redacted]

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's approach to risks shared with the PSCP is outlined further in Section 3.1.9.
- The Trust will make use of existing national and local frameworks, tendering where necessary and through OJEU, depending on the value.
- 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 currently leases some medical equipment and will continue to adopt this principle in the new hospital.
- Wards / Departments are responsible for ensuring they receive adequate instruction manuals for new equipment.
- The Trust's existing Management of Medical Device Plan will remain in place.

There is no intention to purchase any high-cost equipment that requires specialist input as part of the HTP. However, we have a strategy in place for procuring this type of equipment.

- Procurement of equipment is through the Shropshire Healthcare Procurement Service.
- Equipment is funded by SaTH.
- SaTH is responsible for operating, maintaining, and replacing equipment.
- Equipment is maintained either 'in house' or through contract servicing (depending on the item, servicing and maintenance requirements and best value for money).

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'.

3.6.3 Digital

Our Medical Device and Equipment Schedule [redacted] outlines the digital elements to be procured as part of the HTP. Both software and hardware are important for the scheme. This is evidenced by the plans for a self-check-in ED. Our Digital Strategy [Appendix S-05] ensures that the digital elements of the HTP enable the plans and processes. It explains that all equipment bought as part of the HTP should be digitally enabled. The ongoing programme of digital development is in line with the frontline modernisation agenda.

All purchases will be made via a process that is compliant with the Public Contract Regulations (PCR2015) and/or Local SFIs, 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, including but not limited to, the evaluation of shared instances and joint procurements relevant to the ICS.

3.7 Key procurement milestones

Table 77 highlights the key procurement process milestones. These dates are dependent on the review of this OBC and will be refined throughout the project as further information and detail on the scheme and supplier market becomes available.

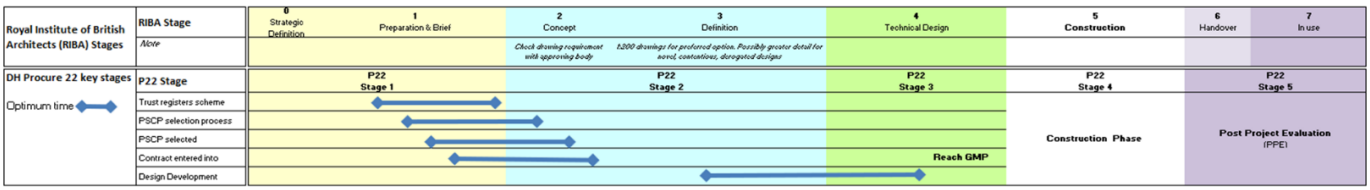
Section 5.25.2.1 of the Management Case summarises the overall programme milestones and critical phases, including these key commercial milestones.

Table 77: Procurement process milestones

Key decision/approval	Date	Status
SOC Submission	April 2022	Complete
Joint Investment Committee approval of SOC and agreement to proceed to OBC	July 2022	Complete
PSCP Initial Engagement	November 2022	Complete
RIBA Stage 2 report	March 2023	Complete
Trust issue P23 Client Invitation to Tender Brief (CITTB)	March 2023	Complete
P23 Expressions of interest (EOI) document Evaluation	March 2023	Complete
PSCP Interview Process	April 2023	Complete
Completion of RIBA Stage 3 draft report	April 2023	Complete
Trust appoint preferred PSCP	May 2023	Complete
Completion of OBC	July 2023	Complete
Joint Investment Committee approval of OBC	July 2023	On track
Completion of FBC (Including PSCP GMP)	January 2024	On track
Joint Investment Committee approval of FBC	February 2024	On track
Begin Implementation of the Preferred Option	September 2023	On track
Completion of the Preferred Option	July 2026	On track

The P23 PSCP has been appointed against qualitative and price criteria and will subsequently work with the Trust to develop a target price, bridging RIBA Stages 3 and 4. Figure 22 below describes the alignment between RIBA Stages and P22 stages, which are expected to be consistent with P23.

Figure 22: RIBA and P22 stage alignment



[redacted]

3.8 Personnel implications (including TUPE)

The HTP incorporates national drivers for workforce including recruitment and retention and increased use of technology. Training and Development programmes are also considered as part of this plan. Our alignment with national policy drivers is outlined in further detail in our People

and Change Plan [Appendix M-09] which is informed by our Recruitment and Retention Strategy and our People Strategy. Our workforce modelling, outlined in further detail in the Economic Case, it also informed by the appropriate guidance to allow for sufficient staffing of clinical areas.

Personnel implications, including workforce, are also described in more depth throughout this OBC. This includes Section 1.1.5.3 of the Strategic Case and Section 5.7 of the Management Case. We are not anticipating any Transfer of Undertaking Protection of Employment (TUPE) at this stage although as plans develop in relation to the FBC and the wider system changes, this position may change.

In terms of non-Trust personnel currently working to support the development of this programme, with Principal Supply Chain Partner (PSCP) engagement, it will be essential that the incumbent design team for the HTP has the knowledge and experience of working with the NEC4 suite of model construction contracts appropriate to the scale of the option being procured. The Trust will novate their design team to the PSCP, as described in Section 3.1. However, the team will be supplemented with additional professional technical advisors to quality check any design changes suggested by the PSCP and to ensure a successful GMP is achieved.

3.9 Impact on contracts

The portfolio of existing commercial contracts held by the Trust (and ICS partners) will be reviewed during the FBC process. There will be particular regard for multi-year contracts that will require contract variation processes to be undertaken when the delivery of the HTP impacts the provisions within these contracts. These will be reviewed by the Trust and any impacted ICS partners as part of the financial due diligence in delivering the new clinical model. This review during FBC will also inform the outturn cost for the project and will benefit from the market testing of work packages by the PSCP.

The impacts on the commercial contract pipeline within the system is already being considered. Specifically, consideration is being given to:

- Opportunities to deliver improved value for money
- Contract management consolidation opportunities such as more efficient services being provided on one site
- Future opportunities with ICS and regional partners

Some examples of known contract categories that will require focus will be:

- Non-Patient Transport and Logistics service contracts
- Managed Print / Non-Clinical IT solutions
- Estates and Facilities Maintenance

Professional removal services are also likely to be required to ensure the reconfiguration of services is completed with minimal disruption. This will be explored in more detail during the FBC once the room-by-room detail of the design is known, and the extent of the departmental relocation requirements have been identified.

3.10 Accountancy, banking, and VAT treatment

The accounting treatment of our proposal will be undertaken by applying the current accounting guidance as laid out by International Accounting Standards (IAS) and International Financial Reporting Standards (IFRS). Currently we understand that the assets will be recognised on our balance sheet along with the corresponding PDC funding.

We have considered the use of a Project Bank Account as part of the HTP. However, this will be discussed further with the PSCP once they are on board. The decision to use a Project Bank Account requires cooperation from the PSCP due to the amount of money involved.

As the ProCure VAT Recovery Service is no longer available, we intend to utilise professional VAT advisors. The Trust is receiving specialised VAT recovery advice and support through our existing arrangements with CRS VAT Consultants. VAT treatment is consistent with 2022/23 NHS / HMRC accounting rules. VAT at 20% is included on the capital scheme, except for VAT on fees which is assumed to be 100% recoverable. All revenue is based on current costs and income which includes VAT.

3.11 Travel and transport

Detailed modelling to understand the impact of the proposed clinical model has been completed as part of the public consultation process and is detailed in the pre-consultation business case (PCBC (11/17)) and decision-making business case (DMBC (09/19)). This included a full impact assessment, (since reviewed), which included specific mitigations for travel and transport impacts resulting from the reconfiguration of services (see Section 5.6). To support this, the development of this OBC has included a review of our Travel and Transport Plan [Appendix C-06]. The plan has identified the following:

- Both sites are situated in good locations with sustainable access opportunities and benefit from a range of sustainable transport and travel links within the immediate area. RSH is reasonably well connected internally. Whereas at PRH, there is intermittent footway and cycle provision as well as a lack of clear onsite signage. However, external cycling provisions are good at both sites, with several existing nearby low-traffic, arterial routes.
- Both sites are served by multiple bus services, which call directly at the hospital sites. However, many of the services do not run into the late evening.
- Discussion with our system partners will allow us to explore further opportunities to improve public transport links such as increased use of park and ride facilities.
- Both sites are located close to train stations which provide onward connections to key towns and cities. This will be considered further as we progress to FBC.
- Demand for parking at both sites is incredibly high, with incidences of unallocated parking found across most of the car parks at the two sites.
- Parking charges have fractionally increased for visitors since the pandemic, but this hasn't reduced demand for parking.
- Following the pandemic, parking permit charges for staff have not been reintroduced which encourages single occupancy vehicle travel to both sites.

To address these issues, the Trust is considering the following interventions:

- Improved management and enforcement of car parking at both sites. A detailed car parking plan for patients and visitors is currently being developed to address this.
- Improvements to bus services which serve the sites in coordination with local system transport providers, including reconsideration of routes and frequency.

3.12 Conclusion

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

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

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

The most cost effective and efficient procurement route is the utilisation of the P23 framework

We have made good progress towards the appointment of a Principal Supply Chain Partner (PSCP), with an expected appointment by 26th May 2023, ahead of Joint Investment Committee consideration of this OBC. We will work collaboratively with the PSCP across the system and with the in-house design team to identify and achieve a guaranteed maximum price (GMP) for the HTP scheme, agreed by all parties prior to construction commencement. This will inform the Full Business Case that will seek approval to sign the contract for the GMP.

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

Partnering
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NHS Trust

4 Financial case

4 Financial case

This Financial case assesses whether the Preferred Option is affordable. It carries out a comparison between the Preferred Option, and the Business As Usual (BAU) option. The impact of the scheme on the Trust Statement of Comprehensive Income, Statement of Financial Position and Statement of Cash Flow are outlined in Section 4.4, 4.5 and 4.6. [redacted]

As at the end of March 2023, the Trust is reporting a forecast year end position of £47.2m deficit with an underlying recurrent deficit of £34.4m. Under the Business As Usual position, in 2037/38 this position improves [redacted] despite increasing costs driven by demand and the cost of running the existing estate. This improvement trajectory results from the delivery of Business As Usual efficiency plans, including significant reductions in agency spend, which are being developed alongside system partners.

Despite this improvement, the Business As Usual comparator is still not sustainable from either a financial, or an operational perspective. Without investment in additional capacity, there will be material additional non-recurrent costs to address future service challenges which are detailed within this case. Furthermore, it will be extremely difficult to deliver the levels of efficiency required without some of the changes to the physical estate layout, clinical pathways, and ways of working. It will also become increasingly difficult to recruit vacancies in key staff groups, who will be unlikely to want to work in the current environment at the Trust.

The total capital requirement for the Preferred Option is £312m, as outlined in the Economic case. The capital funding requirement is expected to be provided from public divided capital (PDC).

Critically, the Preferred Option will deliver the primary investment objective to bring a step change in clinical care for patients across Shropshire, Telford and Wrekin and Mid-Wales, delivering the improvements in emergency and planned care that were committed to in 2018. This model will ensure that we can provide our patients with safe and high-quality emergency and planned care in a timely and accessible fashion, from modern fit-for-purpose buildings.

[redacted]

4.1 Financial context and Business As Usual

As at the end of March 2023, the Trust has an underlying deficit of £34.4m. This is part of a wider ICS underlying deficit within STW of £87.9m for financial year-end 2022/23. The Financial case has been constructed using assumptions as per national planning guidance for 2023/24, which results in an underlying plan of £40.89m as per the Trust's Long Term Financial Model (LTFM).

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

The planning assumptions as part of this OBC, as well as the wider system plans, have been developed and agreed as part of the ICS sustainability programme. As such, all planning assumptions have been jointly agreed and are consistent with system planning assumptions to create a projection of our Business As Usual financial position. The same assumptions are also used in the ICS sustainability plans, Trust plans and this case to ensure full alignment and consistency across the system.

In line with most longer-term financial planning exercises and similar redevelopment programmes, the financial information used to support this financial case focusses on the recurrent underlying position and develops forecasts on that basis.

We are committed to the ICS financial ambition to deliver financial balance although as illustrated by the outputs shown below, the Trust will be unable to achieve this without the significant transformation that will be delivered by the HTP.

[redacted]

As at March 2023, the Trust has an underlying deficit of £34.4m. [redacted] Figure 23 shows the contribution of each component, starting from the 2022/23 position to the forecast recurrent position in 2037/38.

In the Business As Usual option, additional revenue expenditure [redacted] is required to meet the Trust's growing demand and capacity constraints. Without additional investment in capacity, the Trust will be unable to meet the future growth in demand in the coming years. Unmet demand will need to be undertaken at increased cost through additional in-house premium expenditure out of hours or outsourced to the private sector. This has been calculated through detailed modelling [redacted]

Additionally, it has become increasingly clear that without immediate action, there will be further pressures on our workforce position. Our existing recruitment and retention position is fragile and the reputational impact of a delay will worsen this. The financial implication of this would be a requirement to use additional agency staff to enable the Trust to maintain operational, with high premium costs being generated. As such, an additional £8.1m recurrent pressure will be seen in the BAU scenario to backfill the expected vacancies created.

Key assumptions used in the financial modelling are:

- **Pay inflation:** National guidance of 2.1% pay inflation plus system estimate of 0.7% incremental drift. Although this could increase in future years, it is assumed to be fully funded through tariff uplifts and therefore cost neutral. Consistent assumptions have been applied to agency pay costs.
- **Non-pay inflation:** non-pay inflation has been included at 5.5% to 24/25, and 2.8% thereafter. This is consistent with both national and system assumptions up to 24/25 and assumed to be a reasonable reflection of non-pay pressures beyond this point.
- **Tariff change:** Tariff has been modelled in line with both national and system planning assumptions, with a net uplift of £9.2m (0.2%) derived from an uplift of 1.3% and an efficiency deflator of 1.1%. Non-NHS income has been based on a growth figure of 1% for the next 5 years and then no growth for the final 5 years of this plan. This is in line with system assumptions.
- **Growth:** Demographic growth has been included at 0.9% until 2023/24, and at 0.8% from 2024/25 onwards. Clinical income growth has been included at 2.6% until 2023/24, and then at 2.7% from 2024/25 onwards. This is in line with system planning assumptions.
- **Marginal rate of activity:** The financial model assumes that the marginal cost of delivering additional activity is 75% of the additional income that would be generated from the activity increase. This rate has been agreed across the STW system and is aligned to both system plans and the workforce modelling for this OBC.
- **Business As Usual efficiencies (cost improvement plans):** [redacted]
- **The Business As Usual efficiency assumptions** described above have been agreed with the system and form part of the wider system plans to return to a sustainable position. This rate of efficiency delivery will be challenging without some of the changes to the physical estate, clinical pathways and ways of working as well as the ability to attract key staff groups that would be difficult to recruit with the Business As Usual model.
- **System transformation:** This reflects savings generated by the Trust towards system wide plans particularly against the reduction of agency premium. It is expected that the increase required in substantive workforce recruitment will be challenging within the landscape of the Business As Usual model. The Trust is committed to the system financial ambition to deliver financial balance although it is difficult to imagine how the necessary transformational changes will be made without implementation of the Preferred Option.
- **Shift to community:** A key enabler for the delivery of the HTP is the ICS commitment to deliver more care in community settings. Through growth avoidance, the ICS has calculated that community interventions at a system level will have a 151-bed reduction on the SaTH bed requirement in 26/27, which is included within the Business As Usual financial model.
- **Depreciation, capitalisation and accountancy treatment** are in line with Trust policies.

[redacted]

4.2 Model Alignment

There has been a full reconciliation between the finance, workforce and demand and capacity models. The same assumptions have been applied in each of the models and the outputs triangulated. The BAU workforce modelling shows that without the HTP workforce would be required to grow by 7.2% to meet demand changes even after the growth avoidance of the 151 beds due to care being provided within the community. [redacted]

Further detail on the workforce modelling can be found in the People Change Plan in Appendix M-09.

4.3 Impact of the investment on income and expenditure

Within the STW system financial improvement plan, the HTP is expected to contribute to reducing the Trust deficit and support overall system sustainability. The Preferred Option will have several impacts on the Trust's income and expenditure position in 2037/38 that contribute to making these improvements:

[redacted]

Finance Costs: This includes the revenue impact of the c. £312m capital investment associated with the Preferred Option. This includes PDC charges on the capital (excluding donated assets) and additional depreciation, assuming 3.5% PDC charges p.a. and a useful asset life of 60 years for new buildings, 40 years for refurbishment and 7 years for equipment, in line with the Trust's depreciation policy. An impairment of 15% on the £312m capital investment has been assumed. At this stage this impairment has not been signed off by the Trust's valuer and is therefore at risk until this is the case. The impact of a higher impairment value has been tested as part of the sensitivity analysis in Section 4.3.2

HTP benefits: In 2031/32, following the completion of the phased redevelopment, the Trust will realise c.£28m of cash releasing benefits at 2022/23 prices. The national assumption of 5.5% non-pay inflation to 24/25, and 2.8% thereafter, results in a c.£10m growth in benefits by 37/38.

A reconciliation has been provided below and sensitivities have been run to confirm that there is no affordability risk, should these not inflate at such a high rate.

Total benefits are net of additional estates costs, where a lower cost per metre squared driven by new buildings are offset in part by increased costs associated with servicing a larger footprint. There are also expected to be length of stay savings delivered by adopting the Preferred Option due to the change in clinical pathways and new ways of working with system partners.

The below table summarises the schedule of benefits at 22/23 prices, as reconciled to the Economic case, and at 37/38 prices per the financial modelling outputs.

[redacted]

A detailed discussion and breakdown of benefits is included in the Economic case and Benefits Register [redacted] The benefits are incremental to the Trust's Business As Usual efficiency programme and should be viewed in this context. The Trust has reviewed these benefits to ensure there is no double count between them, nor with any additional ongoing schemes including the Planned Care hub Business Case and schemes relating to agency reduction.

Overall, the additional net cash-releasing financial benefits linked to the capital investment, net of the additional revenue costs (PDC charges and depreciation) associated with the investment, lead to a [redacted] improvement, prior to adjustments, compared to the Business As Usual model.

If the Preferred Option is not implemented, there will be an increasing risk that material additional non-recurrent and recurrent costs will be incurred to address ongoing and future service challenges, as demonstrated by the BAU modelling. This will also result in non-delivery of schemes related to efficiency and improved ways of working and create an unsustainable financial and operational position for the Trust.

4.3.1 Capital funding requirements

The total capital requirement for the Preferred Option is £312m. This includes optimism bias at 16.23%. Further detail is provided in the OB forms included in Appendix E-05.

There is also an allowance for inflation, equipment costs (at 11% of departmental costs) and fees (at 15.17% of works costs). Detailed costings are included within the OB forms in Appendix E-05. The phasing of capital expenditure is outlined below and is aligned to the CIA model.

Table 79: Capital phasing (Preferred Option, inc. VAT, £m)

£m	2021/ 22	2022/ 23	2023/ 24	2024/ 25	2025/ 26	2026/ 27	TOTAL
Capital funding requirement	1.1	3.3	27.6	130.1	144.9	5.1	312

Within this allocation, this OBC seeks approval for the drawdown of £6.6m to support the development of the FBC. These costs support the high-level technical design input required to inform the clinical model and to enable the completion of a conceptual layout that delivers the requirements of the Preferred Option.

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

The capital requirement is based around a timeline that has been plotted considering the expected approval processes. Whilst ambitious, it ensures that the £312m of allocated capital delivers as much value as possible. Any further delay would likely result in greater inflationary pressures, adjustments to PUBSEC calculations and a potential reduction in scope of what can be delivered.

One of the key risks to the timeline is associated with timely progression through approval to proceed gateways, a risk that could potentially delay the delivery of the scheme and result in additional inflationary capital pressures.

