Committee and Date	Item No
Joint Health Overview and Scrutiny Committee 19 December 2011 2.00 p.m.	**3** Public

TELFORD & WREKIN COUNCIL/SHROPSHIRE COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview and Scrutiny Committee held on Tuesday, 23 August 2011 at 5.00 pm in the Reception Suite, Civic Offices, Telford

PRESENT – Councillor D White (TWC Health Scrutiny Chair) (Chairman), Mr D Beechey (SC), Councillor K Calder (SC), Ms D Davis (TWC), Councillor V Fletcher (TWC), Ms J Gulliver (TWC), Councillor T Huffer (SC), Councillor J Minor (TWC), Mr R Shaw (TWC) and Ms A Thorn (SC)

Officers – V Beint (Corporate Director: Health & Care, SC), P Taylor (Social Care Specialist, TWC), S Jones (Scrutiny Group Specialist, TWC), F Howe (Committee Officer, SC), P. Smith (Democratic Services Team Leader, TWC)

JHOSC-8 APOLOGIES FOR ABSENCE

Councillor G Dakin (SC Health Scrutiny Chair)

JHOSC-9 DECLARATIONS OF INTEREST/PARTY WHIP

None

JHOSC-10 MINUTES

RESOLVED – that the minutes of the meeting held on 16 July 2011 be confirmed as a correct record.

JHOSC-11 THE FUTURE CONFIGURATION OF HOSPITAL SERVICES: OUTLINE BUSINESS CASE

Adam Cairns (Chief Executive, Shrewsbury & Telford Hospital NHS Trust), Steve Jarman-Davies (NHS Telford & Wrekin), Kate Shaw (Programme Manager, Shrewsbury & Telford Hospital NHS Trust) and Nick Henry (Divisional Manager, West Midlands Ambulance Service) were in attendance for this item.

Adam Cairns gave a presentation to Members on the Outline Business Case (OBC) for the proposals for the future configuration of hospital services in Shrewsbury and Telford. This followed extensive public consultation on the strategic options and subsequent approval by the Hospital Trust and Primary Care Trusts Boards of Option 2 – to move some services from Shrewsbury to Telford and some services from Telford to Shrewsbury. A copy of the full OBC document had been sent to Members in advance of the meeting.

The OBC had been prepared in accordance with Department for Health and Treasury guidance, and followed the approved format of the Five Case Model, which allowed the proposals to be explored from the following perspectives:
1) the Strategic Case – this included looking at demographic changes and assessing the future capacity needs for acute services. The Trust was committed to moving into the upper performance quartile for length of stay – which potentially could lead to a reduction of 217 in-patient beds over the next five years. For each of the medical specialisms affected by the reconfiguration, productivity improvements had been agreed with clinical staff, which would feed into the future capacity requirements.
2) the Economic Case – a full appraisal (both non-financial and financial) had been made of all the shortlisted options for the physical configuration of services on each of the hospital sites. Following detailed analysis, the preferred option at the Princess Royal site was a new 2 storey development for paediatric services. This would be an extension to the existing pattern of buildings, and would allow for the postnatal ward and assessment to be co-located with obstetrics and neonatology. The preferred option at the Royal Shrewsbury site was for no new-build, with all the reconfigured services to be accommodated through conversion or refurbishment of existing facilities and buildings.
3) the Commercial Case – this tested the likely attractiveness of the preferred options to developers, and outlined the approach of using the Department of Health's P21+ best practice framework to deliver the project. P21+ offered best value in terms of capital and revenue costs through improved efficiency and elimination of waste.
4) the Financial Case – the capital cost of delivering the improvements was £28.6m at the Princess Royal site and £6.2m at the Royal Shrewsbury site. This was well within estimates, and NHS capital spending allocations. There would be an additional annual revenue cost of £1.5m in 2014 rising to £1.6m in 2021. This would be mitigated through savings generated by the Trust's Cost Improvement Plan. It was stressed that while there was an additional cost arising from the re-configuration of services, the 'do nothing' option would result in cost pressures of between £2.4m and £3.2m per annum in increased maintenance costs etc.
5) the Management Case – this highlighted implementation issues and demonstrated the Trust's capability for delivery.

The OBC would now go to the Trust Board (on 25 August) for approval, and subsequently to the Primary Care Trust Boards and the Strategic Health Authority. Once approved, a Full Business Case would be developed, including support to a capital loan request of £34.98m.

Members then asked a number of questions, and sought clarification on various elements of the Outline Business Case, including:

- **the Cost Improvement Plan** – Adam Cairns stated that the Trust was aiming to achieve revenue savings of £20m next year, which would put it in a strong financial position. It was anticipated that significant savings could be achieved by reducing the use of locum doctors and agency nurses. In response to questions, Mr Cairns stated that he was very confident that the savings could be achieved through being more efficient and delivering services in a different way that reflected the outcomes that patients wanted. In relation to reducing the use of agency nurses, this was already being implemented and there had been a 37% reduction in their use during July 2011. There was a clear step by step plan to realise the identified savings.
- **The list of consultation/engagement events** in Chapter 6 should also have included the JHOSC visit to the Royal Shrewsbury Hospital and the JHOSC meeting in February 2011.
- **Progress of discussions with partner organisations and stakeholders** – Adam Cairns reported that the West Midlands Ambulance Service and their Welsh counterparts had developed much closer co-operation which meant their control rooms could now talk to each other. There was an improving relationship with health bodies in Wales.
- **Potential job losses** – as reported recently in the local press. Adam Cairns stated that there would be fewer people as a result of the proposals, but that this could be managed through natural wastage and staff turnover. As part of the drive to reduce the use of locum doctors and agency nurses, the Trust would be looking to recruit more of its own doctors and nurses.
- **Proposals for transport links/provision between the two hospital sites** – Adam Cairns and Kate Shaw reported that discussions and consultations were taking place on a proposed shuttle bus between the two sites. The Trust would be producing an overarching travel/transport plan to address these issues
- **The availability of an “out of hours” consultant at the proposed Paediatric Assessment Unit at the Royal Shrewsbury Hospital.** Adam Cairns clarified that in the night time period, the priority if a child needed to be admitted would be to get them to the Princess Royal Hospital. However, in an emergency situation at the RSH, a consultant could be called in to assist the A&E team to stabilise a child prior to transfer to Telford or Birmingham. In response to a question concerning the current position of paediatricians on the proposals, Mr Cairns advised that, while not everyone was strongly in favour of the proposals, they had signed them off as safe and deliverable. Some individuals were engaging positively in the process of change.
- **Estimates of Capital costs** – in response to questions, Adam Cairns stated that the proposals had been thoroughly costed and tested by professional advisors. He was therefore confident that the figures in the OBC were sound. It was not possible to move revenue expenditure into capital spending.

- **Discharge of patients from hospital** – how could this be speeded-up? Adam Cairns advised that various initiatives were being examined to improve patient turnover, including making sure the patient's "go-home" medication was available sooner, getting patients discharged from wards before 12 noon, and a better interface with community services.
- **Patient appointments** – in terms of getting more patients to the right place at the right time, Adam Cairns reported that administrative systems were being rigorously reviewed so that by April 2012 there would be less duplication and more efficient processes.

The Chairman reminded Members that attached to the agenda was the latest update from SaTH to the issues previously identified by the Joint Committee for monitoring.

