Walsall Hospitals
NHS Trust

WALSALL HOSPITALS NHS TRUST

HOSPITAL REDEVELOPMENT SCHEME
OUTLINE BUSINESS CASE

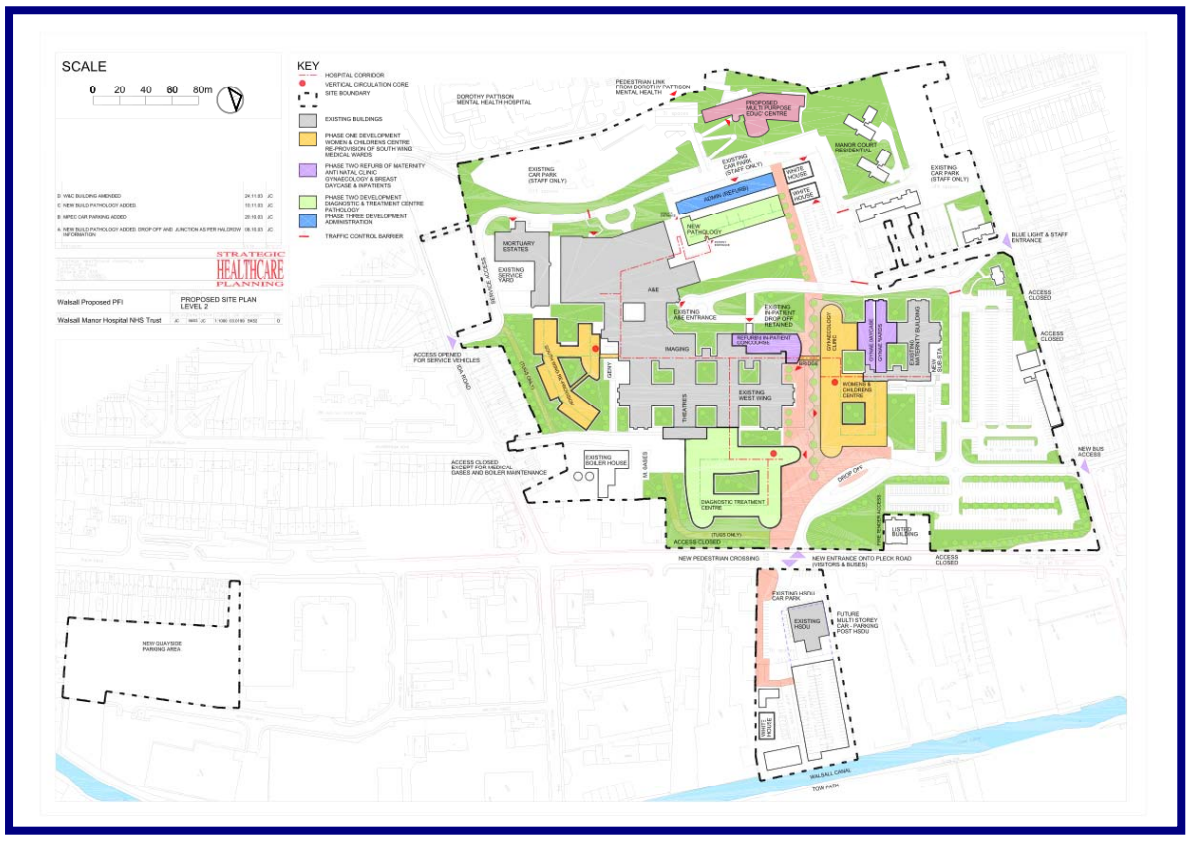

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TABLE OF CONTENTS

SCHEDULE OF TABLES 2

SCHEDULE OF FIGURES 3

SCHEDULE OF APPENDICES 4

SECTION 1: EXECUTIVE SUMMARY 5

SECTION 2: BACKGROUND AND INTRODUCTION 21

SECTION 3: STRATEGIC CONTEXT 25

SECTION 4: THE CASE FOR CHANGE 49

SECTION 5: FORMULATION OF OPTIONS 72

SECTION 6: NON-FINANCIAL APPRAISAL OF OPTIONS 91

SECTION 7: FINANCIAL AND ECONOMIC APPRAISAL OF OPTIONS 96

SECTION 8: THE PREFERRED OPTION 110

SECTION 9: THE PRIVATE FINANCE INITIATIVE 121

SECTION 10: PROJECT ARRANGEMENTS 123

SECTION 11: TIMETABLE AND DELIVERY 128

SECTION 12: CONCLUSION AND RECOMMENDATI0NS 129

SCHEDULE OF TABLES

Table 1. Key Elements of the Strategic Outline Case 5
Table 2. Activity and Facility Comparison..... 14
Table 3. Summary of Preferred Option 16
Table 4. Capital..... 17
Table 5. Revenue 18
Table 6. Funding Sources 19
Table 7. Project Timetable..... 20
Table 8. Key Elements of the Strategic Outline Case..... 21
Table 9. Procurement Packages 22
Table 10. Activity and Facility Comparison..... 26
Table 11. Out turn Activity Levels 2002/03 in terms of FFCEs..... 29
Table 12. Service and Facilities Distribution..... 30
Table 13. Population Age profile 2002..... 31
Table 14. Black Country Population Shift 2000 – 2010..... 31
Table 15. Summary of Economic Indicators 33
Table 16. Ethnicity..... 34
Table 17. Standardised Mortality Ratios and Years of Life Lost 35
Table 18. Functional Suitability..... 41
Table 19. Space Utilisation..... 41
Table 20. Energy Performance 41
Table 21. Physical Condition..... 42
Table 22. Summary of Estate..... 42
Table 23. Total Growth Levels and Projected Activity Levels 2010/2011 60
Table 24. Children and Younger People's Service Requirements..... 62
Table 25. Women's Service Requirements..... 63
Table 26. Overall bed requirement 2010/11 64
Table 27. Theatre Sessions 66
Table 28. Theatre Provision Changes 66
Table 29. Outpatient Clinic Requirements 67
Table 30. Outpatient Clinic Room Provision..... 68
Table 31. Imaging Modality Distribution 68
Table 32. DTC Functional Content..... 69
Table 33. MPEC Functional Content..... 71
Table 34. Project Benefits..... 76
Table 35. Description of Options..... 81
Table 36. Summary of Options..... 90
Table 37. Criteria Weightings..... 92
Table 38. Option Scores..... 93
Table 39. Key factors affecting the Non-financial Appraisal..... 94
Table 40. Capital Costs of Options..... 96
Table 41. Summary of Revenue Budget 2003/04..... 99

Table 42. Summary of Cost Driver Changes 101
Table 43. Forecast 2010/11 Revenue Costs (at 2003/04 prices) 102
Table 44. Option 6 Forecast Revenue Cost Changes 103
Table 45. Option 6 Annual Profile of Cost Changes 104
Table 46. Option 6 Attribution of Annual Change 105
Table 47. Cost Impact of Option 6 by Commissioner 105
Table 48. Summary Economic Analysis of options 107
Table 49. EAC Switching Values 107
Table 50. Scenario Summary 108
Table 51. Overall Evaluation Summary 110
Table 52. Benefits of Preferred Option 112
Table 53. Summary Project Plan 128

SCHEDULE OF FIGURES

Figure 1. Model of Care 12
Figure 2. Process for Change Development 13
Figure 3. Process for Change Development 26
Figure 4. Map of Walsall showing location of Manor and Goscote Hospitals 28
Figure 5. Walsall Areas of Deprivation 33

SCHEDULE OF APPENDICES

APPENDIX A:	Aerial Photos of Hospital Sites
APPENDIX B:	Contracted Activity 2002/03, 2003/04 and 2004/05
APPENDIX C:	Details of Current Sites and Accommodation
APPENDIX D:	Forecasts of Activity and Facility Requirements
APPENDIX E:	Schedule of Accommodation
APPENDIX F:	Description of Options
APPENDIX G:	Site Plans for Short-listed Options
APPENDIX H:	Non-financial Appraisal of Options
APPENDIX I:	Financial Appraisal of Options
APPENDIX J:	The Preferred Option
APPENDIX K:	Timetable for Construction of PSC
APPENDIX L:	Risk Register
APPENDIX M:	Project Plan
APPENDIX N:	Benefits Realisation Plan
APPENDIX O:	Statement of Commissioner Support

SECTION 1

EXECUTIVE SUMMARY

1.1 Introduction

In November 2000, the Walsall Health Community submitted a Strategic Outline Case (SOC) for the development of healthcare facilities within the Borough. On 15th February 2001, the Secretary of State approved this proposal as one of 29 schemes prioritised to progress through the government's Private Finance Initiative (PFI). The key elements of development contained within the SOC are summarised in the following table:

Table 1. Key Elements of the Strategic Outline Case

Key Elements
Hospital Replacement of East Wing, Manor Hospital Ambulatory Care Centre, Manor Hospital Multi-Professional Education Centre
Community Mental health for the elderly Re-provision of learning disability accommodation Learning Disability Assessment Centre Child Development Centre Mental health rehabilitation
Primary Care Primary Care Resource Centres

Walsall Teaching Primary Care Trust (tPCT) is preparing business cases for the Community and Primary Care elements. This OBC has been produced by Walsall Hospitals NHS Trust to set out the case for the remaining elements of the SOC related to the acute hospital provision and incorporates the Multi-Professional Education Centre (MPEC) requirements.

1.2 Strategic Context

1.2.1 The Trust and Locality

The Metropolitan Borough of Walsall is formed from the old Staffordshire towns of Aldridge, Bloxwich, Brownhills, and Walsall along with the Black Country towns of Willenhall and Darlaston. It is located approximately 10 miles from Birmingham, with excellent road and rail communications.

The Borough has a population of just over 260,000. This population is predicted to fall marginally by 2010, but this decrease masks an increase in the older population. Walsall is currently the fifth most deprived district within the former West Midlands Region; 39% of the population falls into "deprived" social classes; the ethnic population in Walsall is almost 10%; and Standardised Mortality Ratios are high (107).

The Walsall Hospitals NHS Trust was established in April 1991, and provides a range of acute secondary care services for the diagnosis, treatment and care of patients whose healthcare needs cannot be met within the community/primary care. The Trust provides a full range of 'District General Hospital' type services to the local population, including certain community based services. These services are currently provided on two sites. The Manor Hospital currently provides the 'acute' focus for this service utilising 638 beds. Goscote Hospital provides a mainly 'rehabilitation' based service with 103 beds. Approximately 53,000 inpatients/day cases and 197,000 outpatients are treated or seen each year.

The two hospital sites provide accommodation which ranges in age from the late 1800s to 1994 at the Manor Hospital and from 1928 to 1980 at Goscote. For the foreseeable future, the local strategy sees the continued use of both the Manor and Goscote Hospital sites. The Trust and Walsall tPCT have agreed, however, that over time the focus of activity at Goscote should evolve towards the provision of community services for older people and intermediate care services. The end point of this process would be for Walsall tPCT to take over running the Goscote service.

1.2.2 The Vision for Future Healthcare

The vision for future healthcare primarily informed by the Black Country Review the details of which are outlined within Section 1.3.

The vision adopted by the Trust embraces corporate objectives which emphasise the vital importance of providing the highest possible quality of care by the right people at the right time and in the right place.

This OBC has been developed in conjunction with health and social care partners within Walsall and the Black Country and is based upon the principles of developing and modernising health services in Walsall and the Black Country by delivering an integrated and seamless service for the users of acute and primary care services as part of the whole health economy.

The work of the Black Country Review 2004 has been embraced within the detailed forecasts which have been made of the future requirements for services from the Trust, developed in conjunction with Walsall tPCT, Wolverhampton City PCT and Royal Wolverhampton Hospitals NHS Trust.