4.3.2 Financial mitigations and sensitivity analysis

At the SOC stage, the robustness of the initial finance outputs was tested through initial sensitivity analysis, in which the value of key cost and benefit drivers were varied within a reasonable range to determine the impact on income and expenditure of the Preferred Option. This has been expanded further at OBC stage with the revised detailed financial information. This analysis suggests that while the I&E position is robust to changes in several key assumptions, the position is sensitive to some key material planning assumptions; PDC dividend rate, impairment and financial benefits achieved. The workforce benefits have been reviewed in isolation as the new workforce model will deliver a significant proportion of the benefits and it is therefore important to test the robustness of this as a stand-alone sensitivity.

[redacted]

4.4 Impact on statement of comprehensive income

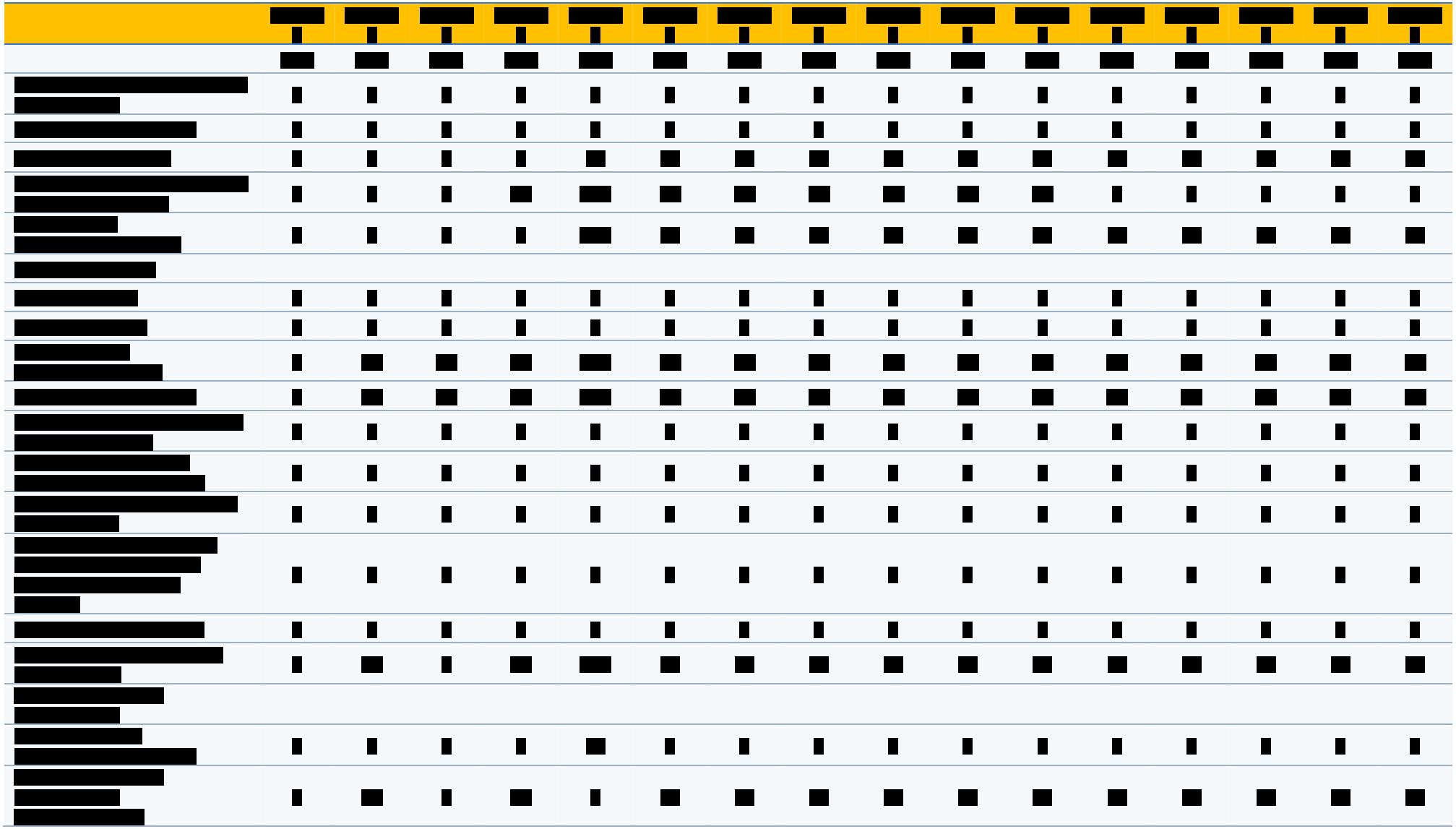
The I&E position is expected to steadily improve year-on-year to deliver a balanced adjusted financial position by 2033/34. The biggest driver of the position is the system sustainability work that the Trust are an integral part of, and for which the HTP is a key enabler, as it will allow further delivery of several of the system transformational schemes, including workforce, local care and outpatient transformation.

The impact of the HTP is a [redacted] benefit, prior to adjustments, when compared to the Business As Usual comparator by 2037/38.

[redacted]

The Table below illustrates the incremental impact of implementing the Preferred Option compared to the BAU.

[redacted]



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Over the period, cash is maintained at a minimal level to provide cover for expenses in line with NHSE guidance. The two main requirements for PDC in this period are for:

- deficit support, which reduces over the period because of the improved financial position, and
- capital support for the Preferred Option.

The phasing of cash is in line with capital expenditure phasing. The net cash generated from operations is in line with the operating surplus/ deficit less depreciation, amortisation and impairments, in addition to the requirement to maintain a £1.7m cash balance. It is expected that creditors will be paid in line with BPPC guidelines.

4.6 Impact on statement of financial position

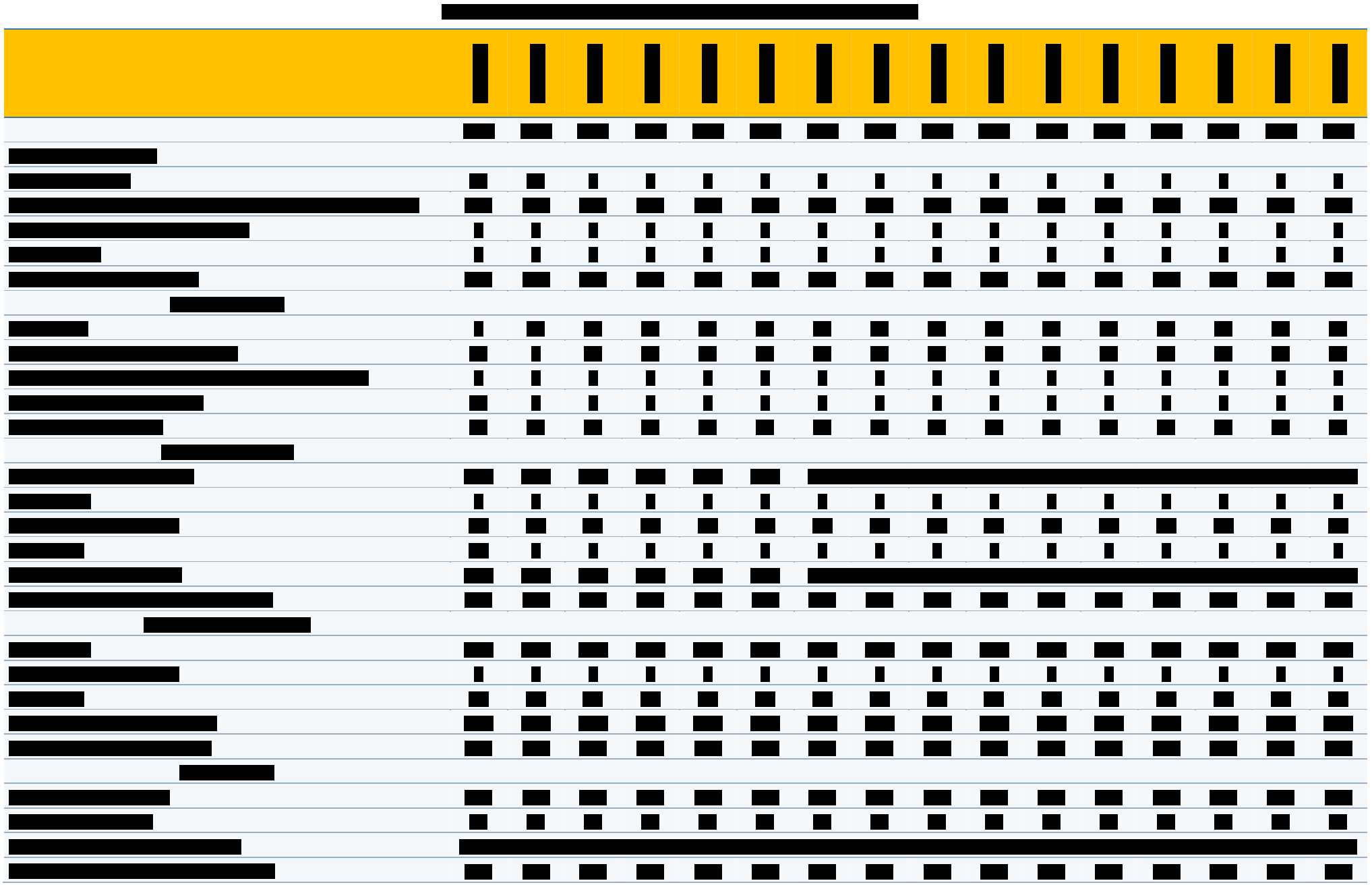
The proposed expenditure will create a new asset on the statement of financial position [redacted] This has been considered in the analysis above.

We have commissioned a report on the value of required impairment from the District Valuers and any changes will be reflected in the financial statements produced at FBC. The 15% impairment assumption is assumed to be prudent and scenarios have been modelled in the sensitivity analysis.

The new buildings will be accounted for in line with IFRS guidance, with the fair value of the asset recognised as property, plant and equipment on the Trust statement of financial position. The statement of financial position assumes a useful asset life of 60 years for new buildings, 40 years for refurbished areas and 7 years for equipment, based on broad assumptions in line with similar projects at this stage of development.

All impairments related to the building are taken to the I&E rather than the revaluation reserve.

At present the working assumption is that as assets depreciate, we will reinvest at the same pace to maintain the value/ quality of our non-current assets.



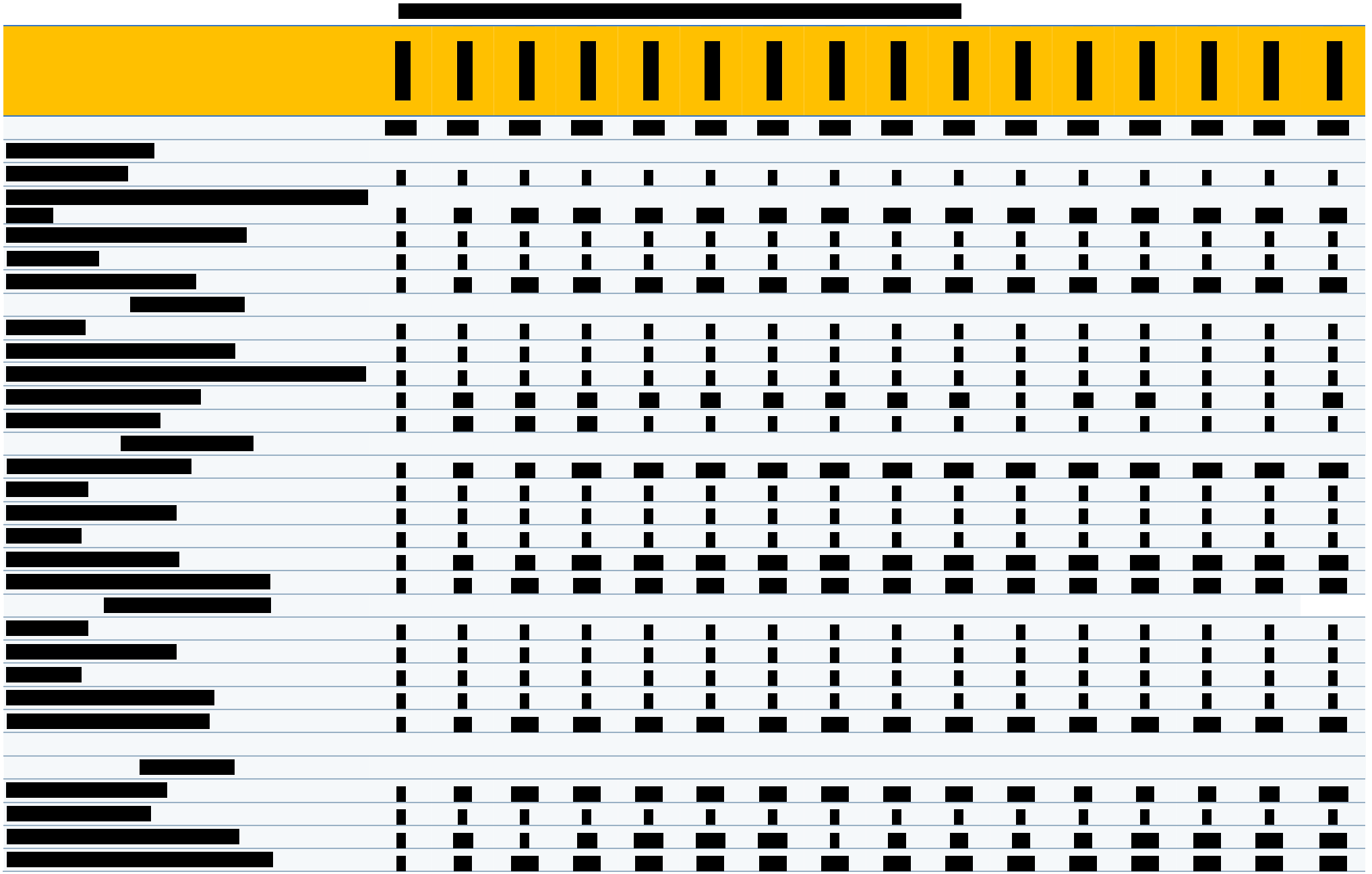


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Table 90: Capital phasing by option

	yea	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	Total
Option 0 - BAU	**1.1**	**3.4**	**19.1**	**18.4**	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**	**72.0**
Option 2 - Preferred Way Forward	**1.1**	**3.4**	**27.6**	**130.1**	**144.9**	**5.1**	**-**	**-**	**-**	**-**	**312.3**
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

The table above demonstrates the capital expenditure phasing for the Preferred Option [redacted]

4.8 Enabling and transition costs

To deliver the £312m envelope the HTP scheme requires a c.£25m enabling package of work at the RSH site. This expenditure is already included within the detailed costing for the £312m investment required. This is specifically aimed around expediting the delivery of the essential elements within and around the ED. The enabling package funding will be requested in parallel with OBC submission [redacted] This work will involve the relocation of some clinical and non-clinical functions to expand the existing ED footprint and compliments the subsequent new build package of work and provides the Trust with a newly defined main emergency door within an expanded footprint, providing more clinical flexibility to alleviate operational pressures. The enabling works will minimise the operational disruption to the ED, allowing the department to operate more effectively, away from the main construction.

This enabling cost is included within the £312m total envelope that will require approval at OBC approval stage to enable the benefits of the enabling package to be realised. The capital will deliver phase 1 of the HTP enabling works comprising the build of a new 6 bedded resuscitation room, a fit for purpose majors facility for ED (adjacent to the existing department) and refurbishment of part of the existing outpatient and Executive office accommodation into clinical space to accommodate the SDEC unit. Phase 1 of the works will run concurrently with the completion of the FBC and onward into the 24/25 financial year.

The short form business case outlines the full details and cost plan for the enabling works including design fees, equipment, IT and contingency assumptions as well as a costed schedule of building works agreed with the appointed PSCP.

4.9 VAT treatment

VAT treatment is consistent with 2022/23 NHS / HMRC accounting rules.

VAT at 20% is included on the capital scheme, except for VAT on fees which is assumed to be 100% recoverable. All revenue is based on current costs and income which includes VAT.

The Trust is receiving specialised VAT recovery advice and support through our existing arrangement with CRS VAT Consultants.

4.10 Sources of capital funding

The Preferred Option has an overall capital cost of £312m. This is proposed to be funded through PDC. A significant PDC injection (on CDEL) is the only viable funding mechanism for the scheme. It is therefore expected that the scheme will be fully funded via PDC.

4.11 Surplus land sales and demolition

There are no plans to demolish or sell any current buildings as part of the plans for the Preferred Option, however several buildings within the existing estate are being re-purposed and optimised

to help minimise the capital investment required. As such, depreciation charges continue to be incurred on the current buildings and there are no identified opportunities to sell surplus land as part of this case.

4.12 Conclusion

The Trust has a 2022/23 exiting underlying deficit of £34.4m. Under the Business As Usual position, the deficit is expected to improve, despite increasing costs driven by demand, agency spend and the cost of running the existing estate. Despite this improvement, the Business As Usual comparator is not a sustainable solution and there is a risk that the financial position will deteriorate further if we do not change the way we operate.

We remain committed to the system financial ambition to deliver financial balance although it is difficult to imagine how the necessary transformational changes included within the system sustainability plan can be delivered without implementation of the Preferred Option.

[redacted]

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

This capital will incur revenue costs of c. £9.7m a year (by 2037/38) due to depreciation and PDC charges. The Preferred Option will generate financial revenue benefits [redacted] This includes the benefits of a more efficient workforce, improved layout and patient pathways, improved patient flow and reduced length of stay, and a better-quality estate.

This means the overall scheme is affordable and contributes to a [redacted] improvement to the Trust's adjusted financial position compared to the BAU option, which creates additional costs from required investments.

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5 Management case

5 Management case

Through the business case process, we have established clear plans to develop and then implement the Preferred Option. This includes strong governance arrangements, a robust delivery plan, and extensive stakeholder engagement plans which gives us confidence that we can deliver this investment successfully.

Through the next stages of the process, including FBC development, we will continue to refine and improve our proposals and respond to feedback on this OBC.

Governance

We have a clear governance structure and risk management approach as part of the HTP, which has been updated since SOC stage and builds on the lessons from many other large NHS capital schemes.

Clear roles and responsibilities were established within both the Trust and health system executive teams at SOC. These have been adapted and will continue to be reviewed.

Delivery plans

The Preferred Option is planned to be delivered through an enabling works package and then a single phase of work with future development plans (options 3 and 4) building on this, subject to further funding.

With rapid approvals supported by the availability of capital, the Preferred Option can be delivered by the end of 2026 and begin offering benefits, including improved clinical quality / experience, sustainable clinical services, access to all emergency medical and surgical clinical teams on one site, reduced cancellations and planned care waiting times and appropriate urgent and planned care capacity.

Risks and inter-dependencies will be rigorously managed to ensure that any impacts on the scope, cost or timelines of this project are identified and mitigated as soon as possible.

Following the completion of the Preferred Option, we will have delivered the agreed clinical model and configuration of services and improved the quality and experience associated with these services for our patients across Shropshire, Telford & Wrekin and mid-Wales.

Stakeholder engagement

The project is engaging with local stakeholders through several routes. These will continue to be developed and expanded during the Full Business Case stage and beyond, augmented by a comprehensive multi-phase stakeholder engagement approach.

Our plans to engage and involve local people and local stakeholders continue to develop and expand to support OBC development and to support the redevelopment of our estate. Patients and service users were involved through the NHS Future Fit process where full public consultation took place and the public continue to be engaged through the use of Focus Groups. The options in this OBC remain fully aligned with the outcome of the public consultation, DMBC and SOC and do not propose any other service changes.

Management of key inter-dependencies with other programmes of work (not in scope of the HTP)

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

Key interdependent programmes include:

(1) ICS wide programmes (LCTP / Urgent and Emergency Care Transformation Programme)

(2) Implementation of a Planned Care Hub at PRH

(3) Provision of infrastructure associated with the new build

(4) Digital Transformation Programme

(5) Car parking

The Management Case sets out how the redevelopment will be managed and how the proposed changes will be delivered.