In the light of the latest updates from SaTH and the responses provided to the Committee's questions, Members were satisfied that the Outline Business Case had been properly scrutinised.

RESOLVED - that the Joint Health Overview and Scrutiny Committee support the proposals laid down in the Outline Business Case, and note the reassurances indicated within the assurance grid.

JHOSC-12 SHROPSHIRE COMMUNITY HEALTH NHS TRUST

Jo Chambers (Chief Executive, Shropshire Community Health NHS Trust), was in attendance for this item, and provided an update on the progress of the Trust following its establishment on 1 July 2011.

The new Trust covered both the Shropshire and Telford & Wrekin administrative areas, and served a population of 459,600 people. It had a budget of £77m in 2011/12, and employed around 2,000 people. Services provided included child and adolescent mental health services, health visiting, community hospital & community services, and sexual health services. The Strategic Objectives of the Trust were explained, along with some of the quality assurances that had been provided by external regulators on the services provided. In terms of modernising local services, new community facilities had been provided in Telford (Euston House) and Oswestry (Primary Care Centre), refurbishments were being carried out at Community Hospitals in Bishop's Castle, Bridgnorth and Whitchurch, and a new Community Hospital was to be built in Ludlow (start on site in 2012, subject to appointment of contractor). Other priorities for developing local services included increasing the number of health visitors, helping people to get home quickly after a hospital stay, and using 'telehealth' to support patients not in hospital. Among the challenges facing the Trust were an increased demand for services and financial constraints arising from general reductions in public spending. The Trust would need to find 4.5% efficiency savings each year.

Members then questioned Jo Chambers on a number of issues, including:

- the variable success in tackling teenage pregnancy rates
Response – it was accepted that the picture was variable across the county, and in those areas where rates were still high, the Trust would be looking to do more of the things that were working well elsewhere.

- what sorts of services were being moved into the community, particularly for older people?
Response – for older people, there were some community matrons who had the right sets of skills, and more of these posts could be provided if GPs and commissioning bodies felt it to be necessary. The Hospital Trust was looking to support the provision of services in the community (eg through use of new technology), but there would need to an agreement as to whether it was worthwhile for consultants to attend community facilities.

- the development of an ophthalmology service at Euston House, Telford , for which the Joint Committee had asked for an update on, and the priority for community services in the Telford & Wrekin area given that it did not have a community hospital.
Response – information on the ophthalmology service would be forwarded. All the community hospitals were available to patients from anywhere in the county. In Telford, there were now nurse consultants, who could provide a higher level of care for patients in their home.

- What was the brief from the Primary Care Trusts to the Community Health Trust, and were they monitoring value for money?
Response – There was a brief from the PCTs on what sort of service they expected. In terms of value for money, the main focus was on looking at how staff spent their time each day - with a view to identifying more efficient ways of working.

- what checks and balances were in place to monitor performance and patient satisfaction?
Response – there were monthly contract meetings with both commissioning bodies, and a monitoring process to look at patient activity. Patient feedback was collated from various sources and methods.

- how would the new Trust build up reserves and balances over the next 3 years without affecting services?
Response – The Trust wanted to re-invest any savings in services rather than build-up a large amount of reserves. The reserves were being maintained at the minimum level required (around 3% of turnover). The Trust was able to borrow money for things like essential maintenance work and repairs.

The Chairman stated that, in terms of the transfer of care from hospital to the home or community, it was important that carers and family members were given sufficient information (and training if necessary) on the patient’s care needs before they returned home. More awareness was also needed on the support services available to patients and their families.

RESOLVED – that the position be noted.

JHOSC-13 GYNAECOLOGICAL CANCER SERVICES

Attached to the agenda was a briefing note from the Director of the Greater Midlands Cancer Network, in response to a request from the Joint Committee for an update on the outcome of the audit on the pathways for gynaecological cancer patients and how patient record access and transfers were being addressed.

The response stated that a small number of patients were being treated at Wolverhampton or Stoke in accordance with the plans presented previously to the Joint Committee. No difficulties had been encountered, and any radiotherapy or chemotherapy was being delivered locally in Shrewsbury as planned. The patients' experience survey was in the detailed planning stage, and user groups had been very useful in the design. It was expected to start collecting information before the end of the year. The 'Somerset system' was in place in all the Trusts within the network, and was capable of sharing patient information such as waiting times, diagnostics carried out and any treatment decisions made..

RESOLVED - that the interim report be noted, and that the matter be considered at a future meeting.

JHOSC-14 CHAIRMAN'S UPDATE

The Chairman reminded Members of the Joint Committee that they were invited to attend a visit to the Hamar Centre at Royal Shrewsbury Hospital on 12 September, organised by the Shropshire Council Health & Community Scrutiny Committee. This would enable Members to see what services were provided at the Centre and to speak to staff etc.

The Chairman also reported on a regional health scrutiny meeting he had recently attended. There had been an update on the consultation around children's heart surgery, and was reassured that under all options being considered, Birmingham Children's Hospital and Alder Hey Children's Hospital, Liverpool would be retained as centres of excellence for paediatric surgery.

The meeting closed at 7.15 pm

Chairman……………………………………

Date……………………………………………

4

The Shrewsbury and Telford Hospital NHS Trust Service Variation Status Report
Last Updated 05 December 2011

Service Variation	Programme or Source	Overview	Lead	Current Status	Next Steps	Engagement
Open Service Variation Issues						
2010/01 **Single site vascular surgery**	Future Configuration of Hospital Services (FCHS)	A single site for vascular surgery is part of the reconfiguration of inpatient and emergency surgical services within the FCHS programme. This will help to ensure safe and sustainable acute surgery in the county, and support our aspirations to be a centre for AAA screening (see below). It is planned to transfer inpatient vascular surgery for the small number of cases currently performed at PRH to RSH during 2012.	**SATH** Clinical Lead: Mr Tony Fox Management Lead: Sara Biffen	The Full Business Case (FBC) for the reconfiguration of hospital services is currently being developed. This includes the design of the reconfigured surgical services at RSH and supporting pathways and workforce needs. The FBC is expected in Spring 2012.	December 2011: Submission of the planning application for the development of new facilities at the Princess Royal Hospital. To Spring 2012: Continue with the development of the FBC and the delivery of the wider FCHS programme , including: • ongoing assurance • models of care and implementation, and • communication and engagement.	There has been ongoing engagement since the end of consultation, with regular public briefings, attendance at meetings in local communities, newsletters and website information. The Communications and Engagement plan for this phase of the reconfiguration programme is in place. This includes a wide range of engagement and involvement activities from regular newsletters to focus groups and from staff briefings to public presentations and question and answer sessions.
2010/02 **Women and Children's Centre at PRH**	Future Configuration of Hospital Services	The development of a Women and Children's Centre at PRH will enable the consultant maternity unit, inpatient paediatric ward and Rainbow Unit to move out of the deteriorating maternity building at RSH. Consolidating the inpatient paediatric service at one site will also enable safe and sustainable medical rotas within paediatrics. A wide range of specialist Women and Children's services will continue to be provided at RSH (Midwife-Led Unit, Paediatric Assessment Unit,, Outpatients, Day assessment etc.)	**SATH** Clinical Lead: Mr Andrew Tapp Management Lead: Cathy Smith	The Full Business Case (FBC) for the reconfiguration of hospital services is currently being developed. The building plans for the Women and Children's Centre have been developed by Aedas architects with the involvement of clinicians, staff, patients, parents, carers and the public. The plans for the refurbishments required at RSH are currently being developed.	As above	As above
2010/03 **Acute Surgery Centre at RSH**	Future Configuration of Hospital Services	See 2010/01	**SATH** Clinical Lead: Mr Tony Fox Management	See 2010/01	See 2010/01	See 2010/01