It has been calculated that over the planning period to 2010/2011 activity within the acute Trust will experience a net increase of 10.4%. This OBC has approached this increase from the perspective of avoiding the need to introduce additional inpatient beds, and embraces the challenge of further increases in the level of day case and outpatient interventions and the development of improved functional adjacencies and clinical linkages. National best practice performance and efficiency measures have been adopted and the implications in terms of the management of services and clinical practice accepted.

The scale of facilities upon which this OBC is based when including the Goscote complement conforms fully to the assumptions agreed as Stage 1 of the Black Country review (utilising agreed best practice assumptions for efficiency and throughput). The outcome of Stage 2 of the Black Country Review (impact of new models of 'care closer to home' particularly in chronic disease management) has confirmed that the facilities proposed for the Manor Hospital site will still be required even with the revised assumptions upon which this stage of the Review is founded. The utilisation of Goscote would, however, change in line with the agreed plans referred to above.

The Trust embraces the significant change that will be required in the way it provides clinical services in the future. This will be influenced by commissioners, clinical developments and the need to respond to changing national priorities. The Trust will continue to develop closer working arrangements with the Walsall and Wolverhampton PCTs, General Practitioners and Royal Wolverhampton Hospitals NHS Trust in delivering these changes.

The Trust is committed to working with Royal Wolverhampton Hospitals NHS Trust to ensure that shared clinical services are planned and developed effectively to meet future site developments. The Walsall and Wolverhampton City PCTs have developed a joint Primary Care Strategy which provides a commitment to develop new service models for intermediate, community and chronic disease services which are consistent across the local health economy. The strategy is consistent with

the parallel moves towards closer commissioning with the shared LIFT programme and the close working evolving between the four Trusts in Walsall and Wolverhampton.

As principal commissioners of service from the Trust, Walsall tPCT seeks to implement the following strategic goals:

- Ensure the provision of high quality care for the residents of Walsall;
- Ensure equity of access for all residents of the Borough based upon clinical need;
- Commission an appropriate level of service to meet the genuine healthcare needs of the population;
- Commission an appropriate level of service to ensure timely access to services when required;
- Ensure provision of services to an appropriate standard having regard to professional advice regarding safety, clinical excellence and outcomes;
- Ensure patients are treated in a safe and high quality environment;
- Ensure, where possible, the provision of services local to the population;
- Ensure the delivery of key targets and goals as set out in the NHS Plan.

The Trust approach to meeting Commissioner service requirements includes the following key elements:

- To improve the health of the local population through the provision of high quality and clinically effective care;
- To improve the Quality of Patient Care by facilitating changes in the pattern of service delivery, including increases in Day Case activity; reduced inpatient lengths of stay; the provision of increased minor procedures in the outpatient setting; supporting the development of community based services to support 'care closer to home' and new models of Coronary Disease Management;
- To integrate clinical services and improve the physical relationship between facilities;
- To provide flexible accommodation capable of keeping pace with technological and service change;
- To maximise access to facilities for the local population, enabling closer links between acute facilities and services provided by the Primary Care Service;
- Improve the standard of facilities, to reduce the level of

backlog maintenance and provide a quality physical environment for patient care;

- To improve operating efficiency, through better utilisation of physical and human resources which will lead to reduced running costs and the opportunity for re-occurring savings;
- To provide a centre of training and educational excellence for all health professionals.

The Project will ensure the provision of a comprehensive range of services which meet the requirements of commissioners within modern, clinically suitable and effective facilities.

1.3 The Black Country Review

The Black Country Review has driven a new approach to service modelling across the health economies of Walsall, Wolverhampton and Dudley. The process involved two stages:

Stage 1 Assessment of efficiency and growth assumptions;

Stage 2 Development of alternative healthcare models using templates for admission avoidance, transfer of care and best practice which were then validated by the clinical working groups, NHS Trusts and PCTs.

The Review was concluded in April 2004 and the outcome reported in the document Health in the Black Country – Better by Design. There was extensive involvement from across the Black Country in the process of the review from Clinicians, Managers and other staff employed by all stakeholders.

A comprehensive public and patient involvement programme was also included as part of the review.

The outcome of the review was to transform primary and secondary service models and instigate a reappraisal of the projected activity for primary and secondary care for 2010. The resulting activity and capacity projections, including the modelling assumptions, were approved and signed off in March 2004 by the Chief Executive Officers of the Trusts involved and have been independently ratified by the Birmingham and Black Country Strategic Health Authority. These agreed elements, forming the cornerstones of this OBC, are:

- The model of care;
- The activity plan for 2010/11;
- Performance Assumptions;
- Growth assumptions;

- Transfers into the community;
- Bed profiles for this OBC.

1.4 The Case for Change

In addition to the changes in the models of care as identified through the Black Country review there are a number of significant local deficiencies in the range of buildings currently used to provide clinical services from the Manor Hospital site, which contribute to the delivery of sub-optimum services. These can be summarised as follows:

1.4.1 Women, Children and Younger People's Facilities

- The requirements of fire certification are severely compromised by the structure of the East Wing building;
- Inadequate engineering services;
- Accommodation substandard;
- Structural integrity of the floor loading;
- The overall condition and suitability of the building;
- Lack of integration of paediatric services leads to inefficient use of resources and a lack of effective clinical linkages and thus significant shortfalls against the requirements of the National Service Framework for Children and Younger People;
- The separation of Women's Services, particularly Obstetrics and Gynaecology, results in a lack of integration of services and skills and an inefficient use of staff resources. It also mitigates against the flexible utilisation of ward accommodation;
- Accommodation does not meet current standards for the provision of modern paediatric services, in particular facilities for parents e.g. facilities for sleeping, washing, beverages etc. These facilities cannot be adequately provided within the cramped accommodation available. The lack of parental accommodation impacts upon the effectiveness of treatment and outcomes;
- Ward space is 30% below current building note standards;
- Lack of suitable adolescent facilities;
- Lack of identifiable day case facilities;
- Schooling facilities are extremely poor and very inadequate.

1.4.2 Outpatients / Day Cases / Pathology

- Sister Dora Outpatients building is over 30 years old and is

nearing the end of its economic life;

- Poor working environment;
- Inflexibility of use;
- Lack of suitable diagnostic facilities;
- Waiting arrangements lead to severe overcrowding;
- Current day case area constraints preclude any future expansion;
- Recovery facilities are totally inadequate to facilitate effective operation;
- Lack of integration of pathology facilities.

1.4.3 Education and Training

- Dilapidated postgraduate centre with inadequate seminar and library facilities, no clinical skills laboratory and negligible computer access;
- Shortfall of training accommodation in Walsall Teaching Primary Care Trust requiring the use of commercial venues for up to 30% of all courses;
- No facility to accommodate more than 70 people within the health economy;
- Additional capacity required to accommodate the increasing medical student allocation;
- No central focus for the development of integrated training and development across the health economy.

1.5 Model of Care

The model of care developed within the Black Country Review identifies the range of services which the local population will need to access and uses the "reverse pyramid" principle to ensure access to healthcare as close to home as possible. This model is outlined in Figure 1.

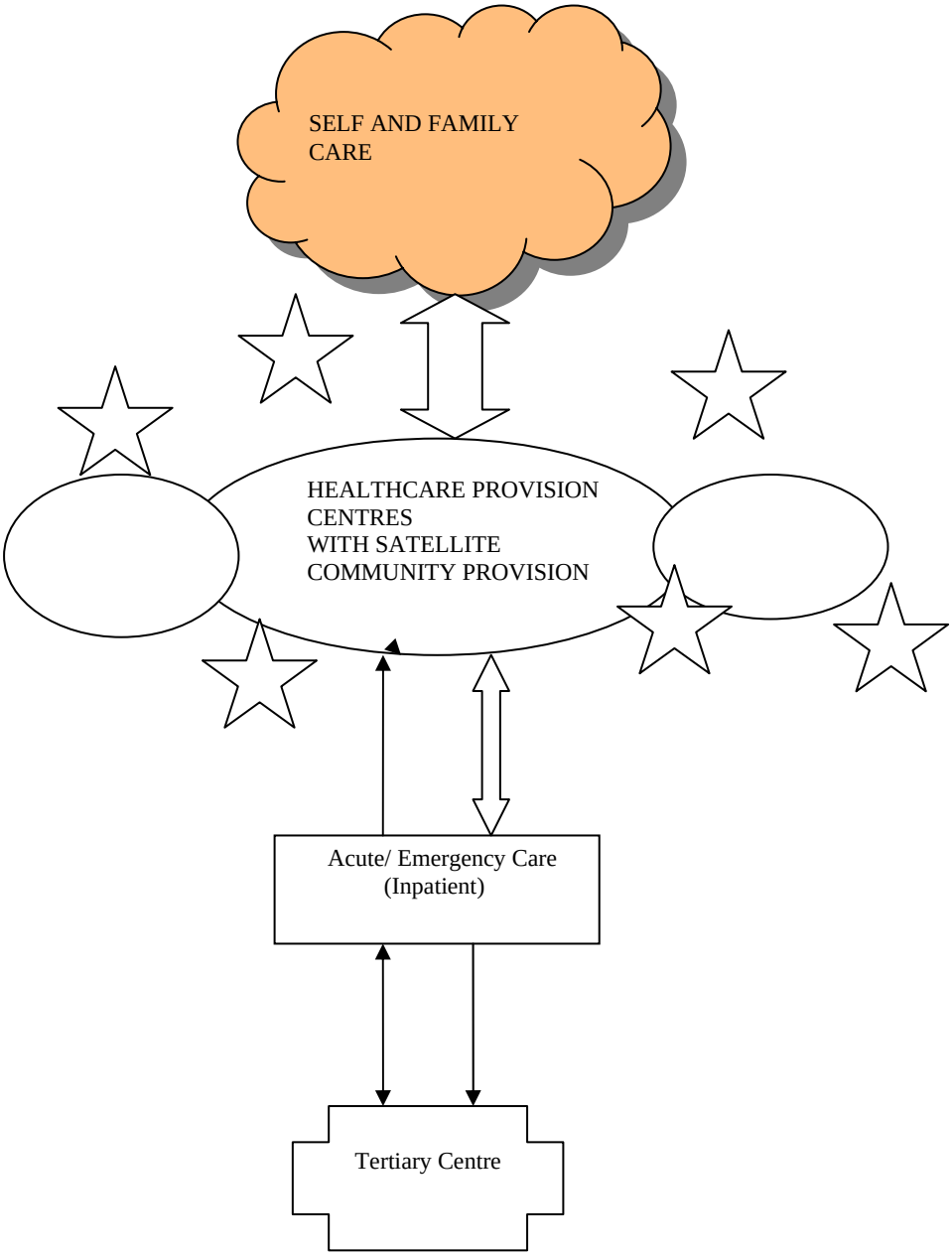
The model focuses on self-help and self/family care, using community based services when required, with emergency centres/acute care available for times of appropriate need and tertiary care for specialised services only.

There is full commitment from the Trust and the health economy to delivering this model and the associated rebalancing of services and resources from hospital to community in the context of overall growth in investment in health services in Walsall.