5.1 Managing project delivery with confidence (project management, performance management and governance arrangements)

Effective project management is vital to the success of the HTP. A project management structure hierarchy and performance monitoring framework were drafted at SOC, providing confidence and assurance to all stakeholders. The updated framework for this OBC builds on the framework in place at SOC. This framework will continue to be developed and adapted to reflect the requirements of the FBC and delivery phase. The project management structure ensures engagement and continuity of resources that have a track record and experience of delivering large healthcare projects in the NHS. These resources are ring-fenced to ensure there is the necessary capacity, focus and support to drive the project forward successfully. These resources are in-house and will be responsible for the management of the design team and PSCP as well as ensuring effective contract management and quality management throughout the life of the project. A gateway programme with detailed phased sub-projects has been developed with clear monitoring of outputs, outcomes and benefits throughout the life of the project. In addition to this, standard progress reporting (including risks and issues) will form a key part of the assurance framework reporting to both SaTH and the ICB.

To ensure that the Future Fit consultation outcome is developed and implemented, we established the Hospital Transformation Programme (HTP) to manage delivery at SOC stage. We have expanded and strengthened the HTP team for OBC stage to ensure that we have appropriate capacity to deliver the desired outputs, have the necessary governance in place to manage the PSCP and are able to make important decisions after the OBC is submitted. We have thorough arrangements in place for the on-going management of the scheme and are committed to ensuring its successful outcome.

5.1.1 Experienced project team to support delivery

We recognise the significant resourcing required to take the reconfiguration forward successfully. We are committed to obtaining the right resource and capabilities necessary to deliver the programme. The HTP team was set up at SOC to provide a dedicated project team, with sufficient experience and capacity to undertake the work and activities required. The HTP team consists of the core members involved in the planning for and delivery of the HTP on a day-to-day basis. The core team has been bolstered at the OBC stage and collectively, they have a wide range of knowledge and experience, including:

- the leadership, management and delivery of major infrastructure schemes within the public and private sector
- developing, maintaining, and implementing project plans,
- co-ordinating working groups as required,
- monitoring progress and reporting according to the scheme's governance,
- managing issues as they arise and escalating as necessary,
- management of multiple third parties, and
- managing risks in line with scheme's risk management strategy.

The skills of the project team by area are set out below:

Table 91: Hospitals Transformation team skills

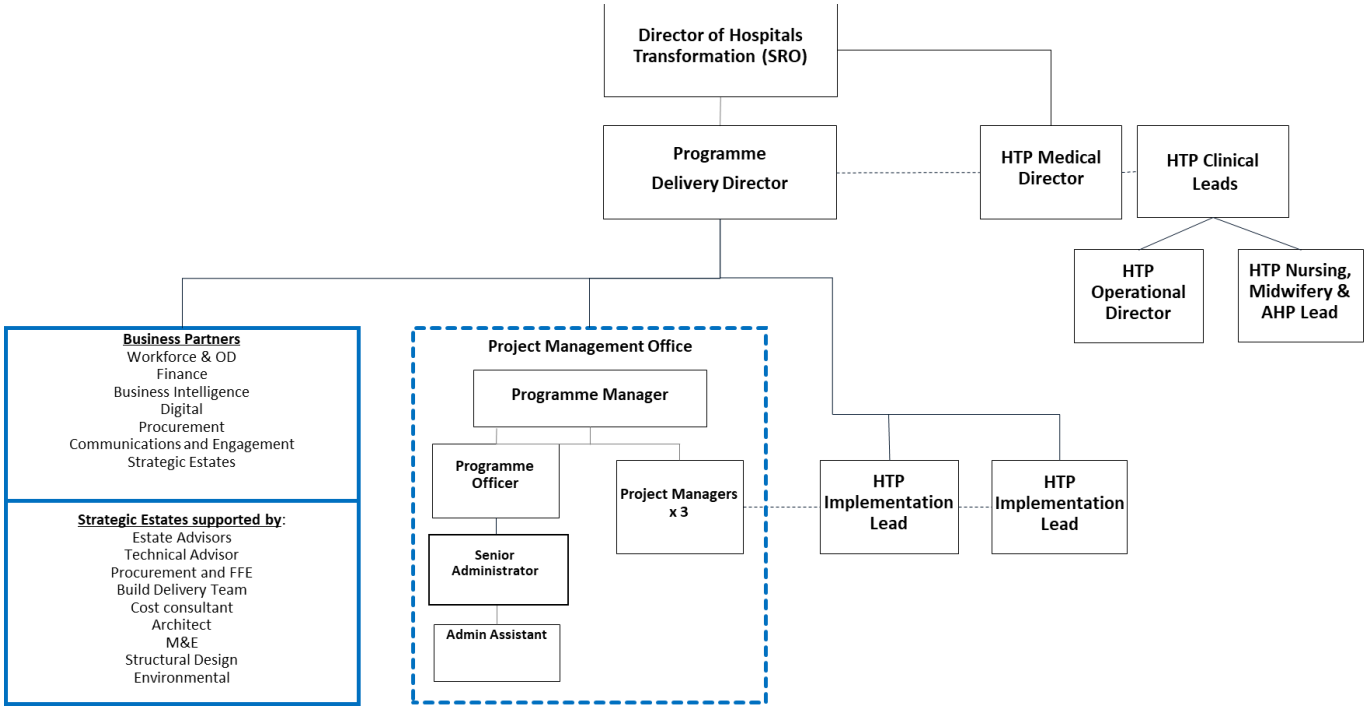
Area	Skills within the project team
Project management / Project leadership	• Experienced project leaders and directors with major experience of large scale infrastructure projects in both the public and private sectors • Experienced project managers with history in healthcare service reconfiguration • NHS management experience • Operational and project management experience • PRINCE2 and MSP qualifications (where appropriate)
Clinical	• Clinical background / experience • Clinical design and planning experience • Experience delivering the reconfiguration of clinical services
Business cases / capital programmes	• Capital project business case experience • Experience delivering high profile capital strategic programmes • Better Business Cases Foundation/Practitioner qualifications (where appropriate)
Communications and engagement	• Communications and engagement specialists • Experience leading on national and regional campaigns, events and partnerships

For activities that cannot be delivered by the internal team, external advisors are engaged as required. The use of these advisors is detailed in Section 5.1.5.

The team structure from SOC was reviewed for the development of the OBC and will be augmented so that it remains fit for purpose as the project proceeds to ensure sufficient resources throughout the project. Since SOC, the project team has expanded to include a Technical Advisor, who has provided experience in delivering capital programmes, and the Programme Delivery Director. Additional administrative support has also been introduced at OBC stage.

Dedicated resources required for the HTP are shown below.

Figure 25: Hospitals Transformation team structure



The structure above reflects the spine of the team and will be supplemented with temporary resources where needed.

Additions to the core project team include:

- dedicated digital resource,
- dedicated financial modelling resource,

- additional project management resource to co-ordinate clinical design activities, and
- additional external support.

As the SRO, the Director of HTP has overall accountability for the delivery of the Programme. This is a Trust Executive role, with the SRO reporting to the Trust Chief Executive and Trust Board of Directors. A detailed description of each roles' responsibilities and accountabilities is outlined below.

5.1.2 Key roles and responsibilities

The project is being led and driven by senior members of the Trust Executive and management team, all of whom have previous experience of business case development and project delivery across the NHS.

Matthew Neal is the HTP's Senior Responsible Owner (SRO). Matthew has a background in infrastructure and provides valuable experience to enable him to lead implementation of the HTP. The SRO is supported by the core HTP team, outlined in Figure 25. Table 92 describes the key roles and responsibilities of the core HTP team.

Table 92: Key roles and responsibilities

Role	Responsibilities
Director of Hospitals Transformation Executive Lead (SRO)	• Overall accountability for the delivery of the HTP (SRO) • Secure business case approval for the HTP following and complying with National requirements and protocols • Leading the development and delivery of the agreed reconfiguration of clinical services and associated new models of care, ensuring compliance with National Standards • Collaboratively working with system partners and other organisations to ensure the successful delivery of the project
Programme Delivery Director	• Responsible for the day-to-day management of the HTP and the line management of the core project team • Responsible for ensuring the Master Programme is up to date and easily accessible, enabling key delivery milestones to be met on time • Work closely with the Director, managing the development of good business case documentation, which complies with National protocols/requirements, to support timely approval • Working closely with NHSE, the Department of Health and Social Care and HM Treasury to support approval of the business cases • Utilising best practice management and implementation methodologies to govern the delivery of the project, ensuring that risks/issues are addressed in a timely way and that key stakeholders always have a clear understanding of project status/progress • Ensure that the project remains on track to deliver the planned changes to the required quality standards and that appropriate mechanisms are in place to fully realise the targeted benefits • Managing the delivery of detailed project communication, ensuring clear communication and feedback to wider stakeholders, which includes the wider health economy and public, demonstrating the importance, activities, and objectives of the project
HTP Medical and Clinical Leads	• Provide overall clinical leadership • Responsible for ensuring the clinical components of the HTP are comprehensively developed and safely delivered • Lead the team of clinical staff that form the vital links between the project, the Divisions and the technical team for design and construction • Responsible for clinical staff engagement and ensuring clinical leadership of the detailed design process and alignment with wider clinical priorities and developments • Conduct regular clinical working sessions with clinicians, to provide the clinical voice, as well as ensuring partners and patient representatives feed into the design phase of the hospital, resulting in facilities being built for quality patient care and safety • Ensuring the clinical components of the HTP are comprehensively developed and safely delivered • Supplying clinical advice on the phasing of clinical components of the scheme
HTP Nursing, Midwifery and Allied Health Professional (AHP) Lead	• Provide overall clinical leadership • Ensure that clinical objectives inform and drive effective delivery of the project • Ensure engagement with nursing and AHP colleagues and leadership of the detailed design process • Provide a clinical voice, and ensure alignment with wider clinical priorities and developments
HTP Operational Director	• Provide overall clinical leadership • Ensure service objectives inform and drive effective delivery of the project • Ensure engagement with operational teams in the detailed design process

Role		Responsibilities
Project Management Office (PMO)	Programme Manager	• Lead in the support, facilitation and monitoring of the progression and implementation of the project and workstreams • Responsible for ensuring the Master Programme is up to date and easily accessible, enabling key delivery milestones to be met on time • Managing risks, including the development of contingency plans, and highlighting any significant changes in risk status to the Project Director • Ensure that the project is managed in accordance with best practice and provide project coordination and planning capability to support the Programme Director • Identifying and obtaining support and advice required for the management, planning and control of the project • Management of benefits realisation reporting and plans
	Project Managers	• Support the delivery of the Reconfiguration Programme through the management of component projects, including managing specific work streams and projects to achieve the intended benefits of the overall programme • Responsible for the day-to-day management of a project; start up, maintaining, supporting, facilitating, monitoring progress, closing and evaluation of the work streams
	Programme Officer	• Providing programme support to workstreams and project managers • Maintaining/supporting project/workstream documentation • Providing administrative support to workstream teams • Organising and minuting workstream meetings • Monitor and escalate project progress and risks
	Senior Administrator Admin Assistant	• Administrative support to the Project Management Office • Diary management, meeting minutes and general support
Implementation Leads	Surgery, Anaesthetics and Cancer Medicine and Emergency Care Women and Children's Clinical Support Services Community and Local Care	• Responsible for working with clinicians to deliver the key milestones and outputs • Ensuring plans align to the agreed clinical model, utilising best practice to meet the needs of patients, staff and visitors • Assist in the execution of workstream-specific tasks or duties • Liaising with design team on all matters relating to the clinical design of the buildings across all Trust sites
Business Partners	Workforce and OD	• Liaising with design team on all matters relating to the clinical design • Responsible for the delivery of the Workforce and OD workstream and its outputs which will be validated through governance arrangements • Support Divisions with Workforce requirements and changes
	Communications and Engagement	• Responsible for creating and over-seeing key workstream communication material including plans and workstream updates • Responsible for developing communications that enable sound public and stakeholder understanding of and involvement in the project
	Digital	• Lead the delivery of workstream outputs and digital support to enable the Clinical Model to be enacted.
	Technical Advisor	• Provides overall technical leadership for the programme • Responsible for the Technical Oversight Group which includes key Business Partners such as Strategic Estates, Procurement and the PSCP Contract Manager
	Strategic Estates	• Provide management and direction of workstreams and external resources • Liaise with technical advisers to ensure delivery of the project objectives
	Finance, Procurement and Business Intelligence	• Lead the delivery of the workstream outputs

5.1.3 Governance arrangements to support successful delivery

The HTP team is made up of all internal team members involved in the HTP. At least one member of the HTP team is involved in each of the Governance Groups outlined in the governance structure (Figure 26) to assist with decision making and to help drive the HTP forward and deliver in accordance with proposed timelines. The Terms of Reference for each group are included in Appendix M-08. These outline the members of each group as well as each group's objectives and reporting arrangements.

The governance structure, including the Trust as the lead organisation on behalf of the system, builds on the outputs of the Future Fit consultation and ensures ongoing partner engagement and co-ordination throughout the development and approval process. This includes the HTP Programme Board, with executive clinical and managerial representation from the ICS Directors, Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH), Shropshire Community Trust and Powys Teaching Health Board. The HTP Programme Board is the main vehicle for wider system assurance and check and challenge and reports to the Trust's Board of Directors. Weekly Executive Review by the SaTH Executive Directors and monthly review by the entire SaTH Board of Directors ensures that issues are escalated and managed in a timely manner. The Board of Directors have signed off the DMBC and SOC and will sign off the OBC and FBC ahead of final submission.

To support the development of the OBC, the SOC governance arrangements have been reviewed and updated where required. These changes have been developed in discussion with the relevant clinical and management teams and reflect the need to support and maintain clinical leadership. These updates allow for the increase in activity and detail that is required for OBC.

At OBC stage, it is particularly important to consider which group is responsible for day-to-day decision making to ensure that decisions can be made quickly and efficiently. It is also imperative to understand how the PSCP fits into our existing structure – we have established a Technical Oversight Group (TOG) to facilitate engagement with the PSCP and manage interdependent projects. The Technical Oversight Group meets weekly and reports to the HTP Programme Board. It will manage the contract relationship with the PSCP and have input from all technical workstreams. The Group will be responsible for making sure that the costed risk register remains up to date and will own the costed plans and drawing reviews as well as overseeing the process of change and managing the technical design documents for the HTP.

By reporting through the STW ICB, we have ensured full alignment to the delivery of the Long Term Plan, system recovery plan (including immediate priorities), changes in local pathways and the Integrated Care Partnership draft Strategy. It also ensures that the HTP forms a key part of the ICS Joint Forward Plan. This alignment will continue through the next stages of this redevelopment and ensure that we remain aligned as system plans continue to mature, in particular using the ICB Integrated Delivery Committee as a mechanism to ensure alignment across the ICB's strategic programmes

Figure 26 shows the updated governance structure for OBC.

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Figure 26: The HTP governance structure

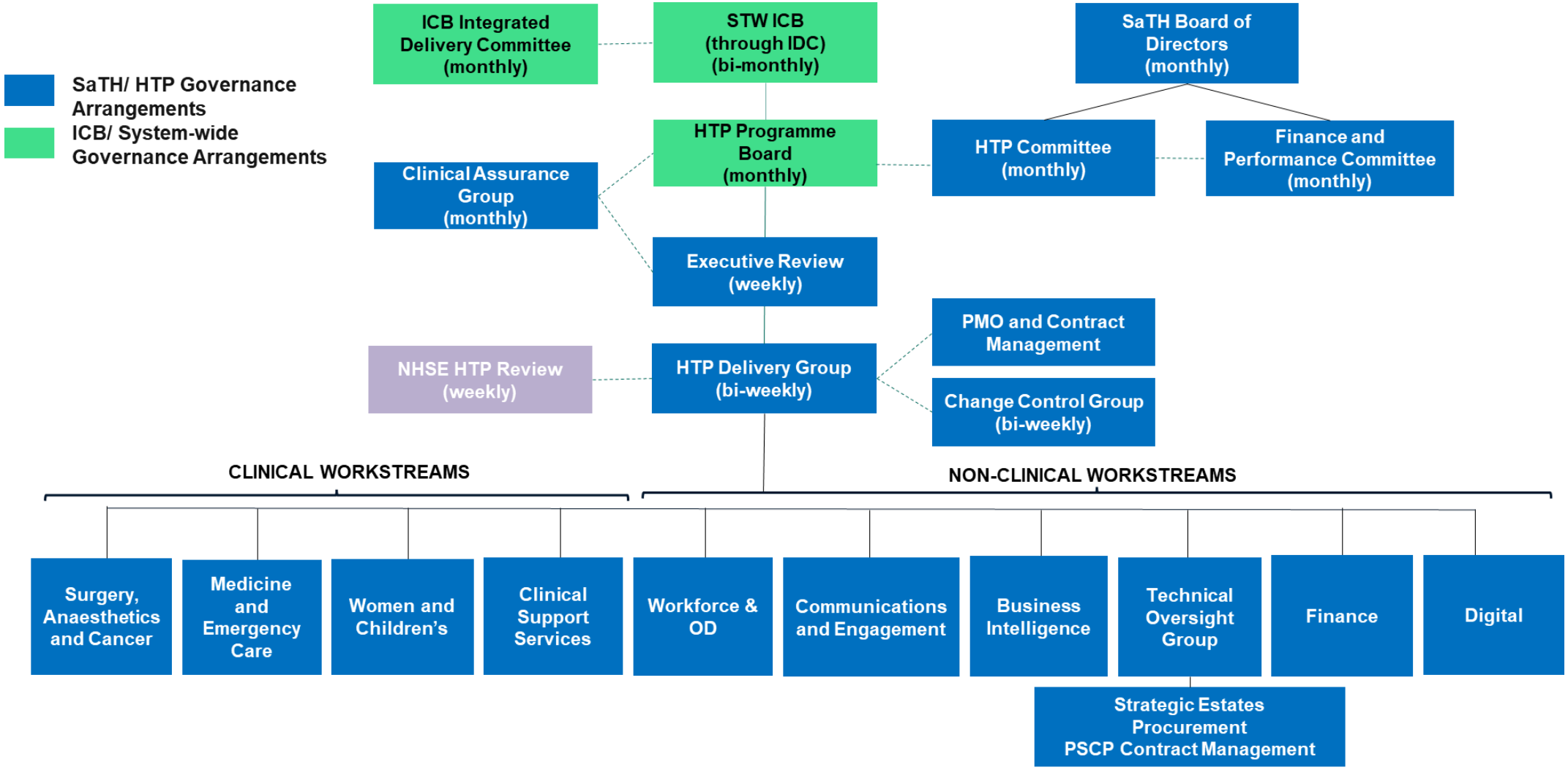

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Table 93 outlines the responsibilities of each governance group

Table 93: Governance group responsibilities

Governance Group	Responsibility	Decision making capacity
STW ICB (through IDC)	• Maintaining strategic oversight and accountability.	• Provision of help in removing barriers that cannot be resolved by the HTP team.
ICB Integrated Delivery Committee (IDC)	• Formal sub-committee of STW ICB. • Ensures that the approach taken to deliver the HTP is in line with the wider system objectives.	• Provision of help in removing barriers that cannot be resolved by the HTP team.
SaTH Board of Directors	• The statutory body responsible for major decisions and formally supporting/ approving documents (on behalf of the ICB) at key milestones.	• Approval of key decisions. • Sign-off of the OBC and the FBC before formal submission to regulators.
HTP Programme Board	• Includes representation from SaTH and system-wide partners/ stakeholders. • To ensure ongoing alignment of the HTP with system strategy and plans. • To drive forward the implementation of the HTP in line with agreed plans, delivering required scope (and benefits) to time and within budget. • To monitor the delivery of key objectives and the achievement of milestones/outcomes across all work streams and activities (including the acceleration of the HTP pathways), ensuring that risks and/or issues are managed proactively and escalated in a timely fashion (if required). • To ensure stakeholders are fully engaged in (and support) the development and delivery of the programme. • To oversee the management of risks and issues within the HTP and support their mitigation. • Includes representation from ICB Executives.	• 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.
HTP Committee	• Only involves representatives from SaTH but includes non-executive oversight. • To oversee all aspects of the implementation of the HTP, including those aspects led by other system partners, ensuring ongoing alignment with both Trust and health system objectives and change plans. • Constructively challenge and seek assurance in relation to our performance as the prime provider for the HTP (on behalf of the health system). • Constructively challenge and seek assurance in relation to key objectives and the achievement of milestones/outcomes across all work streams and activities (including the acceleration of the HTP pathways), ensuring that risks and/or issues are managed proactively and escalated in a timely fashion.	• To coordinate the Trust and other system partners and ensure that the approaches are aligned. • Recommend any key actions to the board that are necessary to support successful implementation of the HTP. • The SRO escalates issues raised in the HTP Committee to the wider system governance groups and report back on issues raised by other programmes.