Service Variation	Programme or Source	Overview	Lead	Current Status	Next Steps	Engagement
			Lead: Sara Biffen			
2010/06 **Cancer Centre Development at the Royal Shrewsbury Hospital**	Local Service Development	A £5m development is underway to improve cancer and haematology outpatient and day facilities at the Royal Shrewsbury Hospital, including a new outpatient unit for haematology and oncology patients, a day unit for chemotherapy and head and neck cancer patients and a new reception area. This development has been funded through charitable donations from a range of charities including the Lingen Davies Cancer Appeal, Shropshire Blood Trust Fund, Shropshire Head and Neck Charity and the League of Friends of the Royal Shrewsbury Hospital.	**SATH** Clinical Lead: Dr Srihari Management Lead: Julia Clarke	Building is currently underway, and we are on target for completion of build by Summer 2012. A public competition has led to the unit being named “The Lingen Davies Centre” and following a public art competition a shortlist of finalists will be exhibited shortly.	Continue building work, and continue to engage with users and the public. Prepare for completion and launch of new facilities Continue fundraising through Lingen Davies for equipment for the new Centre.	Key activities have included: • 18/2/11 – Staff engagement event (5-7pm) • 10/5/11 – Public engagement event (6-8pm) • 10/5/11 Launch of naming and art competitions • 9/6/11 – Staff interior design event (1-5pm) • 24/6/11 – DDA Group – new build meeting (2.30-3.30pm) • 20/7/11 – Turf cutting ceremony (3.30-5pm) • 23/8/11 Formal launch of build by Interserve (1-4.30pm) • 26/9/11 Interior design workshop for staff and public (4-6pm) • 20/10/11 Results of naming competition announced and shortlisted art entries competition entries chosen • 8/11/11 -meeting with rep from T&W LINk to discuss DDA issues Next steps include a public exhibition of the shortlisted artworks. Selected artworks will be displayed in the Centre.
2011/01 **Trauma Unit at RSH**	Development of Regional Trauma Network	There is a regional process to designate hospitals as Trauma Centres, Trauma Units and Local Emergency Hospitals. Our application for Trauma Unit designation for the Royal Shrewsbury Hospital has been accepted.	**West Midlands Specialised Commissioning** Clinical Lead: Dr Rob Law Management Lead: Kerry Malpass	Submission for designation has been submitted and we have been approved as a Trauma Unit subject to meeting the designation standards. We have a plan in place to achieve this.	To March 2012: Continue to implement plan for Trauma Unit at RSH	West Midlands Specialised Commissioning is holding a Trauma Care Implementation Planning Day in Birmingham on 19 December. This event is open to key stakeholders including patient groups, LINks and HOSCs.
2011/02 **AAA Screening Centre at RSH**	Development of national AAA screening programme	As part of the national Abdominal Aortic Aneurysm (AAA) screening programme the Trust will invite 65 year old men registered with Shropshire and Telford and	**National AAA Screening Programme** Clinical Lead – Mr Tim Sykes	The programme is on target to start calling men for screening from April 2012. The AAA screening programme for Wales is due	Technicians are in post and have started their training, whilst recruitment will begin shortly for the screening coordinator and other support posts.	We propose a presentation to the Joint HOSC in January 2012, including a demonstration of the kit and scanning process. An update will be included in the

Service Variation	Programme or Source	Overview	Lead	Current Status	Next Steps	Engagement
		Wrekin GP practices for a simple ultrasound scan undertaken by a trained screening technician. Screening sessions will be held locally in GP practices and community hospitals.	Management Lead – Kate Shaw	to launch later in 2012/13. Links have been made to ensure that a joined up service is provided for men in the borders.		next edition of Looking To The Future and in GP Connect. A Communication and Engagement Plan has been developed and approved by the AAA Screening programme steering group.
2011/03 **Transforming Care Programme – Bed Bundle and Bed Reconfiguration**	Transforming Care Programme	The Trust currently has significantly more beds than similar hospitals. However, we are funded based on the average for hospitals in England, and as a result our resources are spread too thinly. We also do not have effective systems for increasing and decreasing capacity to reflect seasonal and other changes in demand. In terms of patient experience, too many patients face inconvenience through delays in hospital, delays in being discharged, multiple moves between wards and other issues that do not add value to their care. As a result the Trust is introducing a new BED Bundle to improve care for patients (covering Board round by 9.30am, Expected Date of Discharge, Discharge by midday for 50% of patients, and the first patients to be transferred from MAU to medical wards by 10am), and making changes to ward configuration.	**SATH** Clinical Lead: Dr Ashley Fraser Management Lead: Peter Skitt	The first phases of bed reconfiguration have taken place at both hospitals, and work is underway to embed the BED Bundle across the Trust.	Continue with the next phase of bed reconfiguration, which is expected to include some of the surgical changes linked to the Future Configuration of Hospital Services programme. Clinically-led discussions are also underway on options for sustaining and improving some specialist inpatient medical services, including endocrinology. This may include options for retaining the majority of care for the majority of patients at both hospital sites whilst consolidating specialist inpatient care for a small number of patients with more complex conditions to one of our two sites.	An occasional Transforming Care bulletin is issued to the Chairs of the Health Overview and Scrutiny Committees and is also published on the Trust website. Updates are provided to local meetings and stakeholder groups (e.g. Shropshire and Mid Wales Cancer Forum).
2011/04 **Hospital Switchboard services**	Local service development	Major improvements are needed to Trust switchboard services before the current systems become obsolete and potentially beyond repair. A major replacement programme is underway to install a modern Voice over Internet Protocol (VoIP) system. This new technology makes the option of retaining two independent switchboard operator systems	**SATH** Management Lead: Chris Needham	Consultation with staff is currently underway and will end on 21 December 2011. A further update will be available following staff consultation.	Conclude consultation with staff, and implement changes based on the outcome of consultation.	Staff consultation is currently underway. Through local media we have invited interested patients and carers to be involved in workshops and focus groups.