The Trust recognises that delivering this new model of care will require close partnership working with the relevant Black

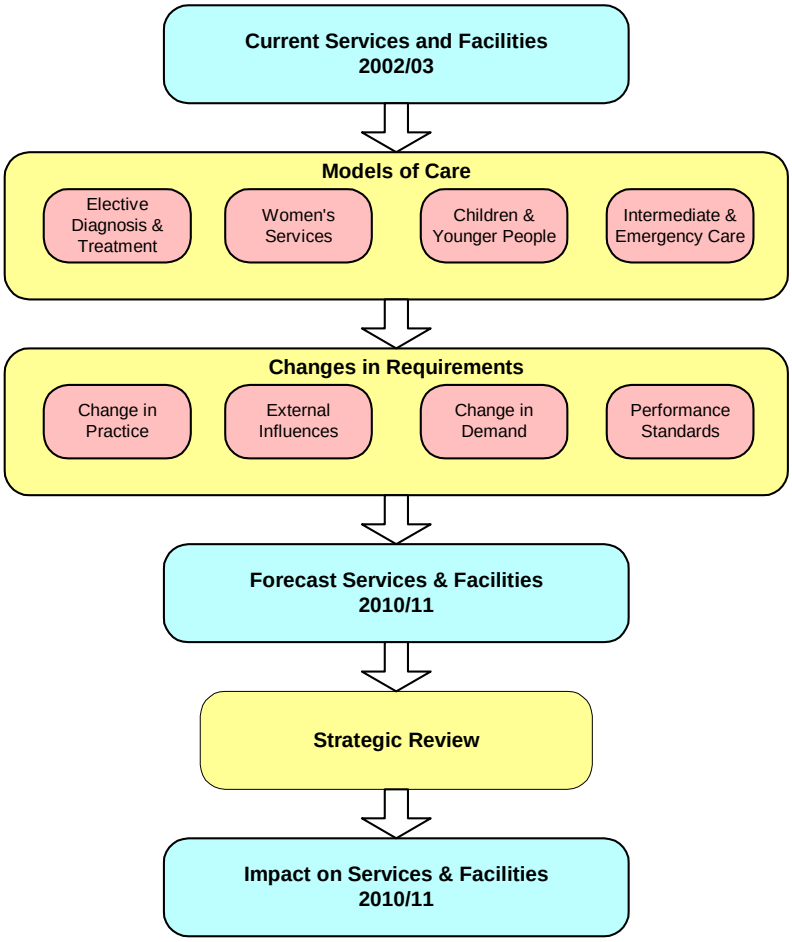
Country PCTs and Acute Trusts particularly Walsall tPCT and Royal Wolverhampton Hospitals NHS Trust, and on going dialogue with the local population. The positive impact of the closer working is already beginning to emerge as the implementation of the Black Country Review has commenced.

Figure 1. Model of Care



The detailed planning process which the Trust adopted in order to ensure that this model of care was reflected in the changes in working practices and facilities provision is summarised in Figure 2 below. The full workings are provided in the main OBC text in Section 4 and ***Appendix D***.

Figure 2. Process for Change Development



Based upon the assessments and forecasts made, the 3 stages (Current 2002/03, Forecast 2010/11 and the Impact of Strategic Change on 2010/11) can be summarised as follows:

Table 2. Activity and Facility Comparison

	Current (2002/03)	Forecast (2010/11)	Impact of Strategic Change (2010/11)
Black Country Review	**Pre**	**Stage 1**	**Stage 2**
Activity			
Outpatient Attendances	195,450	218,138	218,138
Elective Inpatient FFCEs	5,638	3,122	3,062
Emergency Inpatient FFCEs	29,320	31,929	30,457
Day Cases	17,641	23,016	23,016
Facilities			
Generic Outpatient Consulting Rooms	38	61	61
Inpatient Beds	741	749	669
Day Spaces	39	78	78
Theatres	11	14	14
Performance			
Bed Occupancy	84.8%	84%	84%
Day Case Rate	76%	88%	88%

The Strategic Review has highlighted potential changes in the delivery of care for a range of interventional procedures and further improvements in the management of patients with chronic diseases including diabetes and COPD. The impact of theses specific changes have been assessed by the health economy and the greatest effect will be in terms of reduced outpatient attendances, admission avoidance and improved management of the post acute phase of care. The resultant plan over time would therefore be a reduction in occupied bed days. This would not impact on the functional content identified for the Manor Hospital site but would instead underpin the changed focus for Goscote referred to in section 1.2.1 above.

The reduction in outpatient attendances has been netted off in the forecast for outpatient activity in 2010/11, and is masked by the growth in demand for appropriate outpatient services which is expected over the same period.

1.6 Option Appraisal

A detailed Option Appraisal, covering both non-financial and economic / financial factors has been carried out as part of the development of the OBC, examining the following 7 options:

Short-listed Options

- Option 1: Do Minimum
- Option 2: The SOC Option
- Option 3: The CABE Option
- Option 4: Two Centre Option
- Option 5: Tower Option
- Option 5a: Tower Option
  (with South Wing Replacement)
- Option 6: Radical Option

Preferred Option: Option 6 – Radical Option

1.7 The Preferred Option

The key criteria identified within the option appraisal process highlighted the importance of the ability to strengthen the fundamental clinical and operational linkages on the site in order to improve patient care and the patient experience whilst providing the Trust with the flexibility to deliver changing models of care into the future.

Although considered to be most radical, the preferred option, Option 6 was considered by clinicians and other stakeholders to most closely meets those key criteria through the provision of an integrated Women, Children and Younger People Centre through an extended Maternity Unit, linked directly to the West Wing; a Diagnostic and Treatment Centre linked to the West Wing and the provision of Generic Acute Beds located adjacent to the crucial diagnostic and treatment areas including Accident and Emergency, West Wing Theatres, Specialist Imaging and Integrated Critical Care.

A key feature of the Preferred Option is the development of a single Hospital Street Network which will enable the hospital to operate as a single clinical building.

The scheme will involve the sequential development of 5 main elements of new build facilities totally approximately 36,000m^2 of new buildings, and the demolition of the poorest quality building stock, much of which pre dates 1900. Indeed, on completion of the scheme no building on the Manor Hospital site will pre-date 1989. The separation of elective and emergency flows into the site also provides the opportunity to develop a landmark building for Walsall with the focal point for access to the site moving to the Pleck Road.

The functional content of each of the 5 elements is summarised in Table 3.

Table 3. Summary of Preferred Option

Women and Children's Centre
To be built adjacent and linked to the existing Maternity Block and to provide: New Women's facility to include: • 20 bed Gynaecology Ward • 8 Day Spaces • Assessment Unit • Outpatient Clinics • 3 Theatres (Shared with Children's) Children and Younger People's facility to include: • 37 inpatient beds • Assessment Unit • Outpatient Clinics

Diagnostic & Treatment Centre
Hospital Based facilities to include: • 36 Generic Consultation Rooms • Specialist Outpatients • 16 overnight stay beds / 36 day beds/trolleys • 4 Theatres • 3 Endoscopy Rooms • Diagnostic Support Facilities

South Wing Replacement
Facilities to provide a replacement for the current accommodation contained within South Block and meeting the overall demand for inpatient accommodation forecast within the Black Country Review: • 135 Beds • Integrated Therapy Suite • Support Accommodation

Pathology Department
An integrated set of accommodation to provide the three main pathology disciplines: • Haematology • Microbiology • Biochemistry

Multi Professional Education Centre
Facilities to provide centralized training and education to include: • Library including IT access • Lecture Theatre for 120+ • Seminar rooms to accommodate between 10 and 50 • Support facilities for junior doctors and medical students • 2 Clinical skills laboratories • Clinical IT skills laboratory

Overall, this development will facilitate improved functionality of existing services, allow for a separation of the majority of elective activity from emergency work, increase the capacity for day cases and increase the number of one-stop outpatient clinics. The creation of a hospital street will improve the management of patient moves and deliveries. It will also mean that clinical services are more appropriately linked, e.g. Medical Admissions Wards will be adjacent to Accident & Emergency.

1.8 Scheme cost and affordability

The overall capital costs of the Public Sector Comparator scheme can be summarized as follows:

Table 4. Capital

	£000's
Works	80,283
Fees	10,128
Equipment	9,086
Non-Works	1,305
Contingencies	15,120
VAT	18,248
Total at MIPS 385 VOP	**134,171**

The additional revenue costs associated with the proposed PFI scheme are outlined in Table 5:

Table 5. Revenue

At 2003/04 pay and price levels	£000's
Net Additional Clinical Costs	29
Net Additional Non-Clinical Costs:	
PFI-related Services	556
Trust Retained Services	-326
Total Additional Revenue Costs (excluding capital charges)	**258**
Net Additional Cost of Capital	8,952
Gross Additional Revenue Cost	**9,210**
Category C Income	-248
TOTAL ADDITIONAL COSTS	**8,962**

The total additional revenue costs for the Hospital Redevelopment Scheme are £9.0 million per annum.

Revenue costs will be met as follows:

- **Additional Activity**

  During the planning period to 2010/11, the Trust will experience a net increase in activity of 7.5%. This activity will generate additional income to the Trust of £4.4 million.

- **Payment by Results (PbR)**

  The Trust is likely to benefit from the introduction of the National Tariff because we are currently reporting a Reference Cost Index of 96. We have modelled the impact of the tariff on current and forecast activity levels and the financial gain is £9.2 million.

  In demonstrating the affordability of this scheme, we have taken a prudent approach and utilized 50% of the benefit, £4.6 million.

  The additional resources identified above are consistent with the pre "Payment by Results" funding earmarked by PCTs and they are fully signed up to this approach.

In summary, the Hospital Redevelopment Scheme will be funded by the following:

Table 6. Funding Sources

	£m
Additional Activity Payment by Results	4.4 4.6
Total Additional Revenue Funding	9.0

1.9 Benefits of the Scheme

The Scheme delivers considerable benefits to the Trust, commissioners of service and the local population, including:

- Provision of modern "state of the art" facilities for the delivery of 21st Century Healthcare for the local population;
- Delivering the forecast additional activity requirements of commissioners for the foreseeable future;
- Providing significant improvements in the clinical relationships between facilities on the Manor Hospital site which will allow for a separation of the majority of elective activity from emergency work, increase the capacity for day cases and increase the number of one-stop outpatient clinics. The creation of a hospital street network will improve the management of patient movement and deliveries. It will also result in improved clinical linkages;
- Provision of the capital requirement to deliver the Trust's Strategic Development Plan;
- Tackling the backlog maintenance liability of the Manor Hospital estate, and reducing this requirement by over £11m;
- Avoidance of the need to provide additional facilities to undertake the forecast increases in activity required from the Trust, through the enhanced clinical performance possible from the new facilities;
- Provision of high quality education and training facilities accessible to the whole economy and the public.

1.10 Scheme Implementation

The following table represents the overall plan to secure a signed contractual agreement with a PFI Partner to develop the project.

Table 7. Project Timetable

Main Project Stage	Date
Outline Planning Permission granted	July 2001
Draft OBC Submission	March 2004
Final agreement of OBC	August 2004
Placement of OJEU Advert	August 2004
Open day for Bidders	October 2004
Selection of shortlist of Bidders	December 2004
Selection of final 2 Bidders	March 2005
Selection of Preferred Bidder	November 2005
Financial Close	November 2006
Start on site	December 2006

As details of the PFI Partner's proposed design and phasing are not yet known, it is not possible to provide a detailed timescale for the development phase of the project. However, based on the approach developed by the Trust for the Public Sector Comparator it is anticipated that proposals will allow for the phased opening of the required new facilities, with full operations being achieved in 2009.

This timescale will create a major lever for delivering the model of care presented by the BCR and facilitate the further development of Primary Care led services on the Goscote Hospital Site. Therefore we are confident that the proposed investment in acute services will not only substantially improve patient care environments and efficient health care within the acute sector, but will also stimulate rapid change in primary care.

1.11 Statement of Commissioner Involvement

Consultation with Commissioners and Key Stakeholders has been undertaken throughout the production of this document, through both formal and informal consultation events and through formal representation in the overall Project Structure. A statement of Commissioner support including growth assumptions, associated revenue costs and timescale for the changes in primary care is included in ***Appendix O.***

SECTION 2

BACKGROUND AND INTRODUCTION

BACKGROUND

2.1 In November 2000, the Walsall Health Community submitted a Strategic Outline Case (SOC) for the development of healthcare facilities within the Borough. This submission was unique in comparison to previous experience in that it sought to integrate the estate development requirements of all of the healthcare agencies within the Borough to deliver a whole systems solution to the future development needs of the local population. The key elements of development contained within the SOC are summarized in the following table.