Governance Group	Responsibility	Decision making capacity
Finance and Performance Committee	• Scrutinize and seek evidence of assurance of the Trust's financial and operational performance plans, major investment decisions, capital plans, performance management and relevant regulatory compliance. • Provide the board with an objective review of the financial position and performance of the Trust and assurance on the delivery of the Trust's performance objectives. • Identify any significant risks and mitigating actions. • Consider the process for the preparation and the content of strategic and operational plans and annual revenue, capital and workforce budgets.	• Make recommendations to the Board where required. • Reports to the Board at least annually on it work. • Monitors performance and finances.
Clinical Assurance Group	• Provides expert clinical advice on other programme deliverables, including expected clinical benefits, the transition plan and workforce impacts. • Includes external members. • Acts as a clinical advisory forum for the clinical programme that informs the Business Case. • Ensures there are clinical advocates for proposals in relevant service areas.	• Assures and approves the clinical design and staffing and activity requirements to feed the estates design for the OBC. • Endorsement of the clinical model and design. • Development of integrated pathways and acute flow.
Executive Review	• Weekly meeting involving the SaTH Executive Directors • Key concerns are escalated to and managed by the Executive Team. • The Executive Directors report any urgent concerns to the Programme Director and HTP team.	• N/A
NHSE Review of the HTP	• Key decisions made in Delivery Group are reported to NHSE when necessary. • Key concerns from NHSE are discussed in Delivery Group.	• N/A
HTP Delivery Group	• Ensures that the HTP aligns with the Trust objectives and the wider ICS transformational plans. • Sign-off of new expenditure. • Approval of any changes to the HTP structure. • Includes representation from the PSCP to ensure the contract is managed effectively. • Oversees the management of risks and issues within the HTP.	• Is expected to make recommendations to the Programme Board. • Monitors the progress of key deliverables. • Can make decisions related to the delivery of the HTP if the meeting is quorate, according to the Terms of Reference.
Change Control Group	• Determines if the proposed change will impact time, cost, or quality of the HTP. • Proposed changes are assessed by the change control committee within 14 days of the proposed change.	• Decides whether to 'accept' or 'reject' a proposed change. • Updates the change status on the master Change Register.
PMO and Contract Management	• Develops and monitors key documentation for the HTP, reporting to the HTP Delivery Group and the HTP Programme Board. • Manages programme delivery in line with objectives, scope and timescales set out by Programme Board. • Oversees the delivery of key outputs and deliverables from each workstream.	• Makes decisions on a day-to-day basis to drive the HTP forward. • Oversees the management of benefits and risks throughout the programme.

To ensure that the HTP is aligned to the ICB / System-wide governance arrangements, Matthew Neal (the SRO of the HTP) sits on and reports to STW ICB through ICB IDC. Matthew Neal (alongside a Non-Executive Director lead for the HTP) also both sit on the SaTH Board of Directors and the HTP Committee.

To deliver the acute reconfiguration required for the project, a combination of supporting workstreams and clinical transformation workstreams are required. They are responsible for delivering the outputs required of their workstream, reporting their progress to the PMO and escalating issues to the HTP Delivery Group. Their key activities and deliverables that still need to be considered during subsequent phases of the HTP are outlined in Table 94 and Table 95 below.

Table 94: Non-clinical workstreams

HTP Support Workstream		Activities	Deliverables
Technical Oversight Group	Estates	• Oversee the Technical Oversight Group to manage the relationship with the PSCP. • Lead the Commercial and Procurement Strategy. • Responsible for procurement activities and management of the design and construction phases, including any enabling works. • Developing the detailed design of the Preferred Option, securing planning approval and management of the build. • Input into Demand and Capacity modelling. • Leading the design and transformation of non-clinical service activities. • Ensuring adequate provision of non-clinical services is in place to support the transformation, utilising best practice and maximising new ways of working.	• RIBA Stage 3 and 4 Designs • GMP • Ownership of the Costed Risk Register • Premises Assurance Model • ERIC and Model Hospital
	Commercial		• Package pricing and GMP • Final contract • Equipment Strategy/ Plan • Property/ Legal agreements
Workforce and OD		• Leading workforce modelling to define future requirements and identify people and change requirements. • Developing and implementing the change management approach. • Responsible for the development and implementation of training and development plans.	• Final staffing templates – nursing and consultant rotas • Ownership of the workforce model • Training and Development Plans • Change management arrangements
Finance		• Responsible for providing financial, economic and activity expertise and oversight on the project. • Responsible for the design and delivery of the financial plan associated with the reconfiguration. • Developing and updating finance, benefits and activity forecasts. • Managing the financial implications of the scheme. • Input into Demand and Capacity modelling.	• Financial Statements • Financial Model and Baseline • Regulator Engagement • Financial planning

HTP Support Workstream	Activities	Deliverables
Digital	• Responsible for working with estates and hospital design teams and clinicians to understand how to best integrate technology into the infrastructure and design of the new/ refurbished buildings and to enable delivery of new model of care. • Digital working will be a key enabler across all workstreams.	• STW ICS Digital Strategy • HTP Technology Requirements
Communications and Engagement	• Ensure timely and open sharing of information, grounded in a clear, consistent and accurate narrative for the project across stakeholder groups to build trust and confidence in our approach and plans for reconfiguration. • Continue to build effective two-way relationships with all key stakeholder groups and facilitate user input and co-design, with the aim to create the best possible, user-focused reconfiguration plans with high levels of patient, public and staff ownership and support.	• Stakeholder Engagement Strategy • Staff impact • Regular engagement with staff and the public • EHIAs
Business Intelligence	• Responsible for provision of historical Trust data to inform outputs and recommendations. • Input into Demand and Capacity and Workforce Modelling.	• Informative and accessible data • Data analysis

Table 95: Clinical Transformation Workstreams

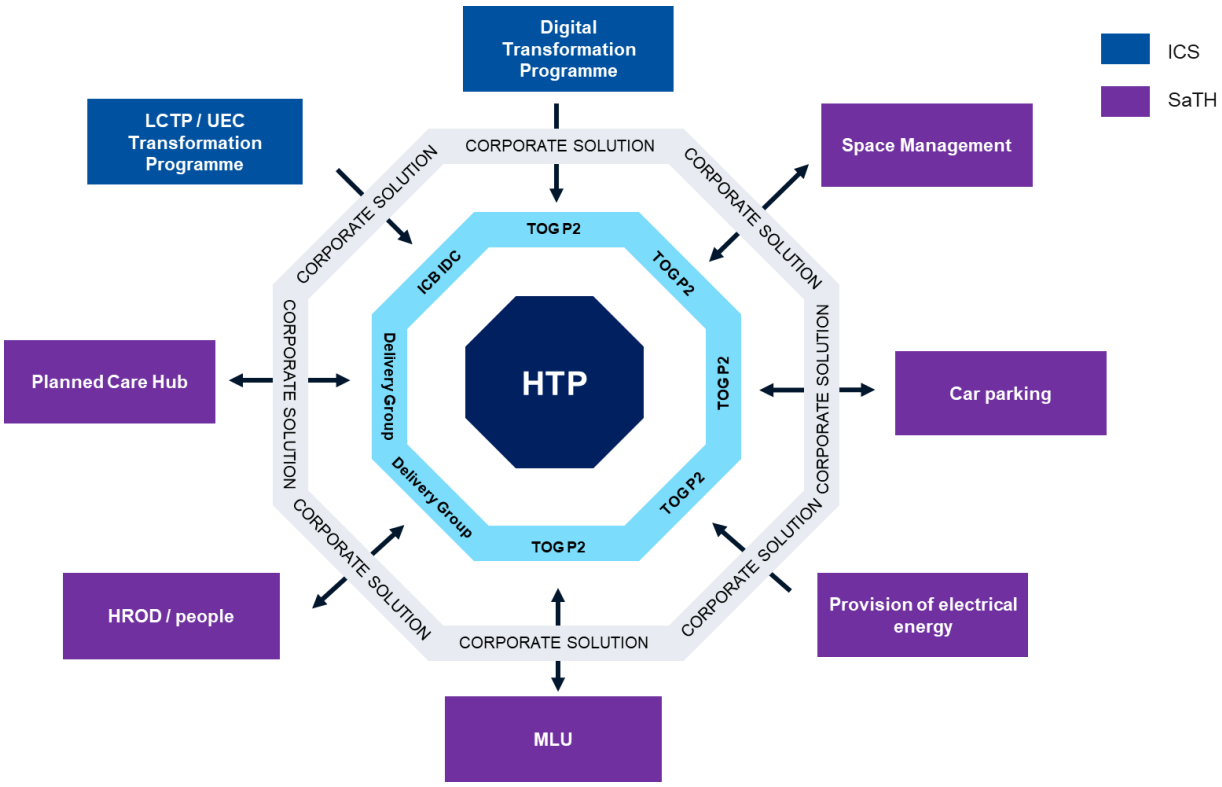
Workstream	Activities	Deliverables
Surgery, Anaesthetics and Cancer Medicine and Emergency Care Women and Children's Clinical Support Services	• Leading the design and transformation of the specific clinical division. • Defining requirements, specifications, adjacencies, and co-dependencies. • Defining principles and pathways. • Managing areas of concern. • Agreeing clinical benefits. • Defining workforce requirements. • Input into detailed designs. • Revisit existing work at department/ speciality level and provide additional detail for Demand and Capacity Modelling.	• Final Demand and Capacity Modelling • Transition Planning • QIAs • ICS Plan alignment

5.1.4 Management of key interdependencies with other programmes of work (these programmes are not within the scope of the HTP)

The successful delivery of this project is dependent on the timely delivery of a number of outputs included in other key SaTH and health system programmes of work. These critical dependencies are outside of the direct control of HTP and are the responsibility of various corporate decision-making bodies. However, HTP Governance groups are responsible for reporting on progress of these critical dependencies to the rest of the HTP Team. Collaborative working arrangements have been established with each of those programmes to ensure that the impact of any changes to assumptions and / or timings are communicated as quickly as possible. The interdependent programmes associated with SaTH and the ICS influence the HTP as the HTP must be in line

with wider system plans. Interdependent programmes associated with SaTH have a two-way relationship with the HTP as they both affect each other. The provision of infrastructure for the new hospital is an interdependent programme that is required for the HTP. The relationship between these interdependent programmes and the HTP as well as how they are monitored is outlined in Figure 27.

Figure 27: Interdependent programmes



Key interdependent programmes are described in Table 96 below, along with the relevant assumptions / deliverables required to support the successful delivery of the HTP. Table 96 also shows how the progress of these programmes is monitored by members of the HTP team which ensures commitment from all relevant parties. Most of these critical dependencies are monitored by the Technical Oversight Group (TOG). TOG meetings are split into two parts and Part 2 of each meeting is dedicated to managing interdependent programmes aligned to the HTP.

Table 96: Key interdependent programmes and how they are managed

Interdependent programmes	Relevant assumptions / deliverables	How the dependency is managed
1) ICS wide programmes (e.g., Local Care Transformation Programme / ICS Urgent and Emergency Care Transformation Programme)	***Local Care Transformation Programme (LCTP) (explained in more detail in Section 1.1.6.2)*** a. Development of Community Diagnostic Centres (CDC) b. Expansion of community and primary care services c. Better integration of pathways between Acute, Community and Primary Care d. Will moderate the increase in demand for acute services (and contribute to avoiding the need for an additional 151 acute beds in the short to medium term, with further ongoing benefit in the long term of 108 beds)	• ***Local Care Transformation Programme (LCTP)*** • The LCTP reports into the ICB Integrated Delivery Committee • The HTP SRO is part of the LCTP Board • The LCTP Manager sits on the HTP Delivery Group • The HTP PMO attends monthly meetings with this programme to share updates and review interdependencies • Other ICS wide programmes such as the Urgent and Emergency Care Transformation Programme are

Interdependent programmes	Relevant assumptions / deliverables	How the dependency is managed
	ICS Urgent and Emergency Care Transformation Programme a. ICS Urgent and Emergency Care Plan is currently being developed b. Monthly IUC Case for Change Transformation Group meetings c. Aligns to National guidance regarding Integrated Urgent Care (IUC) d. Contributes to avoiding the need for an additional 151 acute beds in the short to medium term	monitored via the HTP Governance structure outlined in Section 5.1.3. The SRO sits on the ICB IDC and reports on the progress of the HTP as well as receiving updates on other ICS wide programmes.
2) Implementation of a Planned Care Hub at PRH	a. Delivers four new day care operating theatres and associated recovery and ward facilities b. Establishes a ringfenced planned day care 'bed' base c. Currently in the build phase d. Phase 1 due to be operational by Summer 2023 e. Phase 2 due to be operational by early 2024	• The Estates workstream reports on progress of the Planned Care hub in their update at the HTP Delivery Group when required.
3) Provision of electrical energy	a. Requirement for new build components of the HTP to comply with latest national requirements / energy efficiency targets, brings forward longer term Trust energy efficiency plans b. Trust needs to be compliant with longer term NHS ambitions for net zero emissions for the care we provide (the NHS Carbon Footprint) by 2040 c. Allows for the necessary increased power supply d. Development of the HTP Net Zero Carbon Strategy (included in Appendix C-02) as well as the Energy Security and Decarbonisation Strategy e. Will address the electrical power demand required for the scheme as well as help to reduce energy usage in areas of the new build / entire site f. Requires alternative funding source. This is likely to be third party funding where appropriate.	• The Technical Oversight Group regularly reviews the plan for energy in part 2 of their meetings and reports on progress / risks / issues associated with this programme where appropriate, in line with the HTP governance structure outlined in Section 5.1.3.
4) Digital Transformation Programme	a. Successful delivery of the health system's digital transformation programme will support the implementation of the new integrated models of care and reconfigured patient pathways b. Funded through alternative NHS capital sources c. Ongoing investment in digital via the Patient Engagement Portal, Digital Diagnostics and Frontline Digitisation Minimum Digital Foundations (FD MDF) to compliment the wider EPR programme	• The HTP complies with the wider Corporate Digital Strategy. • The HTP Digital Workstream Lead sits on the Technical Oversight Group part 2. • The Technical Oversight Group regularly discusses the digital transformation programme in part 2 of their meetings and reports on progress / risks / issues associated with this programme where appropriate, in line

Interdependent programmes	Relevant assumptions / deliverables	How the dependency is managed
		with the HTP governance structure outlined in Section 5.1.3.
5) Car parking	a. Ensures that there is appropriate car parking available for visitors of both sites b. Requires input from staff / patients and visitors to confirm numbers in order to be correctly scoped	• The Technical Oversight Group regularly discusses car parking in part 2 of their meetings and reports on progress / risks / issues associated with this programme where appropriate, in line with the HTP governance structure outlined in Section 5.1.3.

5.1.5 Use of specialist advisors

Specialist advisors have been appointed to support internal resources and are outlined below in Table 97.

Table 97: Specialist advisors used for this OBC

Area	Advisor
Architects	AHR
Mechanical and Electrical Engineering	DSSR
Structural and Civil Engineering	Ramboll
Quantity Surveyors	Edmond Shipway
Healthcare Planners	Strategic Healthcare Planners (SHP)
Planning Consultants	Nexus
Strategic Estates Project Management	Trust Capital Estates
Business Case Support/ Strategic Partner	PA Consulting

In addition to the external resources utilised during the OBC stage, we are taking early action to identify the resources that will be required through FBC stage and into delivery, taking into consideration the procurement process and the lead time required to commission specialist advisors. The arrangements for procuring the support needed for OBC and FBC stages, and enabling works, is provided in Section 3.1 of the Commercial Case.

In addition to the above specialist advisors, the Trust has an incumbent professional technical design team, appointed via the SBS Framework. All external professional advisors have relevant expertise and successful track records of delivery in healthcare. This team provides the Trust with the necessary professional advice on Health and Safety, Fire, Sustainability, Information Technology, Planning, Build Control, Cost, RPA, Equipping, Net Zero Carbon legislation and other matters relating to the buildability of the scheme. All advice is aligned to the Trust's existing Clinical and Estates Strategies.

The technical advisors work collaboratively with the Trust's in-house clinical teams to ensure that all necessary actions are completed following the RIBA stages of work. This means that all essential guidance and legislation is adhered to and incorporated into the design and guarantees that all pre-construction activity is completed to the necessary standards.

Lastly, to support the development of this OBC and the progression of the project, we have engaged PA Consulting as a key strategic partner who have provided experience of delivering Green Book compliant cases, including many within the NHS.

Where relevant, the Trust's approach to novation of technical advisors is set out in the Commercial Case.

5.1.6 Project management methodology

The project is being managed in line with PRINCE2 methodology, which is the de facto standard for the public sector in the UK. It is primarily resourced from within the Trust, with a dedicated project team – the HTP team – which is supplemented by external specialist consultants where appropriate and necessary. The SRO, Programme Manager, Finance Lead and Estates Lead have all undertaken and achieved a Better Business Cases qualification to Foundation / Practitioner level, as per the NHSE requirement for capital investment business cases over an approval value of £15 million.

The governance of the project is carefully structured with clearly defined roles for individuals; this ensures all team members understand their role and responsibilities and provides a clear and auditable route for decision making and the escalation of risks and issues.

The project structure and activity requirements are informed by a set of objectives which were agreed from the outset as outputs of the Future Fit consultation:

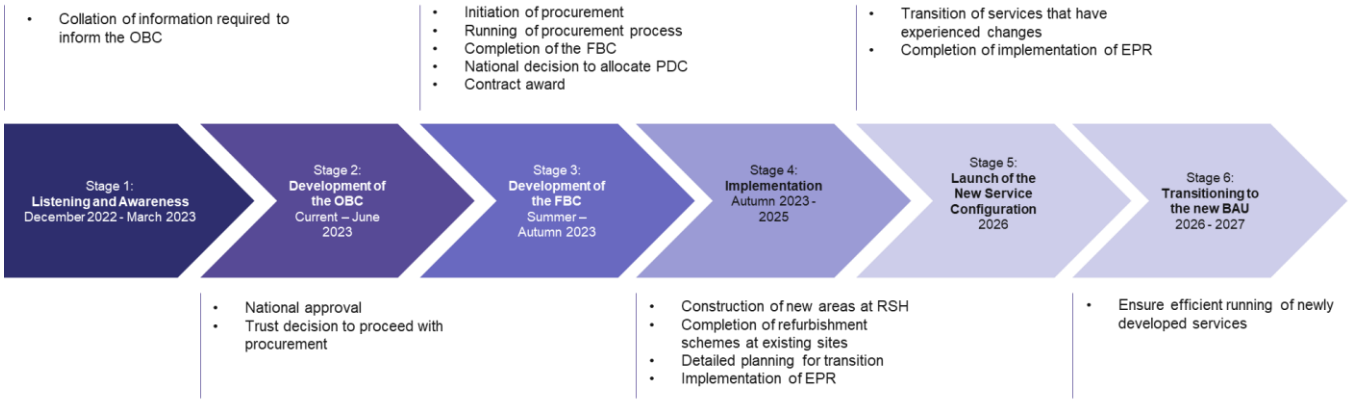
- to develop the best model of care that will deliver the outputs of the consultation and meets the needs of the urban and rural communities in Shropshire, Telford & Wrekin and mid-Wales,
- to prepare all business cases required to support the proposed clinical and service changes,
- to secure all necessary approvals for any proposed changes, and
- to implement all agreed changes.