Service Variation	Programme or Source	Overview	Lead	Current Status	Next Steps	Engagement
		both financially and technically unsustainable. It also gives us opportunities to review the way we provide telephony and switchboard services to: • Improve the patient and public contact experience with the Trust • Improve communication facilities for staff • Use technology to make it easier for callers to reach the relevant department, which will in turn reduce the number of calls handled by telephonists so that those people who most need to talk to an operator are able to do so • Reduce the waiting time for callers and dropped calls • Reduce on-going revenue maintenance costs for the telephony system				
2011/05 **Patient and Visitor Car Parking**	Local service development	The Trust is currently reviewing parking arrangements at our hospitals. Whilst it is anticipated that there may be some changes in car parking charges for the first time in five years, it is also intended to introduce improvements such as payment on exit, improved concessions and improved publicity for concessions.	**SATH** Management Lead: Chris Needham	Patients and communities were asked to provide feedback via our "A Healthier Future" newsletter on October/November	Continue to develop options and communicate widely. Ensure improved publicity for concessions available, for example through the Healthcare Transport Costs Scheme and local concessions for regular visitors and people on long term treatment plans. Improve awareness amongst staff of the concessions so that they are able to promote these to patients and visitors.	Patients and communities were asked to provide feedback via our "A Healthier Future" newsletter on October/November. Development of options draws on feedback from patients and visitors and best practice (e.g. Which? charter for hospital car parking and "Fair For All Not Free For All" guidance)
2011/06 **Pathology Services**	National independent report by Lord Carter on the future of pathology services	Lord Carter's report set out proposals for sustaining the quality and cost-effectiveness of pathology services across the country. Work is underway across the country to consider options for sustaining and improving	**Strategic Health Authority**	Local discussions are being led by the Strategic Health Authority on the development and implementation of managed pathology networks across the region. The Shrewsbury and Telford Hospital NHS Trust is working with Sandwell and West Birmingham Hospitals NHS Trust, Walsall Healthcare NHS Trust, The Dudley Group NHS Foundation Trust and Robert Jones and Agnes Hunt NHS Foundation Trust (for whom we provide pathology services) on the development of sub-regional pathology network arrangements. These discussions are expected to lead to changes in the way in which pathology laboratory services are delivered in future.		

Service Variation	Programme or Source	Overview	Lead	Current Status	Next Steps	Engagement
		pathology services.				
2011/07 **Telehealthcare**	Local service development	We aspire to provide more care outside hospital settings, using the latest technology to provide safe convenient care closer to home.	**SATH** Clinical Leads: Dr Darren Warner and Mr Mark Prescott	Telehealthcare plans are currently at a developmental stage, with discussions underway with health and care partners, technology providers and patients & public representatives.	Continue exploratory work to devise and agree telehealthcare plans and priorities.	A joint conference between the Trust, local PCTs and the Institute for Rural Health took place at the Royal Shrewsbury Hospital. Further activities will be planned as these discussions progress.
Closed Service Variation Issues						
2010/04 **Renal Dialysis Satellite Unit in Ludlow**	Local service development	Develop a Renal Dialysis Satellite Unit in Ludlow	**SATH** Management Lead: Kerry Malpass	The renal dialysis satellite unit is now fully operational and providing renal dialysis for 8 patients, with scope to expand for a further 8 patients subject to changes in demand.	N/A	An official opening was held on 22 November involving patients, staff, League of Friends of Ludlow Hospital, representatives from The Shrewsbury and Telford Hospital NHS Trust and representatives from Shropshire Community Health NHS Trust
2010/05 **Sterile Services**	Local service development	Consolidation of sterile services to a single state of the art off-site facility in Telford.	**SATH** Clinical Lead: Mr Tony Fox Management Lead: Gerald O'Hara	Queensway is now fully operational and continues to deliver decontamination services to both SATH and the wider health community	Continue to identify opportunities to further develop the service.	Continue to identify opportunities to further develop the service.
2010/06 **Ludlow Midwife Led Unit Refurbishment**	Local service development	Refurbishment of facilities at the Ludlow Midwife Led Unit to improve and maintain standards of facilities ahead of the planned move to the new Ludlow Hospital in 2014.	**SATH** Clinical and Management Lead: Cathy Smith	Work was completed on schedule. Inpatient services needed to be suspended whilst the works took place, but community midwives continued to provide a local service.	N/A	N/A

4(i)

The Shrewsbury and Telford Hospital
NHS Trust

The Future Configuration of Hospital Services

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

Volume 2: Executive Summary

19 September 2011 – amended version

1.0 Executive Summary

1.1 Introduction

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

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

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

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

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

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

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

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

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

1.2 Public Consultation and Assurance

1.2.1 Strategic Options

The Trust initially identified four strategic options for appraisal:

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

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

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

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

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

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

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

1.2.2 The Proposals

Surgery

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

Maternity/Gynaecology/Neonatology

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

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

Children's Services

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

1.2.3 "Keeping It In The County"

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

1.2.4 The Assurance Framework

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

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

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

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

1.2.5 The Outcome of Consultation and the development of the OBC

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

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

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

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

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

1.3 The Strategic Case

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

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

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

1.3.1 Safety and Viability of Services

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

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

1.3.2 Workforce Challenges

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

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

1.3.3 Facilities for Women's and Children's Services

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

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

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

1.3.4 Constraints and Risks

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

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

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

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

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

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

1.4 Planning Assumptions in Developing the Options

1.4.1 Clinical Pathways and Service Briefs

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

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

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

1.4.2 Wider Capacity Planning Assumptions

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

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

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

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

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

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

1.4.3 Efficiency Assumptions for the Reconfigured Services

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

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

1.4.4 Physical Solutions for RSH and PRH

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

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

1.5 Workforce Assumptions

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

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

Key assumptions underpinning this plan are:

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

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

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

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

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

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

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

1.6 Development of the Options

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

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

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

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

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

1.7 Economic Case

1.7.1 Qualitative benefits scoring

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

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

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

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

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

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

1.7.2 Capital Cost Estimates

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

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

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

1.7.3 Revenue cost Estimates

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

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

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

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

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

- Option R0 results in no additional income and expenditure items

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

The table below summarises recurrent income and expenditure assumptions for RSH

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

1.7.4 NPV Appraisal and Ranking

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

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

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

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

1.8 The Preferred Option

1.8.1 Description of Preferred Option for PRH

1.8.1.1 Obstetric and Neonatal Services

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

1.8.1.2 Midwife Led Unit

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

1.8.1.3 Children's Services

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

1.8.1.4 Women's Services

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

1.8.1.5 Head and Neck

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

1.8.1.6 Site Works

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

1.8.2 Description of Preferred Option at RSH

1.8.2.1 Midwife-Led Unit

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

1.8.2.2 Obstetrics

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

1.8.2.3 Children's Services

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

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

1.8.2.4 Surgical Inpatients

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

1.8.2.5 Clinical Support

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

1.8.2.6 Non Clinical Support

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

1.8.3 Design Strategy

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

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

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

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

1.9 Commercial Case

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

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

1.10 Financial Case

1.10.1 Capital Funding Requirement

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

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

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

1.10.2 Impact on the Organisation's I&E Account

The preferred options will allow the Trust:

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

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

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

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

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

1.10.3 Revenue Impact and Affordability

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

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

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

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

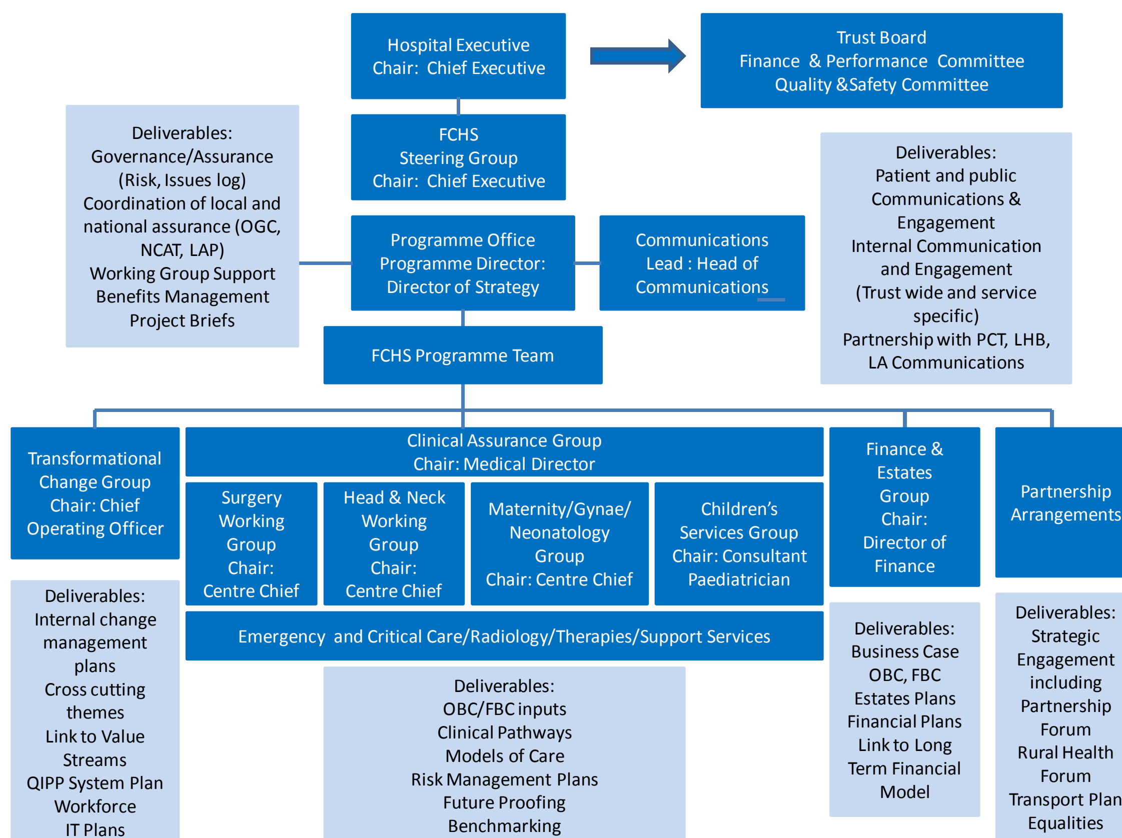
1.11 Management Case: Programme Management Arrangements

1.11.1 Programme Governance

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

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

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



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

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

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

1.11.2 Benefits Management Strategy and Post Project Evaluation

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

1.12 Recommendations

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

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

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

4(ii)

The Shrewsbury and Telford Hospital NHS Trust

Trust Board - 27 October 2011

The Future Configuration of Hospital Services Programme

Executive Lead	Adam Cairns, Chief Executive
Author	Kate Shaw, Future Configuration of Hospital Services Programme Manager Debbie Vogler, Director of Strategy / Programme Director
Strategic Domain	C. Quality and Safety A. Financial Strength
Organisational Objective	C3. Provide the right care, right place, right professional C4. Deliver services that offer safe, evidence, based practice A1. Development and implement sustainable clinical strategies
Executive Summary	This paper provides an update on the Future Configuration of Hospital Services Programme. Key activities since the last update have included: • Planning for this next phase of the programme – including the progression to Full Business Case (see Section 1) • Starting the process for the selection of the Procure 21+ partner for the construction and development at the Princess Royal Hospital (see Section 2) • Maintaining staff, patient, public and stakeholder engagement and involvement (see Section 3) • Continuing the ongoing assurance element of the programme through submissions to the Joint Health Overview and Scrutiny Committee, the Boards of NHS Telford and Wrekin and Shropshire County PCT and the PCT Cluster and Strategic Health Authority (see Section 4).
Recommendations	The Trust Board is asked to: • **NOTE** the plans for progression to Full Business Case and delivery of the wider reconfiguration programme • **NOTE** the process for the selection of the Procure 21+ partner • **NOTE** the ongoing delivery of the Future Configuration of Hospital Services programme

The Future Configuration of Hospital Services Programme

Contribution to Inspection, Registration, Assurance, Performance and Delivery

Risks and Assurance	The Future Configuration of Hospital Services Programme will support the local NHS to address risks to the clinical quality of services.
Contribution to Key Performance Indicators	Not applicable
Compliance with Clinical and other Governance Requirements	The Future Configuration of Hospital Services Programme will support the local NHS to address risks to compliance with a range of clinical safety standards.
Engagement and Decision-Making Process	The Trust Board, Boards of the PCTs and Strategic Health Authority approved the Outline Business Case on 25 August 2011, 13 September and 27 September 2011 respectively. The Outline Business Case was also received and supported by the Joint Health Overview and Scrutiny Committee at its meeting on 23 August 2011. Ongoing public and stakeholder engagement remains central to the programme and will be integral to Phase 2b of the Future Configuration of Hospital Programme. This will continue to support the NHS to address legislative requirements on engagement and consultation set out in Section 242 and Section 244 of the NHS Act 2006 and related policy and guidance.

Strategic Impact Assessment

Quality and Safety	The Future Configuration of Hospital Services Programme will support the local NHS to address risks to the clinical quality of services.
Financial Strength	The proposals are not driven by financial considerations and will not lead to financial savings. Instead they aim to deliver safe, sustainable services within available resources. The financial implications of the option for reconfiguration in terms of capital and revenue detailed within the Outline Business Case and will be refined further within the Full Business Case.
Learning and Growth	There are no immediate workforce implications from this paper. The workforce implications of the option for reconfiguration are detailed within the Outline Business Case and will be refined further within the Full Business Case.
Patients, GPs and Commissioners	The proposals that are being developed further during this phase of the Future Configuration of Hospital Services Programme will change the way that some patients access local hospital services, and the way in which GPs refer some patients to our services. A comprehensive programme to communicate changes with patients and GPs will be needed.
Equality and Diversity	There are no immediate equality and diversity implications from this paper. The potential equality and diversity implications, including issues raised within the PCTs' Equality Impact Assessment during the consultation and assurance phase of the programme, are being considered as part of the Phase 2b delivery programme.
Legislation and Policy	The Future Configuration of Hospital Services Programme will support the local NHS to fulfil legislative requirements for patient and public engagement and policy requirements as set out in government guidance on service configuration.
Communication and Marketing	Communication and engagement activities continue throughout the programme. A communication and engagement plan for Phase 2b of the Future Configuration of Hospital Services Programme is under development and will be submitted to the Future Configuration of Hospital Service Project Board in November 2011.

The Shrewsbury and Telford Hospital NHS Trust

The Future Configuration of Hospital Services Programme

Trust Board Update

27 October 2011

This paper updates the Trust Board on the progress of the Future Configuration of Hospital Services (FCHS) Programme.

Following the approval of the Programme Governance structures at the Trust Board on 29 September 2011 the FCHS Steering Group terms of reference have been reviewed and amended to include a Non-Executive Director; the new Transformation Director; Commissioner; and Procure 21+ Project Director and Manager. These were signed off at the Steering Group on 13 October 2011. The FCHS Project Board will therefore replace the Steering Group with immediate effect. The Project Board will meet monthly and will report progress to the Hospital Executive and Trust Board each month.

Key activities since the last update have included:

- Planning for Phase 2b - delivery of the wider FCHS programme and the progression to Full Business Case (see Section 1)
- Starting the process for the selection of the Procure 21+ partner for the construction and development at the Princess Royal Hospital (PRH) (see Section 2)
- Maintaining staff, patient, public and stakeholder engagement and involvement (see Section 3)
- Continuing the ongoing assurance and partnership elements of the programme (see Section 4).