Table 8. Key Elements of the Strategic Outline Case

Key Elements
Hospital
Replacement of East Wing, Manor Hospital
Ambulatory Care Centre, Manor Hospital
Multi-Professional Education Centre
Community
Mental health for the elderly
Re-provision of learning disability accommodation
Learning disability assessment centre
Children's development centre
Mental health rehabilitation
Primary Care
Primary care resource centres

2.2 On 15th February 2001, the Secretary of State for Health announced that he proposed to approve 29 schemes which had previously been submitted to be prioritised to progress through the government's Private Finance Initiative (PFI) in three waves to commence planning and procurement between 2001/2 and 2003/4, including the proposals for the Walsall Manor Hospital Re-development.

2.3 In accordance with the requirements of the NHS Capital Investment Manual (CIM) the delivery of the next stage of development, in meeting the aspiration contained within the SOC, requires the production and agreement of Outline Business Cases for the various elements of the whole Strategy.

2.4 It is not feasible to deliver the entire content of the SOC through a single procurement, as the range of developments contained within is very varied in nature, complexity, timescale and in terms of potential funding options. In order to achieve the next stage, it is important to identify 'packages' of development, which can be delivered through a number of formal procurement processes.

2.5 In terms of the delivery of the SOC it was therefore agreed it is appropriate to separate key elements into 3 packages for procurement:

Table 9. Procurement Packages

Packages
Package 1 Replacement of East Wing, Manor Hospital Ambulatory Care Centre , Manor Hospital Pathology, Manor Hospital (part of existing outpatient building)
Package 2 Multi-Professional Education Centre
Package 3 Primary Care / Community Developments

Therefore this business case concentrates on Package 1.

2.6 In delivering the services under consideration for this OBC there are five key priorities:

- Replacement of East Wing, Manor Hospital;
- Improved day case facilities;
- Outpatients;
- Pathology;
- Quantum of In Patients facilities required by the Health Economy Strategy and confirmed through the Black Country Review.

2.7 The key reasoning for the selection of these five priorities was as follows:

Replacement of East Wing

Current building is of Victorian stock, of inadequate standard to provide modern clinical services, cannot provide appropriate accommodation to Health Building Note (HBN) standards, suffers from considerable backlog maintenance of approximately £3.3m and fails to meet fire regulation standards. Total replacement is required.

Improved/Expanded Day Case Facilities

The dedicated day case units on site are of insufficient capacity to enable all day case activity to be provided in modern dedicated accommodation which is both clinically and cost effective. Short term proposals will ensure maximum utilisation of existing capacity is achieved with minimal capital outlay. A strategic solution is required to replace the current facility.

Outpatients

Although constructed in the 1970s, the main outpatient department is of lightweight construction and the basic fabric and services have a very limited future economic life. The design/layout is very inflexible and although a limited upgrade was undertaken within the last 5 years this was largely cosmetic in nature, as major re-configuration to meet current standards of ambulatory care is not economically practical within the constraints of the existing building. The only practicable alternative is total replacement.

Pathology

The departments of haematology, biochemistry and microbiology are housed within the same lightweight construction building as outpatients and therefore suffer from many of the same difficulties. Increased automation requires a radical rethink of pathology service provision. Replacement of the building is required. Histopathology and associated mortuary accommodation is housed in good quality accommodation at the north/east end of the site. This accommodation is of good physical quality and functionally suitable.

Quantum of In Patients facilities required by the Health Economy Strategy and confirmed through the Black Country Review

The distribution of beds between the Goscote and Manor Hospitals has altered little for several years. The beds at Goscote Hospital are largely occupied by longer stay patients undergoing active rehabilitation or awaiting placement in short or long term residential accommodation. Patients are generally referred to Goscote site following a period of Acute care at the Manor Hospital. The impact of the predicted future growth of activity in clinical

practice, both within the hospital setting and in the community, is predicted to have an impact on the number and distribution of beds. This is likely to alter over a period of time, but the estimated total bed requirement will be key to maintaining service activity.

2.8 The identification of the resource requirements has been endorsed by the Black Country Review which was concluded in April 2004 and the outcome reported in the document Health in the Black Country – Better by Design.

Stakeholders included in the review consisted of Public and Patient Involvement, Clinicians, Managers and other healthcare staff.

The Black Country review process also established a forum for debate across the health economy of the likely changes in practice in the longer term and the impact on the amount of resources required in Acute and Intermediate Care. The resource requirements as developed within this case therefore account for the impact of the Black Country Review in the medium and long term, in both secondary (hospital) and primary (community) care.

This document supports the assumptions agreed as the first stage of the Black Country Review, which brought together examples of good practice in both secondary and primary care.

Whilst Goscote hospital will remain, the care provision offered will reflect the second stage of the Black Country Review and provide care needs 'closer to home' particularly in chronic disease management. This area of care will be provided via the primary care setting.

SECTION 3

STRATEGIC CONTEXT

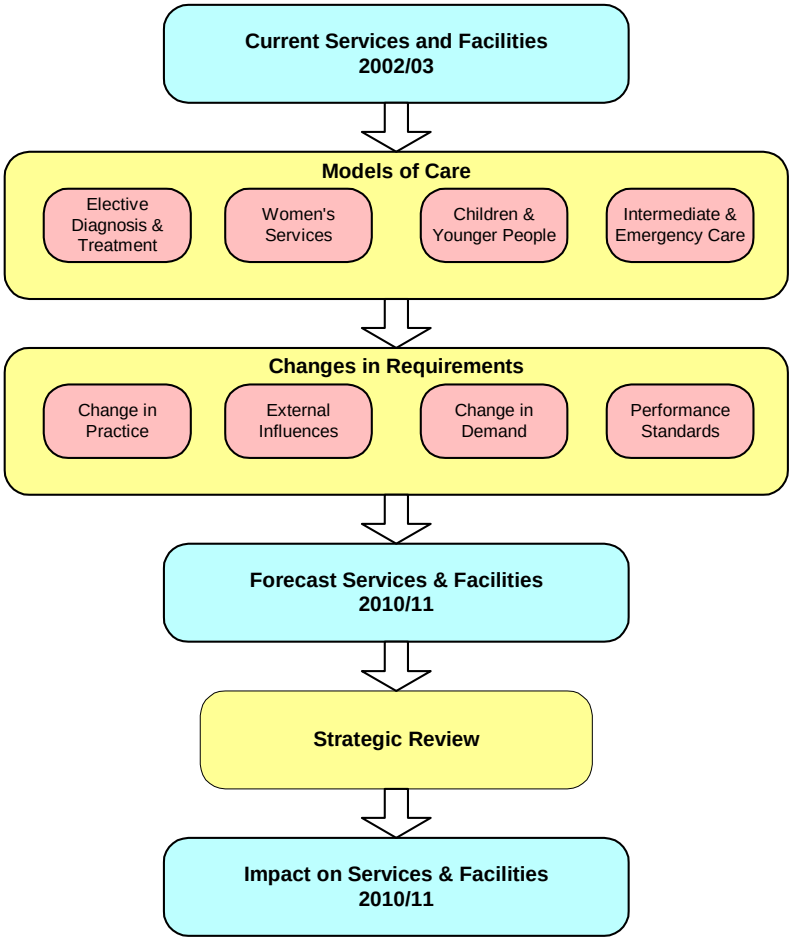
THE CASE FOR CHANGE

3.1 The Case for Change within the OBC is based upon the need to address 5 key objectives:

- Models of Care for the delivery of Acute Services from the Manor Hospital site that deliver modern healthcare in the context of the overall integrated strategy for the Black Country;
- Facilitating changes in clinical practice and the effective delivery of care to support the overall strategy;
- Meeting the forecast demands for the services required from the site, based on detailed analysis of the likely changes in workload over the next decade, confirmed with commissioners;
- Ensuring the achievement of performance standards that equate to best practice within the NHS;
- Addressing the estates liability of the Manor Hospital site through the replacement of aged facilities with ones that meet modern standards for the delivery of care in an acute setting.

Additionally, the Strategic Review being conducted within the Black Country requires the OBC to consider the potential impact of further changes in the pattern of healthcare delivery within the Health Economy, and demonstrate the way in which the proposed solutions can respond to these broader strategic issues. The process for developing the scale and nature of facilities required has therefore followed a 3 stage process that can be summarised as follows:

Figure 3. Process for Change Development



Based upon the assessments and forecasts made, the 3 stages (Current 2002/03, Forecast 2010/11 and the Impact of Strategic Change on 2010/11) can be summarised as follows:

Table 10. Activity and Facility Comparison

	Current (2002/03)	Forecast (2010/11)	Impact of Strategic Change (2010/11)
Activity			
Outpatient Attendances	195,450	218,138	218,138
Elective Inpatient FFCEs	5,638	3,122	3,062
Emergency Inpatient FFCEs	29,320	31,929	30,457
Day Cases	17,641	23,016	23,016
Facilities			
Generic Outpatient	49	61	61

	Current (2002/03)	Forecast (2010/11)	Impact of Strategic Change (2010/11)
Consulting Rooms			
Inpatient Beds	741	749	669
Day Spaces	39	78	78
Theatres	11	14	14
Performance			
Bed Occupancy	84.8%	84%	84%
Day Case Rate	76%	88%	88%

3.2 The Strategic Review has highlighted potential changes in the delivery of care for a range of interventional procedures and further improvements in the management of patients with chronic diseases including diabetes and COPD. The impact of theses specific changes has been assessed by the health economy and the greatest effect will be in terms of reduced outpatient attendances, admission avoidance and improved management of the post acute phase of care. The resultant plan over time would therefore be a reduction in occupied bed days. This would not impact on the functional content identified for the Manor Hospital site but would instead underpin the changed focus for Goscote.

3.3 The reduction in Outpatient attendances has been netted off in the forecast for outpatient activity in 2010/11, and is masked by the growth in demand for appropriate outpatient services which is expected over the same period.

DESCRIPTION OF TRUST AND LOCAL POPULATION

3.4 The Trust

3.4.1 Hospital facilities in Walsall date back to the opening of an 8-bed Cottage Hospital in 1863. The Sister Dora Hospital was opened in 1878 and was funded entirely from voluntary subscriptions. The Hospital was named in memory of Sister Dora, whose pioneering work and determination transformed Walsall's Hospital services in the nineteenth century.

3.4.2 The Trust currently provides services on two hospital sites, the Manor Hospital located 1 mile to the North West of the town centre, and Goscote Hospital located 2 miles to the East of the town centre and 3 miles from the Manor Hospital.

Figure 4. Map of Walsall showing location of Manor and Goscote Hospitals

3.4.3 The present Manor Hospital began life as the local Old Poor Law Infirmary and still has buildings dating back to the 1840's. Over the years the hospital has been altered and adapted and in the 1980's a major programme of development eventually enabled services to be transferred from the former Walsall General Hospital, and integrated to the Manor Hospital site in 1989.

3.4.4 The Manor Hospital remains the main 'District General Hospital' in Walsall has a complement of 638 beds covering the whole range of general acute specialties including obstetrics. All the main clinical and support services are located on the Hospital site with the exception of HSDU which is on an adjacent site on Pleck Road.

3.4.5 Goscote Hospital was originally built in 1914 and has provided a variety of services over the years. The hospital currently operates 103 staffed beds primarily for rehabilitation and care of elderly patients. In addition to the currently staffed beds a further ward is currently vacant and not used for patient care. Although a limited x-ray facility is provided on site the main support services are provided from the Manor Hospital. One key exception is catering services, which are provided from Goscote Hospital for the entire Trust.