5.2 Project plan and milestones

5.2.1 Key milestones and critical path

There are 6 Critical Stages of the programme, outlined in Figure 28. We are currently nearing the end of Stage 2 of the programme.

Figure 28: Critical Stages for the Programme



The HTP team will manage the delivery of key approvals to a clear and robust plan. The key milestones for the Preferred Option, along with the dates by which they are anticipated to be achieved, are outlined in Table 98. The key approvals that have already taken place are in grey.

This is an ambitious timeline that seeks approval through to FBC so we can begin to deliver benefits as quickly as possible. It is dependent on national support to make rapid progress through the relevant approval processes and to resolve the issues we face; dates post OBC submission are dependent on NHSE, DHSC and HMT reviews and the availability of capital. Since SOC, the appointment of the PSCP has moved to Q1 2023/24 but this is not expected to impact the

completion date of the scheme, to align to overall timelines. This timeline is supported by ongoing engagement with all our stakeholders.

As outlined at SOC, there is an important package of enabling works required for the scheme to maintain pace and the timeline set out below. This will start during the FBC period (commencing in September 2023), with a separate short form business case [redacted] provided to secure approval to commence these works.

Table 98: Summary of key milestones / approvals

KEY DECISION/APPROVAL	KEY DATES
SOC Submission	April 2022
Joint Investment Committee approval of SOC and agreement to proceed to OBC	July 2022
Approval of OBC by ICB	May 2023
Appoint PSCP	May 2023
Approval of OBC by Trust Board of Directors	June 2023
Completion of OBC	April 2023
NHSE and Joint Investment Committee approval of OBC	July 2023
NHSE, DHSC and Joint Investment Committee approval of funding	July 2023
Joint Investment Committee approval of Temporary works funding	August 2023
HMT approval of OBC and funding	September 2023
Completion of FBC (Including PSCP GMP)	January 2024
Approval of FBC by Trust Board of Directors	February 2024
Joint Investment Committee approval of FBC	February 2024
Begin implementation of the Preferred Option	September 2023
Completion of the Preferred Option	July 2026

The timeline has been constructed to consider the expected approval processes and whilst ambitious, it ensures that the £312m of allocated capital can deliver as much value as possible. Any further delay would be likely to result in greater inflationary pressures, adjustments to PUBSEC calculations and a potential reduction in the scope of change that can be delivered. The impact of a delay to the HTP is explored further in Section 2.8 of the Economic Case, as per the JIC conditions. One of the key risks to the timeline is associated with timely progression through approval to proceed gateways, a risk that could potentially delay the delivery of the scheme resulting in additional inflationary capital pressures. However, the changes to the design of the Preferred Option since SOC have positively impacted timelines due to the reduction in the requirement for temporary works, enabling us to progress as planned. The changes to the design and the advantages of this are outlined in the RIBA Stage 2 Report [Appendix C-02].

The HTP Technical Group meet regularly with both local planning authorities (Shropshire, and Telford & Wrekin) to discuss construction and potential changes across both sites due to the HTP. They are verbally supportive of the scheme. Site visits have been conducted and we submitted a full planning application in March 2023, with a full planning decision expected ahead of the JIC OBC decision. PRH consists of internal reconfiguration and therefore doesn't require planning permission but building regulations will be adhered to within the detailed design. Consultation with planning authorities and other third-party system members will continue throughout the detailed design process. We have ongoing engagement with the Air Ambulance, West Midlands and

Welsh Ambulance Services and Shropshire Fire and Rescue, ensuring all affected parties are consulted throughout the design process. This is explained in more detail in Section 3.2 of the Commercial Case as well as in Appendix C-03 and C-11.

Figure 29: Detailed Delivery Master Programme Gantt Chart (Delivery Plan on a Page)

Prog No:
Date:- 05/10/2022
Rev No: M
Rev Date: 06/04/2023

Shewsbury & Telford Master Programme

FBC, ENABLING & CONSTRUCTION

£25m ENABLING

Line	Task ID (WBN)	Name	Start	Finish	Duration
	234040	FBC, Enabling and Construction Works - ENABLING SCINARIO 3 (£25m)	26 May 23	30 Nov 26	177w 2d
2	234715	PSCP appointment	26 May 23	26 May 23	
3	234710	OBC approval (JIC)	27 Jul 23	27 Jul 23	
4	234235	FBC ENABLING WORKS	28 May 23	26 Jul 23	9w 3d
5	235080	FBC Approvals for Enabling Works	27 Jul 23	25 Aug 23	4w 2d
6	234240	JIC / APPROVALS	29 Aug 23	29 Aug 23	
7	234055	Enabling works (A&E)	30 May 23	29 Jun 26	155w 1d
8	234250	Complete RIBA Stage 4 design for Enabling works	30 May 23	23 Jun 23	3w 4d
9	234255	PSCP Site set up (Mobilisation)	01 Aug 23	25 Aug 23	3w 4d
10	234260	Complete stage 4 design for ED works	30 May 23	21 Aug 23	12w
11	234265	Relocate Exec corridor & Ward 29 Beds for Phase 1	29 Aug 23	25 Sep 23	4w
12	235070	Enabling Works Phase 1	29 Aug 23	26 Feb 24	24w 3d
13	234195	Externals (Works)	29 Aug 23	23 Feb 24	24w 3d
14	234200	Phase 1 (Relocate)	29 Aug 23	12 Sep 23	2w
15	234205	Phase 1A (Works)	12 Sep 23	08 Jan 24	15w 4d
16	234120	Phase 2 (Relocate)	09 Jan 24	23 Feb 24	6w 4d
17	235090	FULL PROVISION OF ENERGY	26 Feb 24	26 Feb 24	
18	234695	ENABLING FOR MAIN CONSTRUCTION COMPLETE	26 Feb 24	26 Feb 24	
19	235075	Enabling Works Phase 2	26 Feb 24	16 Sep 24	28w 1d
20	234230	Phase 2A (Works)	26 Feb 24	21 Mar 24	3w 4d
21	234090	Phase 2B (Relocate)	22 Mar 24	02 May 24	5w 3d
22	234225	Phase 3 (Works)	26 Feb 24	02 Sep 24	26w 1d
23	234125	Phase 4 (Relocate)	03 Sep 24	16 Sep 24	2w
24	234115	RSH Energy Centre	03 Feb 25	29 Jun 26	71w
25	234080	FBC Programme	30 May 23	26 Feb 24	37w 2d
26	234270	Complete contractor review of OBC and formulate proposals	30 May 23	07 Jul 23	5w 4d
27	234275	PSCP presents proposals / PID for development of GMP / FBC	10 Jul 23	28 Jul 23	3w
28	234680	Appointment of MEP subcontractors	10 Jul 23	10 Jul 23	
29	234685	Complete Subcontractor review of MEP proposals	04 Aug 23	04 Aug 23	
30	234690,235070,235075,235090	PSCP Cost plan updates	10 Jul 23	13 Nov 23	
31	234280	PSCP market testing / GMP	18 Sep 23	24 Nov 23	10w
32	234285	Develop GMP	27 Nov 23	22 Dec 23	4w
33	234700	Trust Sign off of GMP	02 Jan 24	02 Jan 24	
34	234130	Design	19 Jun 23	02 Jan 24	26w 4d
35	234110	FBC Authoring	31 Jul 23	12 Jan 24	22w 3d
36	234135	FBC Approvals Process	02 Oct 23	26 Feb 24	19w 4d
37	234245	Construction detailing design (RIBA 5)	02 Jan 24	25 Mar 24	12w
38	234045	Construction Programme	26 Feb 24	30 Nov 26	139w 4d
39	234140	Enabling Works	26 Feb 24	08 May 24	10w
40	234105	Substructure	10 Apr 24	08 Nov 24	30w
41	234095	Superstructure	02 Aug 24	07 Mar 25	23w 4d
42	234085	Façade	05 Nov 24	07 Aug 25	37w 3d
43	234050	Internal Fit out	10 Mar 25	02 Oct 26	80w
44	234220	Testing & Commissioning	13 Jul 26	27 Nov 26	20w
45	234705	PC	30 Nov 26	30 Nov 26	

5.2.2 Plans for the enabling works

To enable the targeted implementation timelines for the Preferred Option to be met and to reduce the impact of inflation, the Trust is seeking the early release of c.£25m for an enabling package of work at the RSH site. The costs associated with the enabling works are included within the overall capital costs of the Preferred Option (£312m).

The enabling works are planned to commence in September 2023 and complete in May 2024. The enabling works are expected to start once the OBC is approved and will be carried out by the appointed PSCP. These works will run in parallel with the completion of the FBC. Once the FBC is approved, the main works will commence and there will be an element of dual running of enabling and main works for the ED at RSH. This will minimise the operational disruption to the Emergency Department because the enabling works will be phased to build the key expansion areas first, allowing the department to operate more effectively away from the main build during the construction phase. The ED will also remain operational throughout the enabling works.

The enabling works will also reduce the duration of the overall scheme and the ability to complete the enabling works in parallel with completion of the FBC will reduce preliminary contractor costs which is likely to reduce the inflationary impact on the scheme.

5.2.3 Costs for the next stage of the programme

Following OBC completion, the next stage of the programme will include:

- Developing the next level of detailed design for the scheme
- Working with the PSCP to secure a Guaranteed Maximum Price (GMP) for the scheme
- Developing the Full Business Case, and all the supporting information
- Delivering Phase 1 of the Enabling Works (as above)

To deliver this, the programme will incur costs for the continued management and delivery of the programme, the internal technical team, external technical advisors, the PSCP costs and the costs for delivering the enabling works (which are set out in the Enabling Works short form business case).

Table 99 outlines the costs associated with delivering the next phase of the programme (from August 2023 to February 2024). These costs enable us to continue delivering at pace and meet the deadlines for completion in 2026/2027. These costing are supported by a more detailed programme budget that is owned and managed by the programme. The costs represent the reasonable expectations of expected costs at the time of writing the OBC and will be dependent on the recruitment and sourcing of the required technical services over the coming months.

Table 99: Costs for the FBC period

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

The costs are driven by the tasks associated with the technical aspects of delivering a detailed and considered FBC as articulated through the relevant RIBA Stages and Greenbook guidance. As outlined in the Commercial Case, the Trust will novate their technical advisors to the PSCP. The Trust will have its own technical team alongside this, and these professionals will be appointed through the nationally recognised SBS framework. This has a line-by-line fee allocation

for the completion of tasks that will support the development of the FBC, as defined in the stated guidance.

Estate's advisor fees for all pre-construction activities are in line with industry standards for the size and complexity of this type of multi-faceted scheme delivered across two live NHS sites.

5.3 Benefits realisation and post project evaluation

5.3.1 Benefits Governance

We recognise the importance of benefits realisation to successful project delivery, so it is essential that we identify the benefits of the proposed changes and how these will be made real, so that a tangible improvement for patients can be seen, felt, and measured. Benefits realisation will run through the design and delivery stages but is predominantly focussed on the post-handover stage.

Responsibility for the operational and clinical delivery of the identified benefits outlined in the Strategic Case will lie with the HTP Delivery Group, which will report to the HTP Programme Board, in line with the existing governance arrangements. These governance arrangements will be kept in place following the completion of the capital build to monitor and manage the delivery of the planned benefits. The HTP Committee will receive assurance in relation to the realisation of benefits and receive monthly updates on progress and the key milestones and benefits mapped against the programme of work, which will also be reported through to the SaTH Board of Directors.

The HTP team will take responsibility for ensuring that the metrics for realisation of scheme benefits are measured and reported. They will also ensure that the measures which relate to wider system delivery are reported on, for example, in relation to the overall financial sustainability of the Trust. The detailed understanding of the benefits and how these link to the service specific benefits will be captured on our benefits realisation tracker.

5.3.2 Benefits Management

As part of the OBC, the benefits realisation plan [redacted] has been developed. This includes specific owners, metrics and timescales for benefits realisation to support assurance and delivery as we move towards implementation. As outlined above, the programme management for the overall scheme will take responsibility for ensuring that the metrics for realisation of benefits are measured and reported. They will also ensure that measures that relate to wider system delivery are reported on.

The table below shows how we will measure the benefits of the programme.

Table 100: Benefits realisation plan

Category	Benefit Type	Benefit	Service Feature	Allocated lead	Proposed KPI	Baseline	Target	How the change will be measured	When the change will be realised	Phasing Methodology
Cash Releasing	Estates benefits	Maintenance	New building	Associate Director of Estates	Reduction in maintenance costs	[redacted]	[redacted]	ERIC data - maintenance costs	26/27	Immediately upon completion
	Estates benefits	Energy and utilities	New building	Associate Director of Estates	Reduction in energy costs	[redacted]	[redacted]	ERIC data - energy costs	26/27	Immediately upon completion
	Estates benefits	Waste management	New building	Associate Director of Estates	Reduction in waste management costs (Domestic, Confidential, Other, Incineration)	[redacted]	[redacted]	ERIC data - waste management	26/27	Immediately upon completion
	Estates benefits	Estates Utilisation	New building	Associate Director of Estates	Reduction in off-site costs	[redacted]	[redacted]	ERIC data – other reportable sites	26/27	Immediately upon completion
	Estates benefits	Car parking income	New car parking spaces	Associate Director of Estates	Increase in car parking income	[redacted]	[redacted]	ERIC data -parking income	26/27	Immediately upon completion
	Patient Safety	Falls reductions	New building	HTP Implementation Lead	Reduction in the number of falls	[redacted]	[redacted]	Trust falls tracker (vs 21/22)	26/27	Immediately upon completion
	Patient Safety	Infection control	New building	Consultant – Medical Staff – Microbiology	HCAIs	[redacted]	[redacted]	Trust HCAI tracker (vs 21/22)	26/27	Immediately upon completion
	Patient Safety	ADEs and electronic dispensing	Automated dispensing	Chief Pharmacist	ADEs	[redacted]	[redacted]	Trust ADEs	26/27	Immediately upon completion
	Clinical Benefits	Elective LOS improvement	Clinical model	HTP Implementation Lead	EL LOS	[redacted]	[redacted]	1) Occupied bed days 2) +7 days, 14+ day, +21 days – proportions (RSH +PRH) 3) EL LOS Planned care hub BC	26/27	Immediately upon completion
	Workforce benefits	Workforce	Workforce model	Workforce and OD Lead	Reduction in spending on staff	[redacted]	[redacted]	Pay spend	26/27	Immediately upon completion

Category	Benefit Type	Benefit	Service Feature	Allocated lead	Proposed KPI	Baseline	Target	How the change will be measured	When the change will be realised	Phasing Methodology
	Workforce benefits	Staff sickness	Improved facilities and workforce model	Workforce and OD Lead	Staff sickness rate	[redacted]	[redacted]	Staff sickness %	30/31	Phased over 5 years per P&C plan
	Workforce benefits	Reductions in turnover costs	Improved facilities and workforce model	Workforce and OD Lead	Staff turnover rate	[redacted]	[redacted]	Staff turnover %	30/31	Phased over 5 years per P&C plan
	Other benefits	Additional capacity	Additional Capacity	Deputy Director of Finance	Additional costs from outsourcing/WLIs	[redacted]	[redacted]	Financial value of work outsourced and WLIs due to lack of capacity	26/27	Immediately upon completion
	Workforce benefits	Reduced Agency spend	Avoided Agency costs	Workforce and OD Lead	Annual staff costs attributable to Agency	[redacted]	[redacted]	Agency costs £	24/25	Prior to completion
NCR	Clinical Benefits	Theatre cancellations	Theatre cancellations	HTP Implementation Lead	Theatre Cancellations	[redacted]	[redacted]	Count of cancellations	+1 year from opening	Immediately upon completion
NCR	Clinical Benefits	Length of Stay / BAU	Clinical model	HTP Implementation Lead	LOS	[redacted]	[redacted]	Trust LOS MFFD reporting	+3 years	50% upon opening Y1 65% Y2 85% Y3 100%
NCR	Clinical Benefits	NEL LOS NCR	Clinical model	HTP Implementation Lead	NEL LOS	[redacted]	[redacted]	1) Occupied bed days 2) +7 days, 14+ day, +21 days – proportions (RSH +PRH) 3) EL LOS	+3 years	50% upon opening Y1 65% Y2 85% Y3 100%
NCR	Patient Safety	ADEs and electronic dispensing	Automated dispensing	Chief Pharmacist	ADEs	[redacted]	[redacted]	Trust ADEs	26/27	Immediately upon completion
NCR	Workforce benefits	Staff sickness / satisfaction	Workforce model	Workforce and OD Lead	Staff sickness rate	[redacted]	[redacted]	Sickness %	30/31	Phased over 5 years per P&C plan
NCR	Workforce benefits	Turnover	Workforce model	Workforce and OD Lead	Staff turnover rate	[redacted]	[redacted]	Turnover %	30/31	Phased over 5 years per P&C plan
NCR	Estates benefits	Reduction in backlog	New build / refurb	Strategic Estates Lead	Level of backlog maintenance	[redacted]	[redacted]	ERIC submission - backlog data	26/27	Immediately upon completion
Societal benefits	Patient Safety	HCAI QALY	New building	Consultant – Medical	HCAIs	[redacted]	[redacted]	Trust HCAI tracker (vs 21/22)	26/27	Immediately upon completion

Category	Benefit Type	Benefit	Service Feature	Allocated lead	Proposed KPI	Baseline	Target	How the change will be measured	When the change will be realised	Phasing Methodology
				Staff – Microbiology						
	Patient Safety	Falls QALY	New building	HTP Implementation Lead	Reduction in the number of falls	[redacted]	[redacted]	Trust falls tracker (vs 21/22)	26/27	Immediately upon completion
	Patient Safety	ADE QALY	Automated dispensing	Chief Pharmacist	ADEs	[redacted]	[redacted]	Trust ADEs	26/27	Immediately upon completion
	Clinical benefits	LOS QALY	Clinical Model and improved facilities	HTP Implementation Lead	LOS	[redacted]	[redacted]	Trust LOS	26/27	Immediately upon completion
	Clinical benefits	Integrated Care QALY	Integrated care investment	Programme Delivery Director	Annual Patients using HWBC	[redacted]	[redacted]	Total number of patients treated	26/27	Immediately upon completion
	Clinical benefits	A&E QALY	New building	Clinical Lead	% over 4 hours	[redacted]	[redacted]	A&E 4-hour target	41/42	Phased over 10 years

To ensure that benefits become part of the ongoing metrics, they will transition to Business As Usual reporting following the conclusion of the benefit realisation and measurement period, aligned to the Trust's existing performance reporting.

5.3.3 Net zero carbon

The Trust supports NHS sustainability and carbon reduction goals. The HTP aligns to the overall Trust and ICS NZC plans. The scheme aspires to achieve BREEAM 'Excellent' and be Net Zero ready. No specific target has been set for Net Zero Carbon Construction, but the design team have identified opportunities to utilise low carbon solutions where possible. Details of our plans to achieve these targets are outlined in our Net Zero Carbon Strategy, which is included in the Stage 2 Report [Appendix C-02]. They are also outlined in more detail in Section 3.4 of the Commercial Case. These plans are informed by the UKGBC's Net Zero Carbon Buildings Framework.

5.3.4 Government Soft Landings

Government Soft Landings (GSL) will form part of the design and engagement process throughout the scheme.