1. Phase 2b (October 2011 to March 2012)

1.1 The Phase 2b Plan was approved by the FCHS Project Board on 13 October 2011 for discussion and approval at the Hospital Executive Committee on 25 October 2011. Once approved at the Hospital Executive Committee, the Phase 2b Plan will be included in the programmes November update to the Board.

1.2 Phase 2b will be delivered through four main work streams. These are:

- Models of Care and Implementation
- Full Business Case Delivery
- Communications and Engagement
- Partnership and Assurance

A detailed plan for each work stream will be developed by the end of October 2011. This will identify the actions, deliverables and milestones for this phase. The leads and key roles within each work stream, including responsibilities, are detailed within the Phase 2b Plan.

1.3 The assumptions within the OBC (for example the shifts of activity into the community; the bed base at RSH; the impact on critical care etc) will be reviewed during the development of the Full Business Case (FBC).

1.4 The timeline and responsibilities for delivery of the FBC are detailed within the Phase 2b Plan. The FBC is being planned for submission to the Trust Board in March 2012.

1.6 The Strategic Health Authority has supported the Trust to progress with the development of an FBC. The SHA Board have stated that the approval of the FBC will be dependent on the Trusts ability to demonstrate delivery of its Cost Improvement Programme (CIP). This will involve monthly monitoring and the achievement of:

- Closure of beds – 100 beds by the end of March 2011 and the stages to delivery
- Reducing the spending on medical locums and agency
- Reducing the spending on nursing agency

The Trust will also need to demonstrate financial balance. Financial balance alone will not satisfy the SHA's requirements. Delivery of the CIP and financial balance are required if the FBC is to be approved by the Strategic Health Authority.

2. Process and Selection of the Procure 21 + Partner

2.1 The process for selection of the Procure 21+ partner is explained in detail within the OBC. The use of Procure 21+ (P21+) for capital programmes is considered NHS best practice and the framework agreement, governance process, and expert advice is provided by the Department of Health team throughout the selection process.

2.2 P21+ offers many benefits in terms of managing capital and revenue costs through improved efficiency, elimination of waste and the reduction of risks to the project costs and timetable.

2.3 The early identification of a construction partner also removes much of the adversarial nature of the design and construction management process that may result from non-P21+ developments and thus avoids the pitfalls associated with focussing on lowest entry cost as opposed to outturn costs.

2.4 Four potential suppliers have been selected from six initial original Expressions of Interest. These principal supply chain construction organisations will present to the Trusts selection panel on 19 October 2011. The panel includes the Chairman; a Non-Executive Director; Director of Finance; Director of Strategy; Centre Chief and Deputy Centre Chief for Women's and Children's; Associate Director of Estates and Facilities Management; Deputy Director of Finance; and FCHS Programme Manager.

2.5 Once selected, the P21+ partner will work with the Trust to develop detailed plans for the development and construction of the new build at the PRH.

2.6 Due to the estate solutions at RSH being refurbishment rather than new build, the procurement solution of the reconfiguration requirements will be further considered, but are not currently excluded from P21+ process. Potential partners have been asked to include their approach to delivering these refurbishments as part of their presentation.

2.7 A Project Director and Project Manager will be appointed by the P21+ construction partner and will participate within the Project Team and the Project Board.

3. Staff, Patient, Public and Stakeholder Engagement

3.1 A revised Communications and Engagement plan is under development for Phase 2b of the programme and will be finalised by the end of October 2011 for approval at the Project Board on 10 November 2011.

3.2 A brief weekly update will be circulated by the Project Team to the Trust Leadership Team; lead clinicians; Transformation Team and other leads as identified to include 'this week…' and 'next week…'

The requirements within each Clinical Centre for wider engagement and involvement are also being discussed with the Centre Chiefs, Managers and Leads.

3.3 Specific activities since the last update have included:

- **Looking to the Future:** The second edition of 'Looking to the Future' has been shared with interested parties and local stakeholders to keep them informed of progress and seek their views and involvement. 'Looking to the Future is also available on the website, at both hospital sites and within each GP practice within Shropshire and Telford and Wrekin.

- **Special editions:** A Women's Service special edition is in development. A two page article will also be placed in the local free press in the coming weeks to inform the general public of the changes; what it will mean for them and how they can get involved.

- **Visiting established groups and networks:** the rolling programme of meetings with established groups and networks continues. Members of the Project Team attended the local National Childbirth Trust nearly-new sale in Shrewsbury on 8 October 2011 with a stand and information. Over 450 people attended the event and many took away further information and have expressed an interest in being involved in the discussions and focus groups.

- **Revisiting communities:** These meetings are now underway. The Chief Executive, Centre Chiefs/Lead Clinicians and Lead Executives are scheduled to visit Local Joint Committees and Councils throughout October and November 2011. These sessions are aimed at giving local people the opportunity to hear about the latest plans and comment and express their views on what this means to them and their community. In addition, two joint events with the Community Trust, Shropshire County PCT and West Midlands Ambulance will be held in south west and north east Shropshire in November 2011.

Two public/patient briefings will also be held on:

- 8 November, 6-7pm at SECC, RSH and
- 10 November, 6-7pm in the Lecture Theatre, Education, PRH

- **Patient and community focus groups:** The response to the Trusts invitation for people to be part of the programmes focus groups has been very positive and these groups are now established.

  The Paediatric Oncology Focus Groups concentrating on the physical environment; met on 14 October 2011 where an interactive session and discussion was held with the architects and Trust clinicians and officers. This group will meet again on 3 November 2011.

- **Staff discussions:** Two briefings have been arranged to update staff on the programme. These will be held on:

  - 8 November, 11.30am-1.30pm, MR1, Treatment Centre, RSH and
  - 10 November, 12.00-1.30pm in the Lecture Theatre, PRH

- **Website:** The website has been updated and has a new location at www.sath.nhs/future This will continue to provide a web channel to share updates on progress and ask for views. It also contains the clinician's blogs and a regularly updated Frequently Asked Questions from patients and the public. In addition, 'story boards' detailing the progress, options and timelines will be put up at both hospital sites.

4. Ongoing Assurance and Partnership Working

4.1 The ongoing assurance and partnership activities of the programme will be managed within the Partnership and Assurance work stream

4.2 An informal update meeting with the Chairs of the Joint Health Overview and Scrutiny Committee will take place this month. A formal update to the Joint Health Overview and Scrutiny Committee will take place in December 2011.

4.3 The formal report to Strategic Health Authority on the progress of the reconfiguration via the PCTs and PCT Cluster was submitted at the end of September 2011. The next submission will be at the end of November 2011.

4.4 The Office of Government Commerce (OGC) Gateway 2 and 3 reviews are described within the Phase 2b Plan. These are planned to take place in late February/early March 2012.

4.5 The programmes Clinical Assurance Group will meet again in January 2012.

4.6 The next meeting of the Strategic Forum will take place in November 2011. This forum includes: GP Commissioners and the PCTs; Betsi Cadwaladr University Health Board; Powys Teaching Health Board; West Midlands Ambulance Service; Welsh Ambulance Service; and lead officers within the Trust. The aim of this forum is to share progress and

promote working together as each organisation undertakes reconfigurations and service change.