3.4.6 A range of new services has also been established on the Goscote Hospital site including the current GP out of hours service (WALDOC). The hospital also forms a base for all of the out-of hours support teams for Walsall e.g. Rapid Access Team, Mental Health Crisis Team etc.

3.4.7 Included as ***Appendix A*** are overhead photos of the two sites.

3.4.8 The Trust provides a significant proportion of the secondary healthcare for the local population. The activity levels for the year 2002/2003 are summarised in the table below. It is this set of data that has been utilised to provide the baseline from which all planning assumptions have been developed.

Table 11. Out turn Activity Levels 2002/03 in terms of FFCEs

Specialty		Day Case	Elective IP	Non Electives	First OP Attend	Return OP Attend	Total OP Attend
100	General Surgery	3,588	1,527	4,760	6,664	17,522	24,186
101	Urology	1,757	600	55	1,389	4,019	5,408
110	Trauma & Orthopaedics	1,338	1,001	1,604	7,701	19,584	27,285
120	ENT	661	1,165	314	4,899	8,630	13,529
130	Ophthalmology	0	0	0	0	0	0
143	Orthodontics	38	0	0	543	4,347	4,890
190	Anaesthetics	107	4	1	565	707	1,272
303	Haematology (clinical)	956	62	34	843	18,017	18,860
400	Neurology	6	1	1	1,005	1,049	2,054
822	Chemical Pathology	0	0	0	424	303	727
990	Joint Consultative Clinic	0	0	0	26	433	459
420	Paediatrics	53	38	3,213	7,726	5,440	13,166
180	Accident & Emergency	77	0	1	8	202	210
	Genito-Urinary Medicine	0	0	0	4,039	5,451	9,490
All Medical		*4,174*	*321*	*11,352*	*7,417*	*23,881*	*31,298*
370	Medical Oncology	2,602	136	1	712	2,901	3,613
	Maternity	0	0	6,604	3,769	10,328	14,097
502	Obs & Gyn (Gynaecology)	2,071	774	1,361	3,926	10,608	14,534
170	Cardiothoracic Surgery	0	0	0	68	181	249
140	Oral surgery	213	2	0	1,149	2,140	3,289
330	Dermatology	0	7	19	2,877	3,957	6,834
Total		**17,641**	**5,638**	**29,320**	**55,750**	**139,700**	**195,450**

3.4.9 It is recognised that 86% of the patients attending the hospital for assessment or treatment are residents of the Borough and registered with Walsall Primary Care Trust (WPCT). However in developing its plans for the future the Trust is cognisant of the relatively high proportion of the Borough's population which receive care in neighbouring hospital facilities, particularly in Wolverhampton and Sutton Coldfield.

3.4.10 The Trust has an annual income stream of £109 million per annum of which WPCT contributes £88.6 million.

3.4.11 Delivery of effective care is dependent upon physical facilities and the skills of the clinical and support staff

3.4.12 In order to deliver the services using existing models of care the Trust provides the following facilities, and staffing establishments across the two sites:

Table 12. Service and Facilities Distribution

Service	Manor Hospital	Goscote Hospital
Beds	638	103
Generic Consulting Rooms	49	0
Day Hospital	0	1
Theatres	11	0
Imaging Units	16	1
Staff	2,952	191

3.5 Demography

3.5.1 The Metropolitan Borough of Walsall was formed in 1974 bringing together the old Staffordshire towns of Aldridge, Bloxwich, Brownhills, and Walsall along with the Black Country towns of Willenhall and Darlaston.

3.5.2 The Borough is located approximately 10 miles from Birmingham, with excellent communications, the area being well served by the motorway network with the M6, M5, M1, M40, M42 and M54 and the new M6 Toll Road close by.

3.6 Population

3.6.1 In assessing the population impact, the Trust has utilised 2001 census data where available, together with the ONS (Office of National Statistics) Estimates for 2002.

3.6.2 Walsall comprises 20 electoral wards and 478 enumeration districts. The Borough has a relatively stable population which was estimated by ONS in 2002 to be 253,500.

3.6.3 In terms of healthcare provision a small but significant proportion of the local Walsall population does not naturally flow towards the Manor Hospital for emergency or elective care. The impact of these outward flows is however balanced against an inflow of population from South Staffordshire and Birmingham.

3.6.4 In summary, the projected population for the planning period covered by this document i.e. for the period to 2010/11 indicates that there will be little change in the overall numbers, but there will be significant shifts in the age distribution. The Walsall age distribution is currently slightly younger than the national average.

Table 13. Population Age profile 2002

Age	Percentage Breakdown	National Percentage (England)
0 -14	20.3	18.9
15 -29	18.0	18.8
30 -44	21.5	22.7
45 -59	18.5	18.9
60 -74	14.6	13.2
75 +	7.0	7.5

3.6.5 Within the overall population numbers, there are marked differences in the age distribution between localities. For example, Palfrey, Blakenall and St Matthews have predominantly young populations whereas Aldridge, Pleck and Bloxwich have a more elderly population than the average.

3.6.6 The most marked change in the distribution will be the aging of the population. Forecasts project an increase in the 65- 74 grouping of 4%; a rise in those aged 75+ of 7%; and a sharp decline (14%) in the number of under 15s.

3.6.7 Historically, a catchment population in the region of 250,000 has been considered an appropriate base for healthcare planning. Increasingly however, changes in models of care, technology and service delivery methods have indicated that consideration should be given to a wider planning population. Consequently, as part of the Black Country Review, the Trust has assessed the potential impact of population changes in conjunction with the Walsall PCT, colleagues within Wolverhampton PCT, Dudley South and Dudley Beacon & Castle PCTs and the local Strategic Health Authority in order to develop an understanding of the whole of the Black Country. During the analysis it was recognised that in planning terms the closest relationships which would affect Walsall were, and would continue to be, with Wolverhampton. Both populations demonstrate similar characteristics and therefore planning assumptions as defined by the Black Country Review reflect those similar needs.

The table below summarises the projected population sizes and shifts for both populations between 2000 and 2010.

Table 14. Black Country Population Shift 2000 – 2010

Measure	Walsall	Wolverhampton
Population – 2000 (Base)	260,900	240,500
Population - 2010	253,500	236,200
Per cent change 2000-2010	-2.8%	-1.8%
% change in under 15's	-14%	-8%
% change in 65 – 74's	4%	-3%
% change in over 75's	7%	3%

3.6.8 This clearly indicates that the overall population of the two areas will fall, but the shift to an older population will have greater

impact in Walsall. The planning assumption adopted therefore reflects the needs of the two populations.

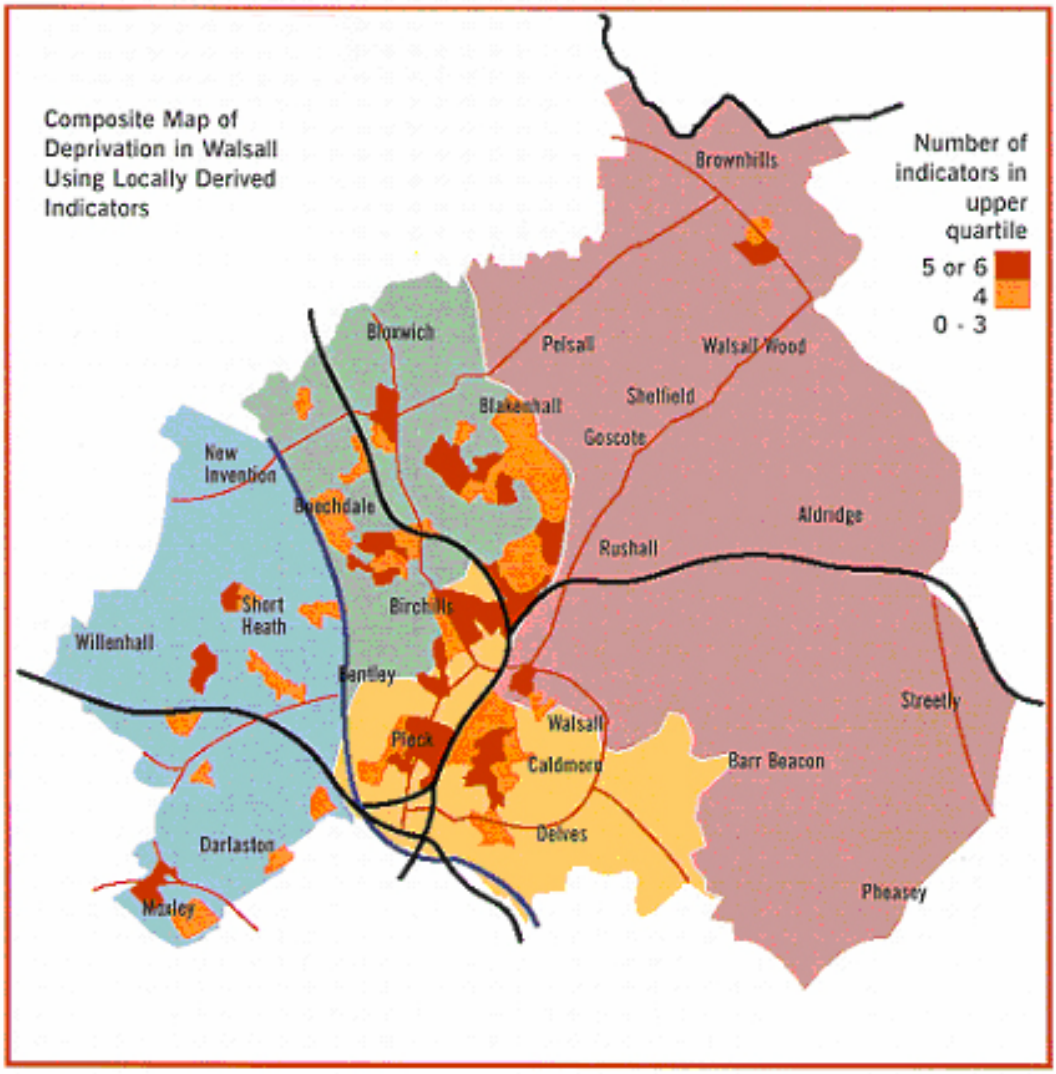
3.6.9 In the light of the obvious similarities between the Walsall and Wolverhampton populations, and the emphasis on the planning of health services for a population base of circa 500,000, colleagues from both health communities worked together to develop the planning assumptions to be adopted, and consequently endorsed by the Black Country Review. The scope of those assumptions and their impact on services and facilities within Walsall are highlighted in Section 4 of this case.

3.7 Deprivation

3.7.1 Social and economic factors are known to have a profound influence on health and the need for healthcare. Walsall is currently the fifth most deprived district within the West Midlands. 40% of the population falls into "deprived" social classes, with eight of the electoral wards having a Townsend score of above 5 (signifying greater than average levels of deprivation) i.e. Birchills/Leamore, Blakenhall, Bloxwich East, Darlaston South, Palfrey, Pleck, St Matthews and Willenhall South. The distribution of the areas of highest deprivation is highlighted in Figure 2. These measures have been derived using the evidence collected from the national census using the Townsend scoring method to assess:

- Economically active residents;
- Households without a car;
- Households not owner occupied;
- Households overcrowded.

Figure 5. Walsall Areas of Deprivation



3.7.2 The area has, in line with the rest of the UK has benefited from rising living standards and steady economic growth in recent years. However, growth has been slower than in the West Midlands and UK as a whole, and relative economic performance lags further behind the rest of the UK, and significantly behind the leading UK regions.