The five stages of GSL across the construction lifecycle from inception to operational use and aftercare have been incorporated into the design discussions at OBC stage. The process will ensure that the designers and the PSCP remain involved beyond practical completion RIBA Stage 7. This it important due to the size and complexity of the build. It will help to minimise any disruption during the first months of operation by facilitating smooth running of the new buildings and ensuring that staff understand how to best use the systems and features.

Further work on soft landings will be incorporated into the detailed design elements of the scheme as we progress through FBC.

5.3.5 Post project evaluation arrangements

We recognise that there are a series of post-project activities which need to be undertaken following completion of the main build elements, these include ongoing defects management, managing in-use issues, and undertaking appropriate post-project review and analysis. We are committed to undertaking a post-project evaluation (PPE) after all key stages of the HTP through a formal evaluation methodology, with involvement from all appropriate internal and external stakeholders. These PPEs will be undertaken as an integral part of the monitoring of benefits realisation and P23 requirements and will follow best practice. The arrangements are in line with the benefits outlined in Section 2.6.1 of the Economic Case and a budget of c.£70k has been allocated for undertaking this post-project review.

These arrangements will be developed further though FBC stage as the benefits, commercial arrangements and timelines increase in certainty. The proposed process is in four stages:

Table 101: Post project evaluation review process

PPE Stage	Timing	Activities	Outputs
Setup	Delivered during FBC stage	Validating benchmark period parameters Validation of the logic model/ evaluation framework Collecting benchmark data (quantitative and qualitative) Thematic analysis of qualitative data	Evaluation framework Benchmark data Benchmark report
Documentation	Within 6 months of completion	Initial documentation issued to all parties to re-state the initial project objectives and what was intended to be achieved and then what was achieved	N/A
Evaluation session	Within 6 months of completion	Evaluation and feedback session with all key staff, including lessons learnt (typically held within 6 months of completion) to comprise a walk-round of the new facilities and then a series of structured sit-down workshops	Formal post-project evaluation report, including lessons learnt, formal KPI recording, and benefits realisation
Follow up evaluation session	Within 2 years of completion	Re-evaluation of achievements against aims and objectives	Formal post-project evaluation report

The evaluation will cover all aspects of the project, including the end product and the process, reviewing what was achieved against the original aims and objectives, recording actual performance (benefits, KPIs etc.), discussing what went well and what didn't go well, and ensuring any lessons can be learnt for future phases of the HTP and for future projects. The outcome of the evaluation will be reported through the HTP Programme Board, to the ICB and the Board of Directors for noting or further action.

The first stage of the PPE approach will be the setup, which will be completed during the FBC stage of the scheme. During this stage, the Trust will revisit the logic model that supports our programme benefits, agree the framework for the evaluations in the remaining PPE stages, and collect benchmark data for the formal evaluation of the programme, within 2 years of completion.

Following completion of the programme, documentation will be issued to all relevant parties to inform their assessment of the outcomes of the programme against the initial objectives. The delivery of the HTP will be evaluated against a range of measures including timelines of start and end dates, costs, and barriers to development. This will result in formal post-project evaluation reports for each area which will also be informed by feedback sessions and workshops.

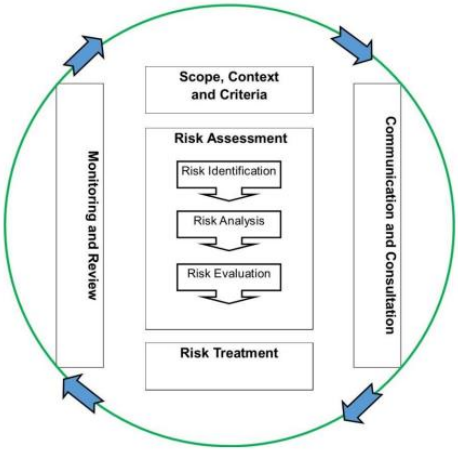
An independent evaluation of the outcomes and benefits of the HTP will be carried out 2 years after the project is completed. This will involve collection of additional quantitative and qualitative data and analysis of this data against the objectives of the HTP to understand the extent to which the benefits (set out in Table 99) have been realised. This evaluation will assess the impact of the whole clinical model through analysis of all the capital schemes.

5.4 Managing risk (approach to risk management)

5.4.1 Trust risk management arrangements

To effectively manage risk, the Trust follows the process set out by the ISO 31000 and shown in Figure 30. We work closely with our ICS colleagues to ensure we remain aligned in terms of our approach to risk. The Trust's Risk Management Strategy is included in Appendix M-12.

Figure 30: Risk Management Process



The Trust risk management process involves 5 key steps:

- **Scope, context and criteria** – allows us to customise the risk management process, enabling effective risk assessment and treatment
- **Risk identification -** involves finding, recognising, and describing risks that might prevent the Trust from achieving its priorities
- **Risk analysis** – involves fully understanding the nature of the risk and its characteristics, including the level of risk
- **Risk evaluation** – involves comparing the results of the risk analysis with the established risk criteria to determine whether additional action is required
- **Risk treatment** – involves selection and implementation of options for addressing risk to ensure timely and appropriate monitoring and decision making, supported by the right escalation protocols

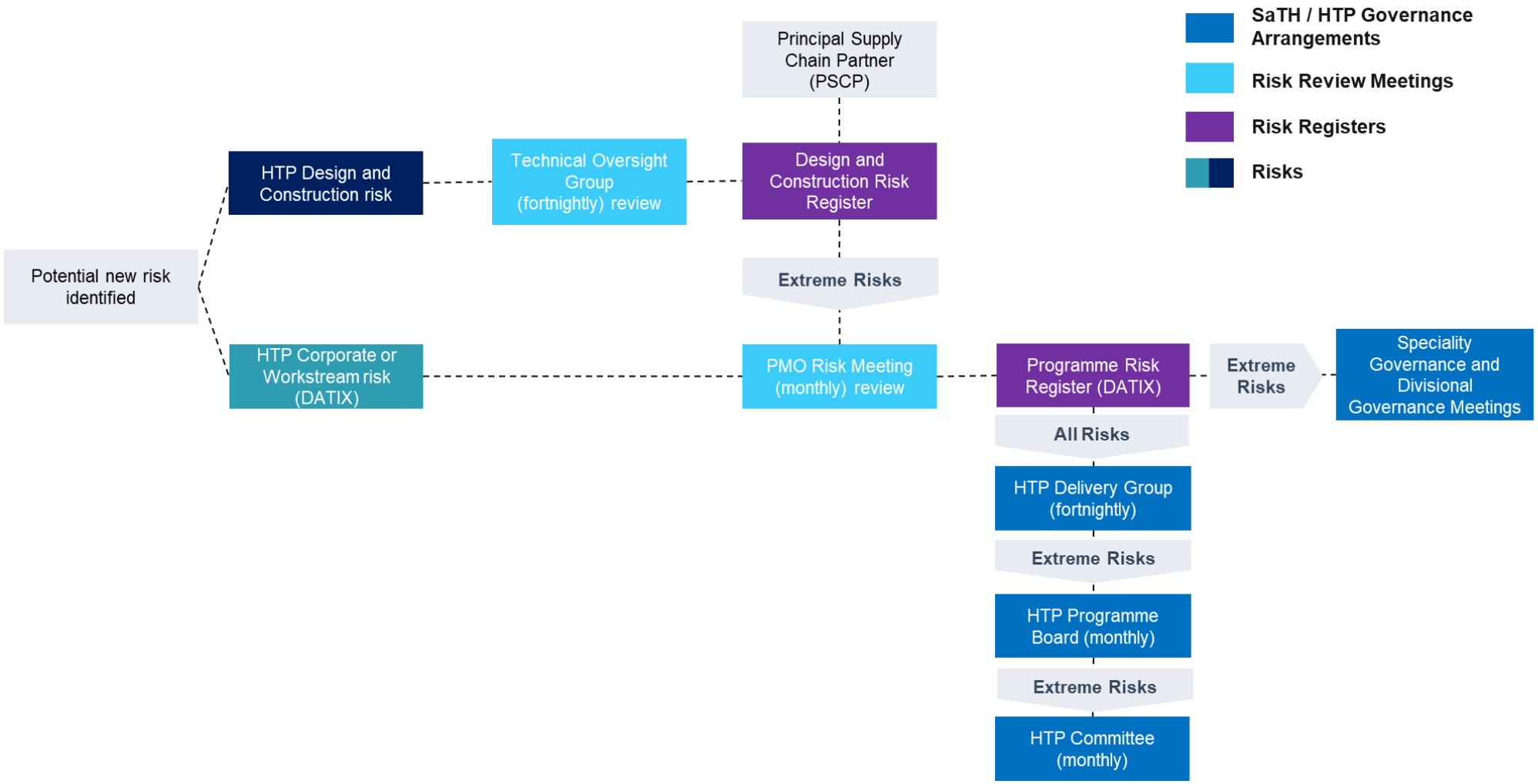
5.4.2 Programme risk management arrangements

Programme risks are dealt with according to the HTP Risk Management Strategy which is included in Appendix M-12 and is in line with the Trust's overall Risk Management Strategy. Risk ownership is key for risk management within the programme. Each risk is owned by the relevant workstream lead. They are ultimately responsible for the risk and have ownership and oversight of this risk.

The PMO has oversight of all programme risks. The programme has a tailored approach to risk management based on the nature of each risk. Technical programme risks are monitored by the Technical Oversight Group, separately to other programme risks. The technical risks are then transferred to the overall Programme Risk Register where appropriate.

The programme risk management arrangements are outlined in Figure 31:

Figure 31: Risk Management Arrangements



5.4.2.1 Risk management for all programme risks (that aren't technical / estates risks)

Risk management at the Trust is predominantly administered through the DATIX system. The DATIX system also holds the Trust's incidents data, complaints and claims information and therefore enables us to align our approaches. The system allows users to input all elements of the risk register quickly and easily and ensures users can update risks as they change throughout the process. All staff involved with risk management have access to the DATIX system and receive training to ensure that they are informed, competent and prepared.

Specific training includes:

- Annual risk workshops to allow staff to meet their specific training needs
- E-learning package aligned to ISO31000
- Bitesize 'How To' recorded videos
- DATIX Risk Register Module, providing guidance regarding recording risks
- Provision of the Risk Management Process Guide

As outlined in Figure 30, risks are first identified at a workstream level via DATIX. Once identified, risks are rated based on their probability and impact. A risk score for initial, current and target risk level is inputted into DATIX, helping to determine whether the mitigations we have put in place are effective. A score of 1 relates to a rare / negligible risk. Whereas a score of 5 relates to an almost certain / severe risk. These two values are multiplied together to determine an overall risk rating for each risk, shown in Figure 32 below:

Figure 32: Risk Matrix

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

Low (1 – 3)	Moderate (4 – 6)	High (8 – 12)	Extreme (15 – 25)

The escalation (and de-escalation) of risks is an important part of risk management. During risk meetings, a confirm and challenge approach is applied to each risk. The risk reporting, escalation and assurance arrangements vary depending on the overall score of the risk.

- Extreme programme risks, with a score of 15 or above are escalated to the Trust. These risks and their scores are reviewed by the Trust. According to the Trust risk management arrangements, they must then be approved at the Speciality Governance and Divisional Governance meetings. They require immediate action and are reviewed monthly.
- High (8-12), Moderate (4-6) and Low (1-3) risks are dealt with at a Programme Level. High risks are reviewed bi-monthly and Moderate / Low risks are reviewed quarterly.

The PMO reviews all risks that are put on DATIX and decides whether they should be transferred to the Programme Risk Register, escalated to the Trust, or just kept at a workstream level. Extreme risks are escalated to the Trust and high, moderate, and low risks are kept at Programme level. The PMO is responsible for maintaining the Programme Risk Register and holds monthly meetings to review risks. All programme risks are reported at the HTP Delivery Group, and all extreme programme risks are reported at the HTP Programme Board and the HTP Committee to ensure that key members of the Hospitals Transformation team are aware of the biggest risks to the HTP.

5.4.2.2 Risk management for estates / technical programme risks

As technical risks fluctuate on a day-to-day basis, they must be managed differently to the other types of risk. Due to their nature, technical risks are captured separately to other programme risks on the Design and Construction Risk Register [redacted] This risk register is shared with the PSCP, and risks are allocated appropriately between the Trust and the PSCP. The Technical Oversight Group are responsible for monitoring all technical programme risks. These technical risks are costed and also scored based on their probability and impact, to align with the overall programme risk management process.

The Technical Oversight Group are responsible for making the PMO aware of all risks on the Design and Construction Risk Register. The PMO reviews all risks on this risk register and transfers any extreme technical risks to DATIX where appropriate. The PMO is responsible for keeping these design and construction risks up to date on the overall Programme Risk Register. This ensures that all risks associated with the HTP are held in one place.

The recommended Design and Optimism Bias risk allowances are factored into the project costs, these allowances form part of the overall risk contingency allocation for the project and will continue to reduce as the detail progresses. The final risk allocation amount will be finalised and agreed by the Trust and the PSCP to enable the agreement of the GMP before work commences.

5.4.2.3 Risk management roles and responsibilities

The management of risk forms part of the Trust's overall approach to governance. Table 102 outlines the key groups mentioned above who are all involved in the management of risk. The programme related governance groups are responsible for managing High, Moderate and Low risks. Whereas the broader Trust governance groups are involved in the monitoring of Extreme programme risks.

Table 102: Risk management roles

Programme Related Governance		
Governance group	Frequency of review	Role in risk management
SaTH PMO	Weekly	Coordinates with workstream leads to ensure risks and issues are identified and assessed consistently. Facilitates the escalation of risks as required. Manages and maintains the Programme Risk Register. Holds a monthly meeting to review the Programme Risk Register.
HTP Technical Oversight Group	Weekly	Oversees the technical programme risks. Clearly identifies and monitors risks that are shared with the Principal Supply Chain Partner (PSCP) via the Design and Construction Risk Register. Updates costed risk on a fortnightly basis.
HTP Delivery Group	Two Weekly	Routinely reviews the programme risk register and discusses risks. Facilitates the discussion of risks by Workstream Leads. Resolves risks and issues which cannot be resolved by the PMO or workstreams.
HTP Programme Board	Monthly	Are responsible for undertaking a formal review of risks. Reports the extreme programme risks. Ensures alignment with ICB risks.
HTP Committee	Monthly	Reports the extreme programme risks. Attended by a Non-Executive Director of the Trust.
Broader Trust Governance (as required)		
Governance group	Frequency of review	Role in risk management
Board of Directors	Monthly	Has overall responsibility for ensuring the Trust has effective systems for managing risk to enable the organisation to deliver its objectives.
Audit and Risk Assurance Committee (ARAC)	Bi-monthly	Includes the Trust Board of Directors Receives the Trust Risk Report to seek assurance that the structures and procedures in place regarding operational risk management within the Trust are robust. Coordinates with other board assurance subcommittees and internal and external audit.
Risk Management Committee	Monthly	Offers support to the ARAC, by obtaining objective assurance that the framework and systems for risk management are robust and effective. Has overall responsibility for establishing a pro-active approach to risk management across the various divisions and directorates across the Trust. Divisions/ Directorates will be expected to present new risks/provide updates on all risks with a current (residual) rating of 15 and above, to allow for constructive challenge, and provide assurances that effective controls to mitigate the risk are in place.
Operational Divisions/ Corporate Directorate	Weekly	Are responsible for reviewing and controlling the risks within their areas. Review relevant extreme programme risks and escalate where appropriate.
Specialities/ Wards/ Corporate Departments	Weekly	Are responsible for reviewing and controlling the risks within their areas.

As we progress to FBC, the programme team will continue to monitor risks and maintain the risk registers. Risks will be escalated where appropriate to ensure that everyone involved in the programme is aware of threats to programme delivery.

5.4.3 Trust Board Assurance Framework

This proposed reconfiguration of hospital services helps to address a number of the strategic risks on the Trust Board Assurance Framework (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 SRO provides a high-level update to the Board of Directors on BAF / the HTP risk alignment at every meeting.

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.

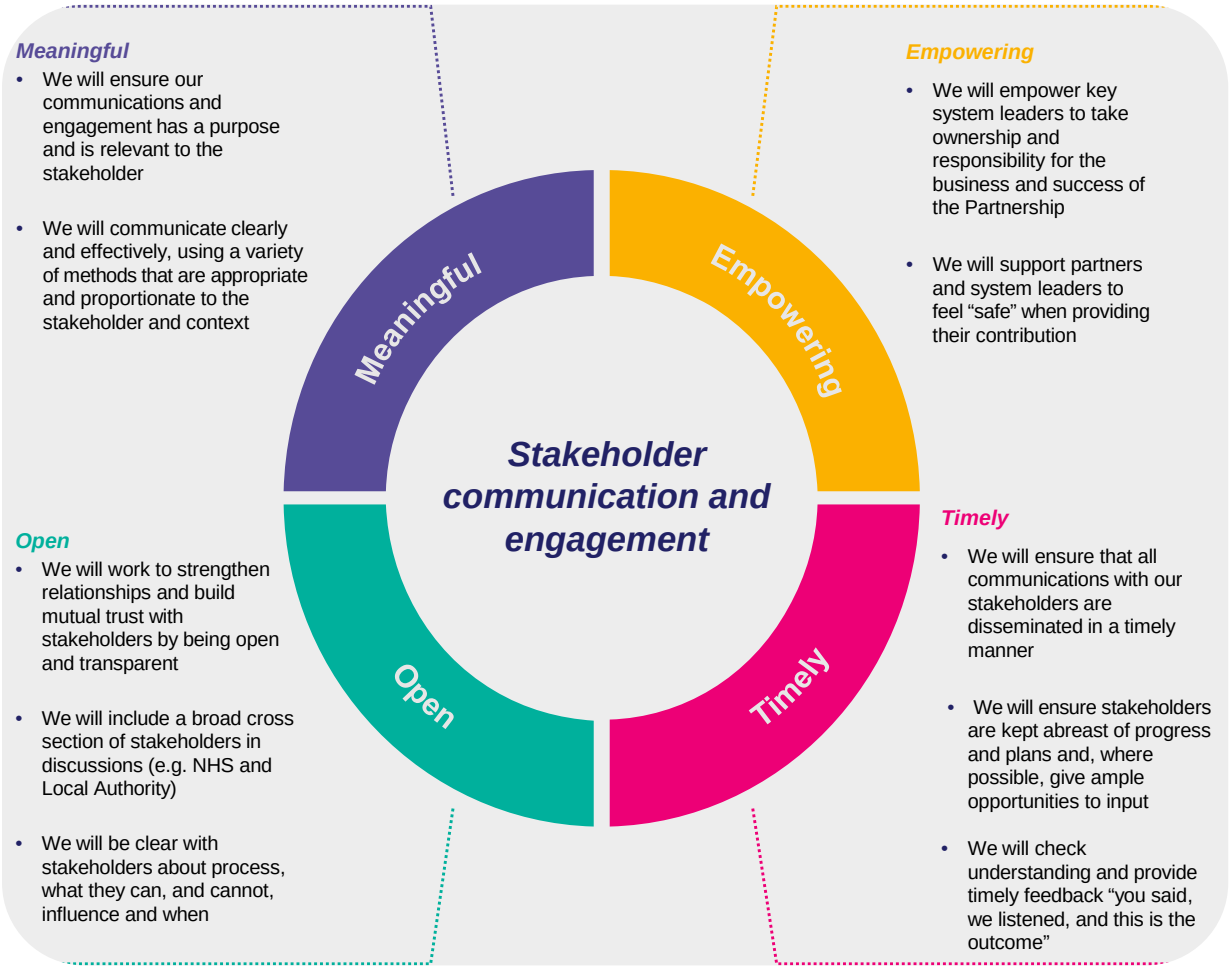
5.5 Engaging our stakeholders

Good communication and engagement are integral to ensuring successful delivery. Our approach is centred on the following objectives:

- To build public and internal awareness of the 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 & Wrekin and Powys.
- To deliver our statutory duties and continue to inform and 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.