5. Recommendations

5.1 The Trust Board is asked to:

- **NOTE** the plans for progression to Full Business Case and delivery of the wider reconfiguration programme

- **NOTE** the process for the selection of the Procure 21+ partner

- **NOTE** the ongoing delivery of the Future Configuration of Hospital Services programme

4(iii)

Assurance Grid - Recommendations from the Local Assurance Panel, National Clinical Advisory Team, Office for Government Commerce, Joint Health Overview and Scrutiny Committee and Equality Impact Assessment: Current Position, Next Steps and Ongoing Assurance
18 August 2011

	Area	(a) LAP	(b) OGC	(c) NCAT	(d) Joint HOSC	(e) EqIA	(f) Current Position	(g) Next Steps
1	**Clinical Care Pathways**	Assurance about clinical risk mitigation for the proposed configuration, focussing in particular on the new risks that are introduced by the proposed changes and with detailed care pathways for categories of patients for whom particular risks have been identified, for instance children with major injuries being taken to the Royal Shrewsbury Hospital.	Complete at appropriate detailed level how the proposed option will work in practice	Define all the pathways affected Identify risks that currently exist and those that are potentially increased by the option	All clinicians working together to ensure clinical pathways and arrangements are in place to mitigate risks	See Governance (12)	Pathway groups continuing to meet and detailed discussions for delivery underway in light of detailed planning around physical requirements/options and assumptions on bed numbers, clinical adjacencies and opportunities for joint working. Detailed workforce planning for pathway delivery completed. Recruitment to new roles (Paediatric Nurse Practitioners) underway	Agree key milestones for implementation, ensuring further clinically-led development and discussion with patient involvement.
2	**Maternity**	Formal pathway risk assessment Detailed arrangements for transfers from MLUs Engagement with Powys LHB on issues for Wales Capacity and capability of WAS finalised Training for midwives in Wales			Further work with GPs and Midwives to assess those considered at risk and appropriate action taken to ensure the safety of mothers and their unborn children	See Governance (12)	Links with Powys LHB , Betsi Cadwaladr UHB and both WMAS and WAS being maintained through the Strategic Forum. Implications for the ambulance services completed demonstrating a negligible impact for WMAS and a minimal impact for WAS (absolute worse case 350 hours per annum). WAS assumption to be tested as many patients will continue to be managed at RSH. Workforce and training implications/planning continue. Maternity clinical working group continuing to meet (1)	Current activity assumptions by WAS to be discussed. Integrated workforce strategy to be in place by March 2012. Specific maternity update agreed with HOSC chairs (to be planned for spring 2012)
3	**Neonates**	Further discussions to take place with consultant neonatologists to identify the risks in the current service and solutions for providing the service in a clinically safe way, recognising that resolving the problem for the maternity building must be part of the solution Workforce plans to be completed				See Governance (12)	All neonatologists invited to be involved in the ongoing pathway work and in the development of the OBC. Second meeting with RCPCH held on 05/05/11. Specific medical workforce meetings held re rotas and ways of working. External rota development experts involved in the final paediatric and neonatology medical workforce plan. Work and discussions to continue within the clinical pathway groups re current risks and solutions.	Ongoing process of involvement and engagement to be discussed and agreed within the context of the specialty and Centre communications and engagement.
4	**Paediatrics**	Clarity on PAU demand/capacity to define purpose, staffing and opening times Workforce modelling to be tested Virtual testing and formal risk assessment of pathways Risk mitigation needs further work The legacy of the Rainbow Unit to be addressed Communication strategy developed for parents accessing paediatric inpatients or PAU			Acknowledgment of the Rainbow Unit and those involved in raising funds should be invited to be involved in the deign of the new unit at PRH, with similar and hopefully improved standards Further work is undertaken with commissioners to develop Hospital at Home to avoid unnecessary hospital admission	See Governance (12)	In depth analysis of unplanned paediatric activity undertaken with information from the CCC. 2-3 children admitted into the Trust across both sites between midnight and 09.00 on average each night. RCPCH guidance sought. Option to locate RSH PAU within A&E developed and agreed. RSH PAU to be open for admissions for 13 hours per day agreed with clinical teams. Physical requirements of the paediatric oncology service and the paediatric service as a whole developed and included in the OBC. Meeting held with parents involved in raising funds for the Rainbow Unit and with parents using the oncology and haematology service. Focus groups established. Next full meeting of the group planned for the Autumn. Newsletter following the meeting produced and available to all parents whose children use the service. Communication plan in place for ongoing involvement and engagement of children, parents and carers. Discussions to be had with commissioners re the commissioning of a Hospital at Home service.	Discussions to continue with the Childrens Working Group and the Triage and Transfers sub-group plus specific discussions with the A&E teams re joint working and delivery. Meetings with parents and carers regarding the Rainbow Unit and haematology and oncology service to continue according to the communications and engagement plan. Hospital at Home service discussions to resume with local commissioners.
5	**Surgery**				Detailed project plan with timescales and workforce planning Arrangements for patients at PRH A&E who cannot be stabilised and transferred to be operated on at PRH	See Governance (12)	Physical options developed and included in the OBC. Pathways agreed.	Timescales for change to be agreed. Outline implementation plan to be developed by March 2012. Plans for developing specific care pathways (alternatives to admission) with GPs and GP commissioners to be agreed.
6	**Support Services**	Further detail on arrangements for anaesthetics, ITU and ENT in the reconfigured services					Clinicians part of all pathway groups.Physical requirements for head and neck developed and included in the OBC. Head Neck Clinical Working Group established. Requirements for ITU to accommodate surgery at RSH scoped and included in the OBC. Long term planning for critical care within the Trust continuing in parallel. Anaesthetic rotas to support ITU and Obstetrics ahead of the proposed service change agreed and recruitment underway.	Discussions to continue with support services in terms of service change and implementation. Links to other developments/parallel workstreams to be articulated and leads identified and agreed.
7	**Communication - clinicians and staff**	The outcome of further discussions with hospital clinicians who had expressed concerns, reported to the panel, regarding the clinical and service risks associated with the proposals.		Develop solutions with fellow clinicians, other stakeholders and patients and the public that meet and exceed current levels of quality and safety	The Trust must do all they can to alleviate the concerns of those who have opposed the proposals. Discussions and work must continue with Welsh colleagues to address the concerns of those in Wales		Clinician and stakeholder discussions have shaped the clinical care pathways and options for delivery which have been included in the OBC (RCPCH involvement) Specific work has also been undertaken with colleagues in Wales and this will continue. Comprehensive communications and engagement plan is place.	The four clinical working groups and the Clinical Assurance Group will continue to meet to enable ongoing discussions. Future meetings planned for discussions with commissioners/providers for September. Plans for a Rural Health Symposium to be progressed. To be held in the Autumn.
8	**Communication - patients and the public**		Produce a 'day in the life of...' scenarios to illustrate how the reconfiguration will work in practice		It is essential that the public are kept fully informed of any service changes and the implications for patients prior to any such change taking place		Widespread public consultation has taken place, as set out in the consultation report. Review of what worked well and what could have been better undertaken in partnership with the PCTs and LINkS/CINcH. Ongoing communications and engagement plans included in the OBC and are underway. Focus groups covering all areas being established. Public briefing sessions have taken place and are planned for the next twelve months. 'Looking to the Future' newsletter published.	Delivery of the communications and engagement plan underway. Future editions of 'Looking to the Future' planned. Health Overview and Scrutiny Committees, Local Involvement Networks and Community Health Councils will continued to be consulted on the delivery of this plan. 'Day in the life...' under development.
9	**Travel, transport and transfers**	Assurance about mitigating concerns about travel and about increased travel times. This should include the outcome of further work undertaken with Welsh and West Midlands ambulance services and other partners to identify how the disadvantages of increased travel times for patients in Wales and some of the more sparsely populated areas in the West of Shropshire could be mitigated		Ensure that transport and travel plans and systems are robust	Reassurance from WMAS that they are able to reach, stabilise and safely transport children the further distance to the PRH plus any additional costs of increased transfers between sites must be taken into account Inter-site transfers for staff, patients and visitors Adequate car parking at both sites	See Governance (12)	SaTH, WAS and WMAS continuing to work together to understand and address current and future transport/transfer challenges. Key areas of development: memorandum of understanding for cross cover and joint working (nearest ambulance response agreement); community paramedics; network of first responders; paramedic skill mix WMAS and WAS members of the Transport Group (with local councillors and PCTs/GPs) and the childrens Triage and Transfers Group Access and transport/travel study undertaken and additional car park spaces at PRH included within the OBC.	All work on travel and transport to be combined and developed into an overarching Travel and Transport Plan (summer 2012). Specific transfer needs within each pathway to be progressed within the Clinical Pathway Working Group to continue to be progressed. See above re sub-group for children's needs. Further detail on travel and transport to form part of the FBC (February/March 2012)