3.7.3 The table below provides a summary of the position of Walsall and Wolverhampton against a range of economic indicators:

Table 15. Summary of Economic Indicators

Indicator	Walsall	W'hampton	West Midlands	UK
Average gross weekly pay	£324	£334	£351	£369
Employed*	57%	54.2%	N/A	60.6%
Unemployed*	4.4%	5.3%	N/A	3.4%

Indicator	Walsall	W'hampton	West Midlands	UK
People claiming Income support* income	11.8%	13%	9.8%	9%

* as a % of residents aged 16 to 74

3.8 Ethnicity

3.8.1 The populations of Walsall and Wolverhampton are more ethnically diverse than other areas of the UK but show significant similarities, although the proportion of non-white in Wolverhampton is greater than Walsall based on the 2001 census the ethnic breakdown is summarized below:

Table 16. Ethnicity

	White	Mixed Race	Asian/ Asian British	Black/ Black British	Other
Walsall	86.4%	1.4%	10.5%	1.4%	0.4%
Wolverhampton	77.8%	2.7%	14.3%	4.6%	0.6%

3.8.2 In terms of Walsall the majority of the ethnic minorities live in the southern part of the Borough with the proportion of the population by ward ranging from 0.9% to 39.3%, the highest proportion being in Palfrey.

3.9 Epidemiology

3.9.1 There is a clearly established link between social and economic deprivation and the health status of the population. The indicators above signify a population from a relatively poor socio-economic background, whose demand for health services is greater than the average.

3.9.2 The recently published Annual Report of the Director of Public Health Medicine 'Examining the Variations in Health in Walsall' draws clear health messages from the relatively high incidence of ill health in Walsall and its socio-economic position. The following conclusions are used to highlight the concern:

a) Social Deprivation (Comparison to other Health Communities in the former West Midlands Region)

Walsall has:-

- 5th most deprived ranking measured by Townsend score;
- 4th highest birth rate;
- 11.7% unemployment compared to 9.8% (regional average);
- 9.6% ethnic minorities compared to 8.2% (regional

average).

b) Ill Health

Compared with the overall regional position:

- Deaths from Coronary Heart Disease are the worst;
- Deaths from breast cancer in females are the worst;
- Deaths from stroke in males are 4th worst;
- Deaths from lung cancer in males are the 4th worst;
- Teenage abortions are the 5th worst;
- Low birth weight babies are the 7th worst;
- Rate of long term illness in Walsall is 13.3% compared to 12.1%.

3.9.3 Additionally, there are significant inequalities in health status within Walsall. There is a marked difference in both socio-economic and health status between the east and west of the Borough, with the west having greater population density, higher unemployment, higher levels of deprivation and at the same time higher levels of death from coronary heart disease and lung cancer.

3.9.4 In terms of standardised mortality ratios and standardised years of life lost, both Walsall and Wolverhampton rank poorly in comparison with PCTs across England and Wales, as summarised in the table below:

Table 17. Standardised Mortality Ratios and Years of Life Lost

Population Base	Standardised mortality Ratio	Standardised Years of life lost (SYLL)	SYLL PCT Percentile
Walsall PCT	107	553.8	66%
Wolverhampton	105	612.4	82%
England & Wales	100	517.3	N/A

3.9.5 Interestingly, if one maps service provision to these powerful indicators, then one would expect to see some correlation. This is not always the case with certain aspects of health provision going to those areas with not necessarily the greatest needs.

3.9.6 Clearly the above important messages must inform and direct the provision of future services and must be used as the basis for the planning and delivery of a comprehensive health service for Walsall aimed clearly at meeting the greatest needs in the most effective and efficient manner.

STRATEGIC DIRECTION AND BUSINESS OBJECTIVES

3.10 Current Pattern of Services

3.10.1 The Walsall Hospitals NHS Trust was established in April 1991 and provides a range of acute secondary care services for the diagnosis, treatment and care of patients whose healthcare needs cannot be met within the community/primary care.

3.10.2 With the existing models of care approximately 53,000 patients are admitted and over 190,000 outpatients are treated at the two hospitals each year. A further 70,000 patients attend the Accident and Emergency Department. ***Appendix B*** shows the Contracted Activity for 2002/03, 2003/04 and 2004/05.

3.10.3 Of the patients treated within the Trust, 85% are residents of Walsall. There remainder of patients travelling from neighbouring Boroughs, mainly South Staffordshire, Wolverhampton, Sandwell but also parts of Birmingham, Dudley and Shropshire.

3.10.4 The Trust currently provides a full range of 'district general hospital' services to the local population including certain community-based services as outlined below. The Trust does not currently provide inpatient regional specialty or other 'high-tech' services, but does provide an increasing number of satellite specialised outpatient/day case services in Walsall to meet the needs of the local population, such as ophthalmology, nephrology, plastic surgery and specialist paediatric clinics.

3.10.5 The Trust is extremely conscious that although it has a significant role to play in the delivery of healthcare to its local population, it is only one of a range of partners within the Health Economy. Historically, hospital-based care has been a central focus in the establishment of models of care and the related planning process. However, with the range of Modernisation initiatives, particularly in terms of the role of Primary Care based practitioners; developments in technology and pharmaceuticals; and the integration of planning between the different health partners and social care; there is a clear recognition within the Acute Service that the pattern of service delivery must change in order to appropriately meet the needs of the local population. Such changes will impact on the level of activity undertaken on the acute hospital sites, and must therefore influence the facilities which are provided within secondary care.

3.10.6 The Trust has developed a number of community-based services, specifically within Obstetrics and Paediatrics, although increasingly in terms of pre-admission planning and post-discharge care. Furthermore, as the boundaries between hospital and community based care shift, the Trust has responded, with the provision of outreach services as a natural extension of hospital care.

3.10.7 The delivery of healthcare services within Walsall is no longer undertaken in isolation, and in response to national directives, but is beginning to reflect the needs of the local population and involve a wide range of stakeholders including Primary Care, Social Care,

the Local Authority, the Voluntary sector and the private sector, together with the patients. There is also an increasing acknowledgement of the clinical and service benefits arising from the introduction of "networks" involving a much broader basis for care design and delivery, with links already established with colleagues in Wolverhampton and Birmingham.

3.10.8 Service delivery must reflect the Modernisation agenda including the full range of National Service Frameworks, and a number of key examples are already in place including:

- Booked Admissions Programme;
- Management of patients who have suffered a Stroke;
- Changes in the management of Chronic disease;
- Diabetes;
- COPD;
- Chronic Heart Disease;
- Cancer services;
- Development of Older People's Services.

3.10.9 The Health community has also acknowledged the significant role played by the improved management of emergency care, particularly for vulnerable patients who experience multiple hospital admissions. The benefits of different models such as those demonstrated by the Evercare Project (of which Walsall is currently a pilot) are recognised as having a significant impact on future models of care delivery and consequently the provision of healthcare facilities.

3.10.10 The full impact of these initiatives, together with the further changes which will arise from the Reforming Emergency Care, Intermediate Care and Patient Choice initiatives, has yet to be realised. In planning the future developments within the hospital services in both the short and long term the need to embrace these developments and provide an environment which supports the totality of care has become a core theme reflected in the Trust's key objectives and service delivery plans.

3.10.11 Although for the foreseeable future the strategy sees the continued use of both the Manor and Goscote Hospital sites the Trust and Walsall tPCT have agreed that over time the focus of activity at Goscote Hospital should evolve towards the provision of community services for older people and intermediate care services. The end point of this process would be for Walsall tPCT to then become responsible for the delivery of Goscote services.

3.11 Strategic Direction of Trust - Objectives

3.11.1 The vision for future healthcare has been primarily informed by the Black Country Review which is outlined in Section 3.12.

3.11.2 The vision adopted by the Trust embraces a number of corporate objectives, which emphasise the vital importance of providing the

highest possible quality of care, by the right people, at the right time and in the right place.

This OBC has been developed in conjunction with health and social care partners within Walsall and the Black Country and is based upon the principles of developing and modernising health services in Walsall and the Black Country by delivering an integrated and seamless service for the users of acute and primary care services as part of the whole health economy.

The work of the Black Country Review 2004 has been embraced within the detailed forecasts which have been made of the future requirements for services from the Trust, developed in conjunction with Walsall tPCT, Wolverhampton City PCT and Royal Wolverhampton Hospitals NHS Trust.

It has been calculated that over the planning period to 2010/2011 activity within the acute Trust will experience a net increase of 10.4%. This OBC has approached this increase from the perspective of avoiding the need to introduce additional inpatient beds, and embraces the challenge of further increases in the level of day case and outpatient interventions and the development of improved functional adjacencies and clinical linkages. National best practice performance and efficiency measures have been adopted and the implications in terms of the management of services and clinical practice accepted.

The scale of facilities upon which this OBC is based when including the Goscote complement conforms fully to the assumptions agreed as Stage 1 of the Black Country review (utilising agreed best practice assumptions for efficiency and throughput). The outcome of Stage 2 of the Black Country Review (impact of new models of 'care closer to home' particularly in chronic disease management) has confirmed that the facilities proposed for the Manor Hospital site will still be required even with the revised assumptions upon which this stage of the Review is founded. The utilisation of Goscote would, however, change in line with the agreed plans referred to above.

The Trust embraces the significant change that will be required in the way it provides clinical services in the future. This will be influenced by commissioners, clinical developments and the need to respond to changing national priorities. The Trust will continue to develop closer working arrangements with the Walsall and Wolverhampton PCTs, General Practitioners and Royal Wolverhampton Hospitals NHS Trust in delivering these changes.

The Trust is committed to working with Royal Wolverhampton Hospitals NHS Trust to ensure that shared clinical services are planned and developed effectively to meet future site developments. The Walsall and Wolverhampton City PCTs have developed a joint Primary Care Strategy which provides a commitment to develop new service models for intermediate, community and chronic disease services which are consistent across the local health economy. The strategy is consistent with the parallel moves

towards closer commissioning with the shared LIFT programme and the close working evolving between the four Trusts in Walsall and Wolverhampton.

As principal commissioners of service from the Trust, Walsall tPCT seeks to implement the following strategic goals:

- Ensure the provision of high quality care for the residents of Walsall;
- Ensure equity of access for all residents of the Borough based upon clinical need;
- Commission an appropriate level of service to meet the genuine healthcare needs of the population;
- Commission an appropriate level of service to ensure timely access to services when required;
- Ensure provision of services to an appropriate standard having regard to professional advice regarding safety, clinical excellence and outcomes;
- Ensure patients are treated in a safe and high quality environment;
- Ensure, where possible, the provision of services local to the population;
- Ensure the delivery of key targets and goals as set out in the NHS Plan.

The Trust approach to meeting Commissioner service requirements includes the following key elements:

- To improve the health of the local population through the provision of high quality and clinically effective care;
- To improve the Quality of Patient Care by facilitating changes in the pattern of service delivery, including increases in Day Case activity; reduced inpatient lengths of stay; the provision of increased minor procedures in the outpatient setting; supporting the development of community based services to support 'care closer to home' and new models of Coronary Disease Management;
- To integrate clinical services and improve the physical relationship between facilities;
- To provide flexible accommodation capable of keeping pace with technological and service change;
- To maximise access to facilities for the local population, enabling closer links between acute facilities and services provided by the Primary Care Service;
- Improve the standard of facilities, to reduce the level of backlog maintenance and provide a quality physical environment for patient care;
- To improve operating efficiency, through better utilisation

of physical and human resources which will lead to reduced running costs and the opportunity for re-occurring savings;

- To provide a centre of training and educational excellence for all health professionals.

3.12 Delivery of Acute Services

The requirement to modernise the NHS, as identified within the NHS Plan, has had a significant impact on Health Services in Walsall and has resulted in significantly greater emphasis on the modernisation of models of care and the facilities in which care is delivered. This has been reflected in a range of National Guidance Documents, and service development initiatives which have clearly influenced the review of local provision within the Black Country, and specifically within Walsall.