Figure 33 (below) outlines our Communications and Engagement Principles that our strategy is aligned to.

Figure 33: Communication and engagement principles



5.5.1 Summary of stakeholder engagement

Since 2019, there has been stakeholder engagement with our staff, service users, public and system partners. We have divided our stakeholders into three groups for communication and engagement purposes. The below table provides an indication as to the three groups of stakeholders and audience types involved. It also provides an indication of the type of engagement activities held and their content.

Table 103: Stakeholder groups and engagement approach

Stakeholder	Audience Type	Type of engagement
Staff (Clinical and Non-Clinical)	• Executive • Divisions • Clinical Leads • Clinical Departments • Partners' staff (as appropriate)	• Project development and design • Task and finish groups • Programme updates • Audit participation • Fact finding • Webinars • Awareness Roadshows • Workshops
Patients and public	• Members of the public • Voluntary sector organisations • Community meetings • Seldom heard groups • Public Assurance Forum with key stakeholders (Healthwatch, CHC, HWBBs etc.) • Patient Groups • Media	• Project updates • Public forums • 'About Health' streamed events • Speciality Focus Groups • Targeted community engagement
Wider Stakeholders	• ICS partners • Commissioners and regulators • GPs • MPs and Councillors • Overview and Scrutiny Committees	• Project updates • Acute care provision and design • System wide programme integration

For the HTP to be a success, ongoing effective, meaningful, and timely, stakeholder communication and engagement is essential. Our communication and engagement plans will continue to be implemented throughout the assurance and implementation phases. It is fundamental to have a clear understanding of the interests of our key stakeholders and implement a strategy to address their needs, with an aim of responding to their concerns and ensuring the benefits for healthcare across the communities we serve are clearly communicated.

Table 104: Stakeholder plan

Stakeholder group	Details	Approach
Patients, service users and their families	We need to communicate and engage effectively with patients and service users and therefore have ensured that patient experience is at the forefront of plans and delivery. Involvement will focus on pathways and what this means for patients.	Focus Groups for the four clinical workstreams as well as an additional workstream for travel and transport (both face to face and digital) Published presentations and Q&As after the Focus Groups Monthly Newsletters to 3000 community members and 300 Voluntary and Community organisations (including all town and parish councils and county/ borough councillors) as well as GP Practice Patient Groups Monthly Community Engagement Meetings Trust Public Assurance Forum Social media Traditional media Updated web presence Attendance at long-standing and targeted local events Development of marketing materials
General public	We need to ensure that our communities are aware of the changes being made and how these may affect them, with the wide-ranging benefits across the area clearly communicated. We recognise that this awareness will build over the coming years and will require sustained communication.	As above

Stakeholder group	Details	Approach
Staff	We employ around 7,000 members of staff, the majority of which live in the local area, meaning they and their families are also potential patients. We need our staff to be champions and advocates, which means it is vital to ensure that staff are informed and feel proud to back the scheme.	Staff newsletters and bulletins Roadshows Workshops Drop-in sessions Development of marketing materials Webinars Provision of a toolkit of resources
Partners	We are working closely with a network of local organisations to deliver healthcare changes.	Newsletters Regular meetings – see the HTP Governance structure Update letters
Media	We need to work constructively with the media to ensure that the case for change is clearly communicated and why no change is not a viable option.	Media briefings Regular press releases/updates
Political	We need to engage and inform with all relevant political audiences and ensure they are fully and regularly briefed on the scheme, including progress towards implementation.	Briefings Update letters
Seldom heard groups	We need to ensure we are listening to and responding to people who fall within the below categories: Protected characteristics: Age, sex, disability, gender reassignment, sexual orientation, race, religion or belief, marriage and civil partnership, pregnancy and maternity Further characteristics the HTP will need to consider: Language (where English is not the first language), Carers, Geography We are working with our social inclusion officer to involve seldom heard groups. Our approach to involvement is being regularly reviewed and will be informed by our updated EHIAs.	See patients, service users and their families and public Accessible tools in addition to this

5.5.2 Stakeholder engagement approach

Since SOC, we have established a Communications, Community Engagement and Organisational Development Group (CE&OD) for the HTP, who meet weekly to discuss the delivery of the implementation of priority actions and ensure the communications and engagement workstream remains on track. It includes representation from SaTH communications, SaTH community engagement and the OD Directorate. It provides regular updates and seeks involvement from the monthly ICS Communications and Engagement group, including representation from NHS, local authorities and Healthwatch partners. This group reports to the HTP Programme Board.

Our Communications and Engagement Strategy [Appendix M-04] describes 5 critical stages (these are outlined in Section 5.2.2, in addition to a 6th stage). Stage 1 of the strategy involved 'Listening and Awareness', it commenced following the approval of SOC and ran from December 2022 to March 2023.

The key objectives of Phase 1 were to:

- Raise awareness of plans to support people in understanding the clinical reasons for change using traditional and digital resources.
- Engage stakeholders to understand their needs and support them in promoting the benefits that these changes will bring.
- Listen to suggestions from staff and clinicians and support them to be part of this change.
- Give staff from across the system the chance to share their ideas through targeted engagement activities.

These objectives are expected to remain consistent throughout the subsequent phases of the HTP. So far, we have utilised existing mechanisms for communications and engagement, including existing patient, carer and public forums across Shropshire, Telford & Wrekin, and Powys and developed bespoke Focus Groups linked to each of our workstreams. Feedback from these Focus Groups to date has been positive. We have also worked closely with the Public Assurance Forum at SaTH to inform our approach. We launched our campaign in January 2023 to encourage people to be part of the change and have a group of key spokespeople who are media trained and will represent the programme.

Phase 2 of the strategy covers the development of the Outline Business Case and Phase 3 of the approach commences during the development of the Full Business Case, and will continue to raise awareness of the programme, clinical benefits and what this means for staff and communities accessing the providing care.

We understand the importance of considering subsequent phases of the HTP and the key plans for the next phases of the approach are outlined below:

- We ran an 'About Health' event in January which was live-streamed and had over 100 registrations. We have scheduled quarterly 'About Health' live streamed events and Public Focus Groups for the next two years. Q&As from these meetings will continue to be recorded and shared for transparency. The core focus groups cover:
- Medicine and Emergency/ Urgent Care
    - Clinical Support Services
    - Surgery, Anaesthetics and Cancer
    - Women's and Children's
    - Travel and Transport
    - PRH Retail Development
- We continue to seek to recruit people to form balanced Focus Groups, including:
    - Patients (recent experience and future)
    - Carers and partners
    - Seldom heard groups/inequality groups or their representatives
    - Representatives from SaTH's Public Assurance Forum (who represent many voluntary/patient groups)
    - Interested groups
- We also distribute information via a newsletter that has c.3,000 subscribers and reaches people from all the parish councils within the area, and we regularly go out to high footfall areas to collect feedback.
- We have started and will continue to develop a range of resources that can be used by relevant stakeholders to promote the programme when attending external meetings in the community. These resources are likely to include:
    - A public summary of this OBC
    - Animations that show the patients journey, subject to funding
    - Clinical videos with a range of system partners
    - Visual representations of initial architect drawings
    - Accessible tools including BSL and easy read
    - Visual resources at both hospitals, including digital screens and information zones within the hospitals for the latest information on the programme
    - Flyers for each of the benefits

5.6 Impact assessment

5.6.1 Equality and Health Inequality Impact Assessment (EHIA)

As a Trust, we understand the importance of addressing health inequalities, in line with the Joint Forward Plan and the ICB Clinical Strategy. An Equality Impact Assessment (EIA) was developed in 2018 and informed the SOC. This took account of the recommendations from the original Future Fit impact assessments, particularly those that set out potential disproportionate impacts on certain groups within the nine protected characteristics.

Since SOC, the clinical teams have developed 12 refreshed service led EHIAs, rather than a single overarching EIA. These include all the protected characteristics and vulnerable groups. EHIAs have been carried out for each of the following services:

- Acute Medicine
- Emergency and Urgent Care
- Cardiology
- Stroke
- Gynaecology
- Paediatrics
- Neonatal
- Obstetrics (Maternity)
- Oncology/ Haematology
- Critical Care
- Surgery
- Paediatric Surgery

[redacted]

The EHIA work examines if protected characteristic groups or other vulnerable groups who face health inequalities, are likely to experience any disproportionate impacts from the proposals – either negatively, positively or neutrally. The work pays particular attention to equality legislation and to showing how the project is considering the needs and views representative of the nine protected characteristics under the Equality Act 2010 and the Public Sector Equality Duty 2011. It also considers the needs of 12 different groups who are likely to face health inequalities.

We specifically targeted four additional groups to engage during consultation:

- People living in rural areas
- People living in areas of deprivation
- Carers
- People whose first language is not English

Some of the recommendations of the EHIAs and how they have been addressed to date are outlined below.

Table 105: EHIA recommendations and actions

Recommendation	How this has been addressed
Develop an effective communications and engagement strategy Develop a strong public awareness campaign	Detailed stakeholder mapping and engagement workshops have taken place, resulting in the communications and engagement strategy that is continually reviewed and updated, outlined in Section 5.5.
Consider the impact of Out of Hospital Care Strategies and Neighbourhood Developments	We have worked closely with out of hospital providers in developing this OBC, which is outlined in the Strategic Case. The plans for the new estate and out of hospital plans are interlinked and interdependent. We will continue to develop these plans together at FBC stage.
Ensure the provision of appropriate accommodation for parents/carers	Parents and carers are considered in new hospital building standards, and the design that has been developed as part of this OBC reflects these standards.
Incorporate the potential impacts for access on protected characteristics groups and groups who face health inequalities	Access requirements will be discussed with individual patients to accommodate their needs. Changes to services will be communicated clearly in patient correspondence. Patient information will be available in different languages and formats to support understanding. Information will be available about eligibility for patient transport and recovery of expenses.

[redacted]

5.7 Supporting arrangements for change (change management)

Service change and organisational development are key considerations, as the services provided to patients, communities and the quality of working life for staff are improved. Whilst implementing the HTP, we are working closely with staff and colleagues to create a change management culture that supports our values, embraces diversity, and ensures that people are empowered and listened to through the entire project lifecycle. We are also exploring partnerships and buddying models with other Trusts which are experienced in large capital builds to enhance our delivery capabilities.

5.7.1 Organisational change management

The reconfiguration to be delivered with this scheme is part of our broader transformation, and as such the change management associated with this project fits into our broader change management approach. As part of the OBC process, this approach was reviewed and updated. As the scheme develops through FBC this Trust change management approach will continue to develop and be refined in response to the design decisions taken.

We are delivering a comprehensive change management approach to continue to improve the delivery of care for our patients. Change in the Trust is managed under the Trust's Management of Organisational Change Policy (included in Appendix M-09) which sets out a framework and principles for delivering change within the Trust; it further aims to provide a positive and transparent approach that will facilitate the timely and successful implementation of change. We have ensured that staff and their representatives have been included in a process of dialogue, as described in Section 5.5. We also have a Change Control Process [Appendix S-13] which outlines our procedures for addressing changes to the scope of the HTP. This process is explained in more detail in Section 3.6 of the Commercial Case. The Change Control Group are responsible for reviewing and addressing proposed changes. This committee includes representation from the clinical, technical and PMO workstreams, in addition to the SRO. This ensures that all changes to the scope of the HTP have endorsement from clinicians and estates specialists and are therefore favourable and achievable.

We have recent experience of implementing major service changes through the reconfiguration of the Emergency Department and will be able to use this experience to the benefit of this scheme. The reconfiguration will be implemented in a staged and systematic way that causes the least amount of disruption to services. Plans for the management of staff during the transition include:

- The HTP ‘triumvirate’ of the HTP Medical Director, Nursing Lead and Operations Lead will manage the clinical service reconfiguration change programme with the support of Clinical and Divisional Implementation Leads.
- The clinical working groups will oversee the transition required within each clinical centre. Within each clinical area (e.g., ED, critical care, women and children’s), clinical implementation teams will progress change within each clinical specialty.
- Implementation will be driven within each clinical division, led by the divisional and centre teams but with full support from the transformation team and corporate leads. Implementation plans with a detailed critical path will be developed for each service. These will be based on the phasing and decanting plans identified by the construction teams. Each implementation plan will be used as the basis for the formal management of change process and the communication and engagement activities within each service area.
- New ways of working and the implementation of new care pathways will be phased and appropriately project managed. We have also engaged with other Trusts who have undertaken similar major configuration processes to seek lessons learnt and best practice from elsewhere. We have met with Epsom and St Helier University NHS Trust to share opportunities and challenges around new ways of working, particularly related to therapy led wards. We have also reached out to Aneurin Bevan Health Board, Warrington Hospital and Ellesmere Port Hospital for further insights on best practice and lessons learnt.
- Work will be undertaken to ensure our clinical and digital teams are able to implement the new IT systems and processes. The workforce and digital workstreams are working together to ensure that the implications of the workforce benefits are in line with our Digital Strategy [Appendix S-05] and we will create training plans for upskilling / re-skilling staff.
- Communication and engagement internally within the Trust, with partners and stakeholders and with patients and the public will be managed by the HTP team.
- Close working with partners to ensure pathways are integrated with primary, community and third sector partners.

5.7.2 The impact of increasing digital maturity

Whilst the HTP is not intended to deliver the Trust’s Digital Strategy, they have both been developed in tandem. The Trust’s 3-year Digital Strategy [Appendix S-05] will allow us to become paper lite which will automate time-consuming elements of clinical and administrative roles and free up staff for value-adding tasks. By the time works begin on the HTP, we will have a new patient administration system (PAS), theatres system and ED system. We are also likely to continue to implement further new digital systems such as Electronic Prescribing and Medicines Administration (EPMA). Increased uptake of digital technologies will allow staff to communicate more effectively and manage patient flow more easily. Not only will this make SaTH a more attractive place to work and contribute to an improvement in recruitment and retention, but it will also improve patient experience. Our ambition to reach Level 5 on the HIMMS EMRAM digital maturity model will therefore have a significant impact on our staff.

5.7.3 Changes to workforce and ways of working

To deliver the clinical model, our workforce will increasingly be:

- Working more autonomously and delivering a more complex case load,
- Working in more flexible ways across traditional professional groups,
- Developed to support new roles required,
- Upskilled to take on extended roles,
- Required to use new technology to deliver clinical care and non-clinical services, and

- Adopting different working patterns e.g., 24/7 on site presence, 7 day working and delivering routine services in the evening and at weekends.

As such a phased workforce change approach will commence from year 1:

Table 106: Workforce Change Approach

Service model	Key service change driving changes	Changes

Emergency Department (ED) / Urgent Treatment Centre (UTC)/ Ambulatory Emergency Centre (AEC)	• Centralisation of all emergency specialist medical and surgical services onto one site, supporting the emergency department
	• A higher proportion of patients attending the UTC on both sites
	• An enhanced UTC at PRH
	• As a result, a higher proportion of patients attending the ED/ SAU/ AMU/ AEC could have:
	  • Higher acuity because of major illness/life threatening conditions
	  • Exacerbation of an acute episode of a long-term condition that cannot be managed within the community environment
		• New models of working. e.g., 7-day on site consultant presence in ED and Acute Medicine and 7-day working models on the site specialising in emergency care
		• Requirement for rapid access to specialist and technical assessments, diagnosis, and treatment across 2 UTC and 1 ED
		• Appropriately staffed specialist clinical teams to deliver timely care
		• Shared workforce through ED/ AEC/ UTC/ CDU
		• Increased utilisation of ACP roles in medical and AHP disciplines
		• Increased utilisation of new roles, such as Nursing Associates, Physician Associates and Operating Department Practitioners
		• Efficient ancillary and administration systems – workforce practices driven by technology

Development of the Surgical and Medical bed base to meet Emergency and Planned Care Treatment	• Development of planned care with planned procedures and operations predominantly at PRH • The transfer of emergency admissions to PRH once on a planned pathway of care • Delivery of emergency medical and surgical diagnosis and treatment at RSH • Greater focus on 7-day working to deliver consistent standards of emergency and IP services 24hrs, 7 days per week • Concentration of provision of Emergency IP services and intense focus on safe acute inpatient care • Enhanced rehabilitation/frailty/discharge to assess model on the site specialising in planned care • Reduction in admissions and LOS associated with long term conditions	**Site specialising in Planned Care** • Development of all clinical and non-clinical workforce to provide more patient focused specialist and quality care provision for patients having planned procedures and operations • Development of AHPs to support 24/7 medical care for patients who have planned surgical procedures and patients transferred on a planned pathway of care (cross-site working) • Appropriate role design for AHPs to enhance career progression • Development of Medical/ Surgical/ Anaesthetic/ Critical Care support to patients at PRH • Provision of a Medical Emergency Team to support care of patients who deteriorate at PRH or attend the enhanced UTC but demonstrate rapid deterioration and require transfer to RSH • Working with WMAS to deliver a process of rapid transfer for deteriorating patients • Development of a Post Anaesthetic Care Unit (PACU) **Site specialising in Emergency Care** • Provision of 7-day working standards for the inpatient bed base • Provision of all emergency and trauma surgery on one site • Provision of specialist teams to deliver timely emergency care • Provide appropriate staffing for the Critical Care Unit • Delivery of inpatient services for Paediatrics, Neonates, Maternity,

Service model	Key service change driving changes	Changes
		Gynaecology, Head and Neck, Stroke and Cardiology **General** • Increase in day case provision • Developing all clinical workforce to work at optimal competency level to provide more patient focused, specialist and quality care provision as well as enhancing role satisfaction and career progression • Development of new roles crossing professional boundaries at advanced and support level • Expansion of roles across all professional disciplines including a focus on improvements for multidisciplinary working and the development of career progression pathways to aid recruitment and retention • Introduction of a 'cluster 'approach to working such that surgical/medical workforce cross cover at subspecialty level • Ancillary and administration support that is appropriate for each site • Efficient ancillary and administration systems - workforce practices driven by technology • Educational programs aligned with need
Day case	• Increased volume of day surgery at PRH	• Scheduling • Increase in demand in advance assistant roles i.e., specialist nurses, physician associates – delivering and or supporting the delivery of minor surgery • Increased use of technology – telemetry, telescopic instruments

In line with our People and Change Plan [Appendix M-09], we have developed a detailed workforce model based on the new model of care, the activity levels anticipated and the agreed Schedule of Accommodation [redacted]. This is discussed in further detail in the Economic Case.

5.7.4 Attracting, recruiting, and retaining staff

As a Trust, we have significant difficulty recruiting people, particularly where there are national shortages such as Medical Staff, Registered Nurses and Therapists. This is partly due to the models of care that are currently in place. To deliver services, we have supplemented our substantive workforce with significant levels of agency support over several years, but our workforce is under increasing pressure and staff turnover is around 12% each year. To address this, we also have a dedicated Recruitment and Retention Strategy [Appendix S-09] which aims to address our high levels of agency staff and develop new roles aligned to our workforce plan. The HTP and new clinical model with an enhanced estate will also help to improve our ability to recruit and retain staff.

The following programmes of work help us to address key challenges:

Recruitment effectiveness

Addressing our recruitment needs by recruiting high quality candidates and improving our international recruitment by exploring partnerships with international hospitals to provide doctors on placement and delivering on-site learning events.

Recruitment experience

Improving the recruitment experience for all candidates by improving the use of technology and introducing a feedback mechanism for candidates.

Brand and reputation

Supporting the enhancement of our brand to improve the reputation of SaTH as a quality employer through improved use of social media and marketing.

Employee retention

Improving retention by analysing why people choose to leave and developing on-boarding practises for new employees. We will also identify high risk, high impact roles and design tailored retention packages to target individuals.