	Area	(a) LAP	(b) OGC	(c) NCAT	(d) Joint HOSC	(e) EqIA	(f) Current Position	(g) Next Steps
10	**Financial planning**	Financial sustainability referred to SCPCT and NHST&W	Complete detailed Financial, Estate and HR plans to support the programmes objectives		Continued transparency in financial and estates planning. Robust plans to be put in place		Clinicians involved in the development of the service briefs which in turn informed the estate requirements. Facility, spatial, capacity and estates plans and supporting estate analysis and work undertaken and included in the OBC. Regular meetings and discussions with SHA colleagues undertaken. Technical Advisory Team appointed. Full economic and financial analysis completed and included in the OBC. Regular meetings and discussions undertaken with SHA colleagues. Link between reconfiguration and the Trusts LTFM explicit. Figures shared with PCT and GP commissioning colleagues.	Further work on the capital and revenue implications to be progressed within the FBC by February/March 2012 as per DH guidance and NHS best practice.
11	**Workforce**	Further detail on the workforce planning which has been undertaken to demonstrate the sustainability of the proposed new arrangements Also see specific specialties above			Detailed evidence of workforce planning and availability. Contingencies to be put in place once the process of transferring services begins to ensure patient safety is not compromised	See Governance (12)	In-depth workforce planning undertaken. Current ways of working challenged and future ways of working agreed. Clinical adjacencies enabling efficiencies in workforce needs. All plans and details included in the OBC. Session held with the RCPCH and specific work undertaken in regards to the paediatric and neonatology rotas (see above) Formal discussion with TNCC on 17/08/11 and TNCC leads identified for involvement in on-going work	A full workforce strategy to be in place by March 2012.
12	**Governance**		Review the governance arrangements for the subsequent phases of the reconfiguration in light of the development of the PMO	Develop a comprehensive governance system with training simulations and testing that keep staff and procedures at high levels of readiness		Continued Equality Impact Assessment in ongoing development and implementation. Action plan for equality strands and ongoing reports on delivery.	Discussions underway with PCT colleagues regarding the delivery of the Equality Impact Assessment recommendations. Patient and public involvement agreed and plans in place (see above re focus groups). Plans for engaging with 'hard to reach' groups being developed. Ongoing programme management resource and governance arrangements to be reviewed (see section 16/17)	Programme plan for part two of this phase to be in place by end September 2011, including an approach to implementation, for each clinical stream within the relevant centre. Implementation plans to include options for road testing pathways, systems and processes prior to service change - March/April 2011. Establish equalities action plan as part of ongoing programme arrangements - Oct 2011.
13	**Governance**		Review the population of the risk register and the arrangements for its active management and rigorous scrutiny				Risk register reviewed and updated following OGC visit. Detailed technical/building/construction risks separated out and included in the appendices of the OBC. Risk sharing detailed within the document. Procurement plan included within the OBC (P21+) Management of risk as the programme develops to be included in the programme arrangements review.	Programme plan for part two of this phase to be in place by end September 2011
14	**Implementation Planning**		Produce a draft implementation plan for transition in order to ascertain resource requirements for the new ways of working		The Joint HOSC request details of any changes prior to implementation		Implementation planning commenced and included within the OBC (eg service adjacencies; coordinated service moves etc). Detailed implementation planning to commence, including change management for staff, after approval of OBC. Focus groups already focussing on final service models and willing to help shape their implementation.	Programme plan for part two of this phase to be in place by end September 2011 HOSC updates scheduled for November/December 2011 and prior to submission of the FBC.
14	**Change Management**		Consider the further development of an integrated change management plan to support the longer term cultural and behavioural changes required				The need to have integrated planning and change management acknowledged, including wider developments and changes within the Trust. Individual service needs in this area to be identified and plans developed between now and submission of the FBC.	Draft Integrated Change Management Plan to be developed by the Transitional Working Group to reflect the wider transformational change programme within the Trust and the changes within the local NHS. To be in place and agreed by the end of March 2012.
15	**Benefits Management**		Put in place a benefits management plan				Benefits management strategy in place. Individual service area benefits identified and included in the OBC. Overarching benefits of the reconfiguration identified and agreed and included in the OBC.	Benefits realisation plans to be progressed to provide a framework for the implementation planning process (December 2011)
16	**Programme Management**		Prepare an integrated programme plan in detail for the next 6-9 months, including dependencies with other key initiatives and workforce transition				See above. 'Part 2' of this planning phase to be developed and agreed. To be received by the Steering Group in September 2011. Links to other developments and plans being facilitated through overarching PMO function. Specific transition plan in relation to workforce to be developed. Initial timescales and milestones included in the OBC.	Programme plan for part two of this phase to be in place by end September 2011
17	**Programme Management**		Produce a detailed resource plan to support the next phase of activities				See above re stock-take and review of programme team, resources and structure. Need for fulltime Programme Director and team identified.	Programme plan for part two of this phase to be in place by end September 2011
18	**Development of the OBC**		Complete the OBC ensuring that the key drivers of quality and safety come across more strongly and that there is a rigorous appraisal of workforce and other affordability implications				Additional sections inserted into the OBC following OGC review to reflect this recommendation.	Next OGC review prior to submission of FBC.
19	**Development of the OBC**		Ensure that the OBC addresses the feedback of the requirements of stakeholders such as commissioners and HOSCs				Assurance grid included in Trust Board papers. Separate work plan developed by the HOSC has been updated (June and August) and discussed at the Joint HOSC meetings. Regular meetings held with joint PCT executive in the development of the OBC (including GP commissioning chairs) Clinical Assurance Group role and membership reviewed in light of changes to NHS structures. Meeting held on 12 July where plans and updates were shared.	Assurance grid to be maintained. Clinical Assurance Group to continue to meet. HOSC workplan to be updated as requested.