3.13 The Black Country Review

The Black Country Review has driven a new approach to service modeling across the health economies of Walsall, Wolverhampton and Dudley. The process involved two stages:

Stage 1 Assessment of efficiency and growth assumptions;

Stage 2 Development of alternative healthcare models using templates for admission avoidance, transfer of care and best practice which were then validated by the clinical working groups, NHS Trusts and PCTs.

The Review was concluded in April 2004 and the outcome reported in the document Health in the Black Country – Better by Design. There was extensive involvement from across the Black Country in the process of the review from Clinicians, Managers and other staff employed by all stakeholders.

A comprehensive public and patient involvement programme was also included as part of the review.

The outcome of the review was to transform primary and secondary service models and instigate a reappraisal of the projected activity for primary and secondary care for 2010. The resulting activity and capacity projections, including the modeling assumptions, were approved and signed off in March 2004 by the Chief Executive Officers of the Trusts involved and have been independently ratified by the Birmingham and Black Country Strategic Health Authority. These agreed elements, forming the cornerstones of this OBC, are:

- The model of care;
- The activity plan for 2010/11;
- Performance Assumptions;

- Growth assumptions;
- Transfers into the community;
- Bed profiles for this OBC.

3.14 The Estate

3.14.1 A major space utilisation study of the Manor and Goscote Hospitals was undertaken prior to establishing the plans for the re-development of Clinical Services. This was further updated in November 2000.

3.14.2 To assess the estate's potential, four primary nationally recognised criteria were analysed:

- Functional suitability;
- Space Utilisation;
- Energy Performance;
- Physical Condition.

Table 18. Functional Suitability

CATEGORY	MANOR		GOSCOTE	
	%	m2	%	m2
A	0.00%	0	0.00%	0
B	57.10%	34,324	23.70%	1,654
C	14.30%	8,650	39.00%	2,714
D	0.00%	0	0.00%	0
Dx	28.60%	17,217	37.30%	2,590
TOTAL	**100.00%**	**60,191**	**100.00%**	**6,958**

Table 19. Space Utilisation

CATEGORY	MANOR		GOSCOTE	
	%	m2	%	m2
E	3.00%	1,807	0.00%	0
U	3.50%	2,118	0.00%	0
F	84.50%	50,849	100.00%	6,958
O	9.00%	5,417	0.00%	0
TOTAL	**100.00%**	**60,191**	**100.00%**	**6,958**

Table 20. Energy Performance

CATEGORY	MANOR		GOSCOTE	
	%	M2	%	m2
A	0.00%	0	0.00%	0
B	57.00%	34,325	100.00%	6,958
C	24.00%	14,465	0.00%	0
D	19.00%	11,400	0.00%	0

TOTAL	**100.00%**	**60,190**	**100.00%**	**6,958**

Table 21. Physical Condition

CATEGORY	MANOR		GOSCOTE	
	%	m2	%	m2
A	11.00%	6,607	0.00%	0
B	45.80%	27,572	0.00%	0
C	41.50%	24,961	79.00%	5,497
D	1.70%	1,051	21.00%	1,461
TOTAL	**100.00%**	**50,191**	**100.00%**	**6,958**

3.14.3 The study concluded that although considerable investment had been made to improve clinical services, with the opening of the West Wing in 1989 and the Maternity Wing in 1994, there were still a number of major anomalies relating to clinical relationships, functional suitability and physical condition which needed to be addressed.

3.14.4 The estate is approximately 19.6 hectares (48.4 acres) of which 7.7 hectares (39%) is made up of building stock. On the Manor Hospital Site 8% of the building stock is category `A', 48% category `B', 18% category `C' condition and 21% category D/DX (5% occupied by Mid Staffs Trust for the provision of laundry facilities). At Goscote Hospital the comparable figures are 6% - 'A', 57% - 'B' and 37% - 'C'. The following table highlights the overall position.

Table 22. Summary of Estate

Manor Hospital	
Total site area	12.64 ha
Building floor area	70,094 sq m
Value of land £k	5,881
Value of building £k	64,180
Fire Safety liabilities £k	400
Statutory & Safety liabilities £k	1,000
Physical Condition liabilities £k	11,400
Goscote Hospital	
Total site area	6.96 ha
Building floor area	8,756 sq m
Value of land £k	1,403
Value of buildings £k	7,111
Physical Condition liabilities £k	2,000

3.14.5 Backlog maintenance on the Manor Hospital Site stands at £12.8m without planned action on major infrastructure changes to improve efficiency, quality and flexibility of clinical services. Goscote has £2m of backlog maintenance.

3.14.6 The study identified the following key requirements for the provision of a quality environment for patient focused care:

- Better clinical and physical integration of facilities;

- Replacement of East Wing;
- Replacement of the existing Out-Patient/Pathology building;
- Modification or alternative use of South Wing to overcome shortcomings in the functional and physical condition of the building;
- Rationalisation of administration and other ancillary accommodation;
- Improvements in access to and around the Manor site.

3.14.7 The two hospital sites consist of accommodation which ranges in age from the late 1800s to 1994 at the Manor Hospital, and from 1928 to 1980 at Goscote. A breakdown of accommodation by age and plans of the Manor Hospital Site is contained in ***Appendix C.***

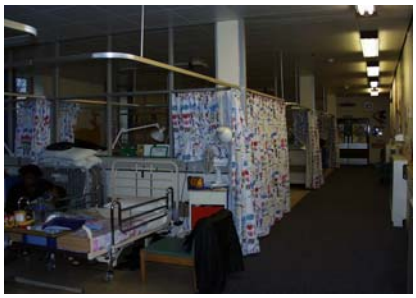
3.14.8 The major building components of the Manor Hospital Site can be described as follows:

- **St John's Block**

Victorian pre 1900 ward block. It occupies a prime corner of the site, and has no long-term future. Building condition is poor and the facilities are unsuited to any clinical use. Currently in use for office accommodation and Wolverhampton University student nurse training rooms.

- **East Wing**

Victorian pre-1900 ward block. Ward accommodation is very cramped, with very limited space available for parents to stay with their children. Available ward space falls considerably short of current Health Building Note standards and is considered unsuitable for current standards of care.



Condition is extremely poor (Condition Dx) and the only viable proposition for the building is demolition and replacement. As the construction of such a facility will take a number of years (minimum 5) a considerable sum of capital (£3.7m) has been invested in the building as an interim measure to maintain the building in use for that time period. Such an investment is the minimum acceptable level to satisfy the basic requirements of current health and safety law and to satisfy the requirements of the local Fire Service until 2007.

- **Sister Dora Outpatients/Pathology**

Constructed in the early 1970s, this block is of modular lightweight construction design. As such its economic lifecycle is limited. Originally constructed for 30 years, the building has recently been re-decorated to provide a cleaner and more airy environment for patients waiting.

This minor upgrade was, however, essentially cosmetic in nature. A fundamental re-design of the building would be required to allow greater flexibility in use to accommodate current working practices in one-stop activities, or services would need to be redesigned to support multidisciplinary working or the establishment of support clinical services.

Again the only practical future for this building is demolition and replacement. The building will reach the end of its economic life

within the next 10 years and, without major expenditure, could not be adapted to meet the current and future requirements for ambulatory care.

- **South Wing**

Constructed in the 1970s, this building is of cladded heavyweight construction and from a building structure point of view has a remaining life of between 10 and 15 years. The block contains 4 wards based on 6 bed bays, together with the Medical Assessment/Admissions Ward, and a Medical Day Ward.

Condition is reasonably fair, but the functional suitability is poor with wards designed in 34 bed format that are not suitable for current medical and nursing practices or the Consumerism standards issued by NHS Estates.

- **West Wing**

Opened in 1989, this building houses most of the core general acute clinical facilities for the hospital. The building is in good overall condition (Condition B) and has a long remaining life subject to a major lifecycle upgrade in approximately 10 years.

The standards of ward accommodation, although significantly more flexible than those within the South Wing also fall below those Consumerism standards established by NHS Estates.

- **Maternity**

The newest of the hospital buildings, opened in 1994, it accommodates maternity services.

3.14.9 Further information on estate condition, including site plans, can be found in ***Appendix C***.

3.15 Estate Strategy and Development Control Plan

3.15.1 Taking the above into account, the Trust has undertaken a detailed review of its estate and produced a Development Control Plan and Estates Strategy (available as a separate document).

3.15.2 This strategy document updates previous reports on condition and functional suitability from which it can be seen that Infrastructure Investment Requirements now stand at approximately £9m with 39% of accommodation at the Manor Hospital being in condition C or above but 50% being in category D in respect of statutory standards. A high proportion of this sum relates to the East Wing/OPD. In terms of functional suitability the East Wing remains in condition Dx.

3.15.3 The strategy then maps out the current and proposed developments on the Manor and Goscote sites including the current proposal.

3.15.4 For the foreseeable future, the Estates strategy forecasts the continued use of both the Manor and Goscote Hospital sites.

3.15.5 The focus for Goscote Hospital will become more rehabilitation/ intermediate care focused leaving the Manor Hospital as the main acute service provision within the Borough.

3.15.6 The developments planned at the Manor Hospital over the short and medium term fall into three categories:

- Facilities to meet the short term (pre PFI) needs of the

Trust for example additional out patient capacity prior the development of the Diagnostic Treatment Centre;

- Facilities which meet the long term needs of the Trust which do not form part of this proposal for example the introduction of a fixed Cardiac Catherisation Suite and Multi Professional Education Centre;
- Facilities, which are, included within this Business Case for example the replacement of separate Surgical Daycase and Out Patients within an integrated Diagnostic & Treatment Centre.

These developments will lead to the demolition of the majority of older accommodation on the site including East Wing, Sister Dora Out Patients, Pathology PGMC, South Wing, Education & Training and St. John's Block.

SECTION 4

THE CASE FOR CHANGE

CURRENT SERVICES AND DEFICIENCIES

4.1 Current Position

4.1.1 The provision of secondary care within Walsall has been managed by the Walsall Hospitals NHS Trust since its establishment in 1991. The trust provides hospital services on two sites, although the patients treated on the Goscote Hospital site are in general receiving ongoing rehabilitation having completed the acute element of their episode of care.

4.1.2 In addressing the need to establish a pattern of service delivery which meets the requirements of a modern health service and is flexible, supportive and meets the needs of the patient, the Trust has undertaken a review of the models of care for each of its services and identified a wide range of issues which need to be addressed.

4.1.3 A key issue for the Trust is the limitation placed upon it by the standard of the accommodation on the Manor Hospital site. In establishing the new models of care, the shortcomings of the existing accommodation have been highlighted and confirmed the need for alternative provision.

4.2 Models of Care

4.2.1 The need to redesign models of care is central to the modernisation of healthcare, in order to ensure that the needs of the individual patient are at the core, and that access is provided to the right care, at the right time by the right professional.

4.2.2 All of the clinical services provided within the Trust have begun to reassess the patterns of their service delivery and identified the changes needed in order to meet the standards and targets identified within the various guidance documents. The approach to developing the models of care has now also embraced the principles adopted by the Black Country Review.

4.2.3 A fundamental difference in approach to the design of services has been the involvement, from the inception of the Project, of colleagues across the Trust and from external partners, including the PCT, social care and neighbouring care providers. The strategic clinical networks which have been established, along with further such developments, will enhance the assessment and planning of the appropriate models of care and underpin the ongoing viability of service provision to the local population.

4.2.4 The work which has been undertaken within the Trust, and subsequently the Black Country Review, has identified the requirement for major changes in the following services:

- Children & Younger People;
- Gynaecology and Breast;
- Routine Elective diagnosis and Treatment;
- Management of episodes in excess of 48 hours;
- Emergency Care.

4.2.5 Children & Younger People

4.2.5.1 The provision of hospital based care for children has altered significantly in response to the changing needs of the local population and in recognition of the need to support the whole of the family not just the sick child.