In addition to these key programmes of work, we aim to:

- Engage with academic institutions such as schools, colleges and universities in the area by attending careers events and job fairs locally and nationally.
- Promote return to practise of nurses, doctors and AHPs.
- Increase apprenticeships from entry-level jobs through to senior clinical, scientific and managerial roles.
- Support the delivery of key development programmes.

The HTP will deliver multiple workforce benefits (outlined in our People and Change Plan [Appendix M-09]) and improve recruitment and retention as a result. These benefits include:

- Improved staff facilities, resulting in improved physical and mental health and wellbeing.
- More streamlined services and improved patient flow, improving service delivery and staff engagement.
- A new workforce model, reducing agency usage and rostering gaps, increasing productivity, and improving morale.

5.7.5 Health and Wellbeing of our staff

We are committed to supporting the health, wellbeing and development of all our people, both clinical and non-clinical. We always strive to provide a well led and safe environment which promotes inclusiveness and personal health and wellbeing. We will consider the needs of all staff and ensure that these are factored into the design for the HTP so that we can continue to make our hospitals a great place to work. We understand the need to ensure that staff have a plan to help them achieve their long-term career aspirations and aim to work with our staff to facilitate a rewarding career at SaTH.

We will work collaboratively with our people and their representatives in a proactive and positive manner and act on feedback from the National Staff Surveys and our quarterly Pulse Surveys as well as improving the ability of all leaders to support open and inclusive conversations. We will also continue to review and develop our engagement and wellbeing activity by measuring the results of our people and make sure to keep our policies up to date so that people are able to identify and follow best practise.

We will ensure our communication is targeted and timely, publicising and promoting positive outcomes and interventions for shared learning and celebration. We aim to work with local and regional bodies to support the management of wellbeing so that we can improve in this area.

5.8 Planning for the Transition of Services

As well as considering the transition from a workforce perspective, we are aware that it is important to plan how services will be run. The planning for the transition of services has already begun and must continue to be developed as part of the wider transformation of the clinical model. As part of OBC planning, we have designed a set of high-level principles that will inform our in-depth plans that will be developed as we progress to FBC stage. We have also identified specific areas that are important to consider, and we are aware of the plans that we need to implement in the near future.

The transition of services will broadly differ depending on whether services are currently on a single site or if they are running on two sites, and whether they are remaining at their current site or moving across sites.

The overarching principles for the transition of services include:

Minimising disruption to patients

The decision whether to move a patient will be determined on a patient-by-patient basis, based on clinical assessment. Consideration for when patients are due to be discharged as well as the acuity and ongoing needs of each patient is important. This will inform the decision to either transfer them during treatment or keep them at their original site until they are due to be discharged.

Minimising double running where possible

Workforce limitations prevent some services from transitioning using a ‘big bang’ approach and they will have to be double run as a result. Double running will have both cost and revenue implications which we will want to keep to a minimum. At this stage, we will assume that double running will lead to a 30% uplift on normal running costs due to patients being spread over a wider geography. The most significant impact of double running is likely to be the increase in costs due to closure of the outpatient clinic and a reduction in study leave at the time of implementation to release staff to inpatient areas.

The following areas to be high risk and therefore require consideration when planning for the transition of services as we progress to FBC:

ED

The emergency department will require a phased transition.

The enabling works (explained in more detail in Section 5.2.2) will allow the Emergency Department to continue to function whilst the new department is built. A phased plan has been created with input from the ED clinical team.

Critical Care

Critical Care will also require a phased transition as it is currently delivered across the two hospital sites. This will need to be slowly phased out in parallel with the phased change in clinical activity at both hospitals.

Women’s and Children’s

The approach to transitioning services will continue to be developed through to FBC stage and there are plans in place to develop this in more detail:

Creation of a Logistics Workstream as part of the HTP

This will be an additional workstream to manage strategy and transformation. It will include clinical leadership from each division who are most aware of the drivers behind their workforce and be led by the HTP ‘triumvirate’. They will manage the logistics of the transition to ensure that each service is being considered. Further development of the Logistics Cell will take place during FBC.

The team will agree a month for transition to take place and propose a cessation of leave for relevant staff during this period. They will also have input into the Business Continuity Plans that are being developed for each service to ensure avoidance of harm to patients.

Utilisation of Focus Groups

The planning will be tested with our Focus Groups to ensure that the public are aware of plans. These core Focus Groups are outlined in more detail in Section 5.5.2. They have been and will be involved throughout the entire process.

Public communication is key to ensure that patients arrive at the appropriate site for the service that they require and alignment with our Communications and Engagement Strategy [Appendix M-04] is imperative.

5.9 Arrangements for contract management

Our contract management arrangements will develop throughout the life of the project. In the initial stages, site reviews and appraisals, will play a bigger part and will be responsible for the contractual arrangements with the relevant organisations eventually leading to the completion of the employer's requirements for the scheme. The project scope and brief will continue to be developed through FBC, being 'fixed' on the completion of FBC in partnership with the appointed PSCP using the NEC4 Option C suite of documents. The NEC documents ensure a high degree of collaboration with the contractor and provide the opportunity to appropriately mitigate risks. Further detail of our arrangements for contract management can be found in the Commercial Case. All key project documentation will be approved and formally signed off at the appropriate points by the appropriate parties, including the HTP Programme Board, ICB and SaTH Board of Directors. The approval process will be led by the HTP team.

Once these documents have been signed off, any proposed changes will need to be carefully considered, including the potential impact, and if required taken back to the appropriate party for the change to be authorised. Any proposed or required changes to the scheme in relation to the contract will be managed under a formal change control process as identified under the ProCure23 process and the NEC4 suite of documents.

The Trust's ProCure23 project manager, supported by the associated project team, will own the change control process, and administer a project change register and change approval form, which will document all significant proposed changes, the impact of the change, and who needs to authorise it. They will then seek appropriate sign-off of the change, ensure that the change is implemented, and appropriate documentation is updated as required. Any potential change which may have an impact on the project will be included in the risk register.

In relation to the design and build elements, NEC contracts utilised under ProCure23 frameworks have a robust management process for dealing with change, using the early warning and compensation event process. Any changes which have a significant impact on the project time, cost, or quality will be escalated to the project team or the HTP Programme Board for approval as required.

A full contract management plan for the development will be outlined in the FBC when negotiations are finalised with the appointed PSCP Contractor.

Our contract management process will ensure that our appointed contractor(s) deliver, and we as the client receives the goods and services required at the right price, at the right time, to the right place and to the agreed quality. Informal communication with the PSCPs has already commenced. These initial sessions have provided an opportunity to give suppliers confidence that the HTP is a significant commercial opportunity and allowed us to collect feedback.

The contract management arrangements will develop throughout the life of the project and, in the instance of the key contractual relationship with the PSCP, it will be supported by the established methodology of the NEC4 form of contract as used in ProCure23 procurement framework.

It is recognised that management of the PSCP contract is critical to successful delivery of the HTP and as part of the project planning which will progress in further detail during FBC, contract management expertise and capacity will be identified with any in-house or external support appointments made with particular focus on NEC4 Project Management best practice. At OBC stage, the Technical Oversight Group has been established to oversee the relationship with the PSCP, as outlined in Section 5.1.1.

Management of contracts and suppliers of other commercial requirements, such as technical advisors and consultants, will similarly use the best practice and behaviours relevant to each requirement. This ensures the supplier/contractor and authority's roles, and responsibilities are clear and managed appropriately. Contract obligations will also be tracked as an explicit activity along with the logging of contractual risks/issues, as outlined in Section 5.4.3.

Any changes considered and then taken forward will ensure risks are allocated to the party best able to mitigate them, with change control process followed for new and updated provisions. These changes will be progressed in line with the HTP governance process to ensure approvals are made with the level of oversight appropriate to the change.

Contract payment mechanisms, including tracking of changes, will form part of the HTP Contract Management Plan that will be developed during FBC.

5.10 Gateway review arrangements

Throughout the remainder of the programme, we will continue to operate within the standard DHSC/NHS gateway process. Table 107 lists the Gateway Review points through the lifespan of the programme that have been discussed as part of this case. The HTP has completed Gateways 0 – 1.2 so far. Gateway 2 will be completed in June 2023 prior to final submission of this OBC.

Table 107: Gateway reviews

Gateway #	Gateway Stage	Description	Approval body	Date
Gate 0	Strategic Assessment	The Call for Action 2014	Trust Board of Directors; NHSE	2014 (continually re-visited, including SOC in Q1 2022/23)
Gate 1.1	Pre-consultation business justification	PCBC	NHSE; CCG Boards	2017
Gate 1.2	Post-consultation business justification	DMBC	NHSE; CCG Boards	2019
Gate 2	Delivery Strategy	OBC	HTP Board; ICS; NHSE; DHSC; HMT	Q1 2023/24
Gate 3	Investment Decision	FBC	HTP Board; ICS; NHSE; DHSC; HMT	Q4 2023/24
Gate 4	Ready for Service	Transition of services	Trust Board of Directors; NHSE	Q3 2026/27
Gate 5.1	Benefits Realisation and Operational Review	Post Completion Review	Trust Board of Directors; NHSE	6 months post completion
Gate 5.2	Benefits Realisation and Operational Review	Post Project Evaluation	Trust Board of Directors; NHSE	2 years post completion

5.11 Summary

We have in place robust performance management and governance arrangements that give confidence that the project will be successfully delivered and reinforce the strong STW ICB commitment and support. The HTP team will work with regional and national regulators following

the Trust Board of Directors approval of the OBC to support the national assurance of the OBC and deliver to the planned timeline.

We have a clear plan, and the resources in place to progress at pace through the remaining business case stages and transition successfully to delivery. We have established robust approaches to managing and mitigating risks through this process and a benefits realisation approach to ensure that the anticipated benefits are delivered and measured.

The Preferred Option will deliver the core DMBC requirements and an improved layout and facilities. The new configuration of services will streamline patient care pathways which will result in better staff and patient experience. The new clinical model will address many of the current problems and deliver significant benefits to our patients across Shropshire, Telford & Wrekin and Powys.

We have strong project management experience and disciplines in place throughout the project, with qualified and capable internal and external resources identified that have a successful track record of delivery within rigorous timescales to ensure delivery.

Following the approval of this OBC, we are confident that we can secure the right resource capacity and capability – both in house and through access to external parties – to deliver the scheme successfully.

6 Conclusion

This OBC clearly outlines the urgent need to address the challenges presented by the current configuration and layout of acute services in Shrewsbury and Telford and to support the provision of long term sustainable, high-quality care for our communities. It seeks approval to rapidly progress and begin implementing these critical changes.

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

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

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

- Delivering the full ambition behind the extensive public consultation (Future Fit).
- Implementing new national standards.
- Establishing a sustainable infrastructure to support the delivery of excellent healthcare.
- The funding available to achieve those changes - the current allocation of funding for this scheme is based on costings, inflation assumptions and national standards from 2016.

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

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

Our proposals offer excellent value for money for taxpayers, with a higher benefit-cost ratio than many public sector schemes (4.4) and a significant positive net present social value. However, this appraisal highlights that if further capital were to become available, Option 4 would deliver greater value to the UK through the increased net present social value and benefit-cost ratio of 4.52.

ProCure 23 (P23) has been selected as the procurement approach for this scheme. To deliver the planned design and investment, the Trust expects to appoint a PSCP in May 2023. We intend to novate our existing design team to the PSCP following regulatory approval to engage the PSCP beyond RIBA Stage 3. The Trust will retain our appointed cost consultants and our construction professional technical advisors for project management after the PSCP is

appointed. The team will be supplemented by other professional technical advisors for quality review of PSCP design changes.

Implementing HTP is financially advantageous generating [redacted] improvement to the financial position by 2037/38 compared to the BAU option, and thus enabling financial sustainability for SaTH and STW ICS.

The Trust has established rigorous governance arrangements (which also involve system colleagues) to support the successful delivery of this project and has a track record of delivering complex infrastructure developments. There are robust risk management arrangements in place to ensure successful delivery. Project timelines are dependent on securing timely progress though gateways. If there are delays in delivery timelines, inflationary pressures are likely to impact capital costs and increase the funding required to deliver the Preferred Option and there is a risk of service collapse.

This OBC seeks approval to progress to the Full Business Case (FBC) with the Core DMBC ('Do Minimum') option as the Preferred Option, with a capital funding requirement of £312m. This OBC also seeks approval for the drawdown of additional capital funding totalling £6.6m to support the development of the FBC and £25m for the delivery of the enabling works scheme.

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

7 Glossary of Acronyms

Acronym	Meaning
2WW	Two-week Wait
A&E	Accident and Emergency
A2HA	Alternative to Hospital Admission
ADE	Adverse Drug Event
AEC	Ambulatory Emergency Care
AHP	Allied Health Professional
BAF	Board Assurance Framework
BAU	Business as usual
BCR	Benefit-Cost ratio
BIM	Building Information Management
BRE	Built Environment Research
BREEAM	Building Research Establishment Environmental Assessment Method
CAGR	Compound annual growth rate
CCG	Clinical Commissioning Group
CCOT	Critical Care Outreach Team
CCS	Crown Commercial Services
CDC	Community Diagnostic Centres
CDE	Common Data Environment
CDEL	Capital Departmental Expenditure Limit
CDU	Combined Day Unit
CE&OD	Community Engagement and Organisational Development Group
CEO	Chief Executive Officer
CHOC	Children's Haematology and Oncology Centre
CIA	Comprehensive Investment Appraisal
CIP	Cost Improvement Plan
CITTB	Issue Client Invitation-to-Tender Brief
CQC	Care Quality Commission
CRB	Cash Releasing Benefit
CSF	Critical Success Factor
CWAS2	Construction Works and Associated Services 2
D&C	Demand and Capacity
DAART	Diagnostics, Assessment and Access to Rehabilitation and Treatment
DBFO	design, build, financing and operational
DCP	Development Control Plan
DH	Department of Health
DHSC	Department of Health and Social Care
DMBC	Decision Making Business Case
ED	Emergency Department
EHIA	Equality Health Impact Assessments
EMRAM	Electronic Medical Record Adoption Model
EPR	Electronic Patient Records
ERIC	Estates Return Information Collection
F&E	Furniture and Equipment
FBC	Full Business Case
FDP	Frontline Digitisation programme

Acronym	Meaning
FTE	Full time equivalent
GIA	Gross Internal Area
GMP	Guaranteed Maximum Price
GSL	Government Soft Landings
HBN	Health Building Notes
HBN	Hospital building notes
HIMSS	Healthcare Information and Management Systems Scale
HMRC	His Majesty's Revenue & Customs
HMT	His Majesty's Treasury
HPCG	Healthcare Premises Cost Guide
HROD	Human resources and organisational development
HTM	Health Technical Memoranda
HTP	Hospital Transformation Programme
HVAC	HVAC
I&E	Income and Expenditure
IA	Implementation Advisor
IAS	International Accounting Standards
ICB	Integrated care board
ICS	Integrated Care System
IDC	Integrated Delivery Committee
IFRS	International Financial Reporting Standards
IPC	infection prevention and control
IRP	Independent Reconfiguration Panel
ITT	Invitation to Tender
JFP	Joint forward plan
JIC	Joint Investment Committee
JSNA	Joint Strategic Needs Assessments
KPI	Key Performance Indicator
LA	Local Anaesthetic
LCTP	Local Care Transformation Programme
LOS	Length of Stay
LTC	Long Term Conditions
LTFM	Long Term Financial Model
LTP	Long term plan
MDF	Minimum Digital Foundation
MFFD	Medically fit for discharge
MLU	Midwifery-Led Units
MMB	Modern Methods of Construction
NOF	NHS Oversight Framework
MPUFT	Midlands Partnership University Foundation Trust
NCRB	Non-Cash Releasing Benefit
NHP	New Hospital Programme
NHSE	NHS England
NPSV	Net present social value
NZC	Net Zero Carbon
OBC	Outline Business Case
ODP	Operating Department Practitioners

Acronym	Meaning
OJEU	Official Journal of European Union
OPD	Outpatient Department
P23	ProCure23
PACU	Post-Anaesthetic Care Unit
PAM	Premises assurance model
PAS	Patient Administration System
PCBC	pre consultation business case
PDC	Public Dividend Capital
PLACE	Patient Led Care Environment
PMO	Project Management Office
POD	Point of delivery
PPE	Post project evaluation
PRH	Princess Royal Hospital
PSCP	Principal Supply Chain Partner
PUBSEC	Public Sector Building Non-Housing
QALY	Quality Adjusted Life Year
QOF	Quality and Outcomes Framework
QS	Quantity Surveyor
RCEM	Royal College of Emergency Medicine
RCP	Royal College of Practitioners
RIBA	Royal Institute of British Architects
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital
RSH	Royal Shrewsbury Hospital
RSP	Recovery Support Programme
RTT	Referral to Treatment
SaTH	The Shrewsbury and Telford Hospital NHS Trust
SB	Societal Benefit
SBS	Shared Business Services
SDEC	Same Day Emergency Care
SOC	Strategic Outline Case
SoCF	Statement of Cash Flow
SoCI	Statement of Comprehensive Income
SoFP	Statement of Financial Position
SRO	Senior Responsible Officer
STW	Shropshire, Telford & Wrekin
SWOT	Strength, Weakness, Opportunity & Threat
TIF	Targeted Investment Fund
TOG	Technical oversight group
TUPE	Transfer of Undertakings for Protection of Employment
UEC	Urgent and Emergency Care
UTC	Urgent Treatment Centre
VAT	Value Added Tax
W&C	Women and Children
WGLL	What Good Looks Like
WLI	Waiting List Initiative
WMAS	West Midlands Ambulance Service University NHS Foundation Trust

8 Appendices

Ref	Item
Strategic Case	
1. S-01	Pre-consultation response and PCBC
2. S-02	Consultation Response and DMBC
3. S-03	SOC
4. S-04	Integrated Care Partnership Strategy
5. S-05	Digital strategy
6. S-06	Digital roadmap
7. S-07	Green Plan
8. S-08	Social Value Model
9. S-09	Recruitment and Retention Strategy
10. S-10	Trust Equality and Diversity Policy
11. S-11	Estates strategy, regional and ICS (including Development Control Plan)
12. S-12	Trust Estates Plan, with the HTP addendum
13. S-13	Change Control Process
[redacted]	[redacted]
[redacted]	[redacted]
16. S-16	Trust Clinical Strategy
17. S-17	ICS Letter of Support and all major commissioning bodies
[redacted]	[redacted]
Economic Case	
19. E-01	Long list appraisal
20. E-02	Risk appraisal
21. E-03	Qualitative options appraisal
22. E-04	CIA Model
23. E-05	Option Summary Cost Plan and Capital Cost Forms (OB forms)
	Optimism bias assessment
[redacted]	[redacted]
25. E-07	Meeting arrangements for option agreement
26. E-08	Lifecycle Costs
27. E-09	Quantitative options appraisal
Commercial Case	
28. C-01	Commercial and Procurement strategy
29. C-02	RIBA Stage 2 Design report
[redacted]	
[redacted]	[redacted]
[redacted]	[redacted]

Ref	Item
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
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[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
45. C-03	Planning - letter of support from local planning authority with conditions
[redacted]	[redacted]
47. C-05	Procurement documentation
48. C-06	Travel and transport plan
49. C-07	Completed NHS premises assurance model (PAM)
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	
[redacted]	[redacted]
Financial Case	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
Management Case	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
61. M-04	Communications and engagement plan (includes summary of user groups / focus groups)
62. M-05	Completed NHSE checklist
[redacted]	[redacted]
[redacted]	[redacted]

Ref	Item
65. M-08	Governance groups Terms of reference
66. M-09	People and Change Plan (Trust Workforce Strategy)
67. M-10	Local Care Transformation Programme plans
[redacted]	[redacted]
69. M-12	HTP / Trust Risk Management Strategy
70. M-13	Evidence of compliance with Government Soft Landings (GSL)
[redacted]	[redacted]
72. M-15	Trust Operational Plan