4.2.5.2 The importance of the involvement of health and other professionals in the provision of a holistic approach to caring for children has long been acknowledged with the models of care within Walsall providing the interface for seamless care.

4.2.5.3 The guidance for planning services for children has clearly identified the need to ensure that their very specific needs are met, particularly the issue of providing care in an environment in which children feel safe and secure, and which is orientated towards children rather than adults.

4.2.5.4 Central to the changing models within Walsall is the need to provide a single, integrated service which meets the needs of all children who need to attend hospital for diagnosis or treatment. The model also recognises the particular needs of adolescents and therefore supports the planning of services in line with the NSF, for children and younger people up to their 19th birthday.

4.2.5.5 It is recognised within the model that contact with the hospital for most children is either on a planned, outpatient basis. However, where emergency support is needed, the focus is upon rapid assessment and initial intervention and monitoring in preparation for support and management in the home, rather than lengthy periods of admission to hospital. Admission to hospital tends to be mainly short, focused interventions in which the parents and siblings are fully involved.

4.2.5.6 The availability of paediatric support to Maternity and A&E services is a fundamental requirement for those services in terms of the delivery of care within a District General Hospital. In designing the nature of the overall Children and Younger People's service the viability of these services is a key objective. Consequently the need for the establishment of networking with neighbouring units has been acknowledged with the potential for joint working with Wolverhampton to support the requirements of both populations underpinning the long term resourcing of the service

4.2.5.7 However, in redesigning the model of care the following issues face the Children and Younger People Services:

- Inpatient Services are provided from two sites at opposite ends of the hospital with Paediatric Medicine in East Wing, together with limited Outpatients with paediatric Surgery and the remaining outpatients provided in West wing and Sister Dora Outpatients;
- Due to the disparate nature of the facilities they are poorly utilised and there is limited scope for further integration of staffing resources;
- There is no flexibility to allow for the consolidation of all outpatients into a single department;
- There are no facilities to support the child protection service;
- There are no dedicated facilities for Adolescents;
- The ability to support parents is limited;
- The provision of the majority of the service within the East Wing in itself raises vital issues in terms of the environment which must be addressed;
- The requirements of fire certification are severely compromised by the structure of the East Wing building. A temporary extension of fire certification has been granted only on the condition that a comprehensive risk management plan has been agreed with the Fire Service and that short term a considerable amount of investment is made in the infrastructure to maintain safe services. This investment only provides a temporary respite for the next five years and not a permanent solution. If the building is not replaced within that timescale further substantial expenditure will be incurred. The impact of this is to provide services which are not considered as safe as they should be;
- Lack of integration of paediatric services leads to inefficient use of resources and a lack of effective clinical linkages contrary to advice from the NHS Executive, National Audit Office, Action for Sick Children etc. In particular this leads to difficulties in recruiting to RSCN nursing posts, since available nurses have to be spread across the entire hospital site. Current guidance (related to the provision of care to children under the supervision of a Consultant Paediatrician with nominated BAPS trained surgical staff) cannot always be followed leading to a reduction in effectiveness of care. (Integrated in this context means that all clinical services for this group of patients is delivered from a single location by a single team of professional staff);
- Accommodation does not meet current standards for the provision of modern paediatric services, in particular,

facilities for parents who have to sleep on camp beds between the children's beds, resulting in a lack of privacy and dignity. There are also no parental facilities within ward areas for washing, toilets or making beverages and snacks. Such requirements cannot be adequately met within the cramped accommodation available. The lack of parental accommodation impacts upon the effectiveness of treatment and outcomes;

- Ward space is 30% below current building note standards, leading to difficulties in the provision of effective modern treatment processes;
- Lack of suitable adolescent facilities; reducing the quality of care for this particular patient group through the inadequate provision for privacy and dignity;
- Lack of separate day case facilities - children are admitted mainly to inpatient beds which is an inefficient use of resources;
- Schooling facilities are extremely poor and very inadequate;
- Inadequate engineering services;
- Accommodation substandard. Built in 19th century, the accommodation in East Wing is poor in terms of the provision of modern health services and suffers from major backlog maintenance. The level of backlog maintenance within the East Wing is currently approximately £5m. Even if these funds were spent on the Wing, 25% of the building would still be in condition Dx in respect of statutory elements;
- The major difficulty with the structure of the East Wing building relates to the structural integrity of the floor loading whereby the upper floors can no longer take the load demanded by the provision of modern health services;
- The overall condition and suitability of the East Wing building means that further investment would represent poor value for money as such investment could not eradicate the basic fundamental problems of this building.

4.2.6 Gynaecology and Breast Services

4.2.6.1 The proposed model of care aims to provide the highest standards of care, in an environment which provides support and encouragement to manage the most sensitive changes a woman can experience.

4.2.6.2 Although hospital based, much of the Gynaecology service is ambulatory in nature, with a significant proportion of care provided on an outpatient or day case basis, and early discharge schemes supporting the early return to everyday living.

4.2.6.3 However, there is a considerable level of workload arising from the treatment and support of women with cancer. The care provided at Walsall is part of the local Cancer Network and the models of care and protocols reflect the wider network agreements.

4.2.6.4 The emphasis within the Unit is therefore to ensure that the patient journey is as seamless as possible in a user/woman-friendly environment.

4.2.6.5 The development of a combined facility for Gynaecology and Breast services is based upon the similarities surrounding the models of care and the needs of the women, in terms of the particular sensitivities relating to treatment, and particularly the impact of surgical intervention.

4.2.6.7 Within the current service structure there is no formal integration of the two services, on either an inpatient or outpatient basis. Although the Breast services are provided within the West Wing, the Gynaecology service (as outlined for children's services) is provided within the East Wing, including theatres. The significant problems within the building are consequently mirrored within Gynaecology.

4.2.6.8 In order to establish the proposed model of care, it is therefore essential that alternative facilities are established.

4.2.6.9 In addition to the integration of Gynaecology and Breast services an essential requirement for the effective and efficient delivery of Gynaecology services is the integration of facilities with those provided for Obstetrics, as in terms of medical staff, it is the same individuals supporting both service needs. Consequently the co-location of these services will improve communications and the effective utilisation of resources. The integration will require the co-location of inpatient facilities but will also involve the relocation of the Antenatal Clinic, to an area adjacent to the Obstetric and Gynaecology provision.

4.2.7 Routine Elective Diagnosis and Treatment

4.2.7.1 A core objective of the modernised health service is the ability to access diagnostics and treatment with the minimum of delay, and on the basis that what is planned occurs.

4.2.7.2 In establishing the model for the future delivery of elective care the changing roles between primary and secondary care are fundamental in order to ensure that patients access services as close to their home as possible. It is essential therefore that the service design is developed upon:

- an increasing ability to support initial diagnosis within primary care;
- where appropriate, the instigation of treatment, with hospital attendances for the more complex diagnostic needs;
- wherever practical a higher level of testing and intervention

occurring at a single visit.

4.2.7.3 In order to achieve a consistent, planned level of access to services; there is a need to ensure that facilities utilised for elective care are separated from those required to support emergency care. Where such separation occurs there is limited risk of cancellation of elective activity and therefore greater certainty for patients, and more effective utilisation of resources, including clinicians and theatres. The establishment of high levels of consistency supports the delivery of increased activity and reduction of waiting times, thus improving the potential for local management of 'Patient Choice', both at point of referral from the GP and, in the event that a patient should wait in excess of 3 months for their elective treatment.

4.2.7.4 On reviewing the activity model within Walsall, the proportion of routine elective work which requires attendance at hospital for more than 48 hours is relatively low. A model of care has therefore been developed which seeks to co-ordinate the elective diagnosis and treatment of all adults (other than gynaecology) whose contact with the hospital will be 47 hours or less, within a single facility providing:

- Outpatient consultation;
- Imaging and other diagnostics;
- Interventional facilities including Endoscopy and Theatres;
- Recovery accommodation.

4.2.7.5 Within the existing facilities the provision of these services is widely distributed across the various buildings on the site. The majority of outpatient and daycase attendances under the existing model utilise the facilities within Sister Dora Outpatients Building. In terms of service delivery the building has a number of constraints:

- Building is of lightweight construction and at over 30 years old is nearing the end of its economic life;
- Facilities for staff are poor, lack of adequate ventilation, poor working environment and general staff facilities are of particular concern as are patient facilities and patient waiting areas;
- Inflexibility of use makes it extremely difficult to use to deliver modern day ambulatory care facilities;
- Lack of suitable diagnostic facilities on site means that patients have to visit several disparate areas of the hospital during a single visit;
- Waiting arrangements lead to severe overcrowding in high volume clinics;
- Current day case area, located within the department, is constrained from any future expansion;
- Recovery facilities are totally inadequate to facilitate the extended use of the facility other than in its current

configuration i.e. general anaesthetics in the morning and local anaesthetics in the afternoon.

4.2.7.6 The redesign of the routine elective pathways has also highlighted the issues surrounding the delivery of diagnostic services within Pathology in particular. The need to provide more flexible services through integrated laboratories is becoming increasingly important for both the hospital and primary care based services. The Pathology Services on the Manor Hospital site are located in the Sister Dora Outpatients Building. Many of the shortfalls of the facility are highlighted above but the issues specific to Pathology include:

- Building is of lightweight construction and at over 30 years old is nearing the end of its economic life;
- The facilities breach CPA accreditation guidelines in terms of laboratory and patient facilities, most notably:
- The specimen reception areas are too cramped;
- The white coat delineation for a safe working environment cannot be made readily identifiable and is therefore inappropriately managed;
- Patient waiting areas are too small with no adequate provision to meet privacy and dignity standards during sample taking;
- Lack of integration of facilities leading to inefficiency in the use of space and equipment;
- Isolated nature of department leads to difficulties in the efficient transportation of specimens.

4.2.8 Management of Episodes in excess of 48 hours

4.2.8.1 The separation of routine elective work as outlined in the model in section 4.2.7.4 also raises implications for the ongoing management of those cases whose episode of hospital care is in excess of 48 hours.

4.2.8.2 There is an increasing acknowledgement that the truly acute episode of care must, quite appropriately, be managed within an acute hospital setting. However, in terms of longer term support and rehabilitation the environment within which this is delivered does not require the full acute hospital resource, and indeed the skills required to implement the care are not limited or specific to acute hospital staff.

4.2.8.3 In developing new models of care, the importance of active care and support for longer term patients is an essential driver to ensure that the principles of intermediate care (and the need to regain independence and return to the home environment) are in place. The focus for the hospital must be the management of the acute episode, with the seamless transfer to the most appropriate ongoing support at the correct stage in the recovery process.

4.2.8.4 This model has a significant impact on the structure of hospital bed provision for the future, with a clear need to differentiate between patients who must be supported on the main Manor Hospital site, and those who would appropriately benefit from a period of support at Goscote Hospital, or indeed at home with assistance and support or in another community setting.

4.2.8.5 The model of care therefore implies a different distribution of beds across the sites, and a change in emphasis for facilities at Goscote, although significant alteration to facilities would not be anticipated.

4.2.8.6 There are also a range of potential changes in the models of care for specific conditions which, when alternative care protocols involving hospital and primary care staff are introduced, will impact on the overall length of stay in hospital for patients thus allowing an earlier discharge, and reducing levels of readmissions.

4.2.9 Emergency Care

4.2.9.1 A fundamental focus for appropriate emergency care is the availability of/access to, appropriate assessment and diagnosis. The delivery of the assessment model is not wholly reliant on the facilities and skills of secondary care, since there are wide ranging options for the provision of alternatives within primary care and other social and community facilities.

4.2.9.2 In developing the model of care within the Trust it is acknowledged that a degree of intensive assessment, diagnosis and treatment will be provided, but the full nature of that service in the long term has yet to be finalised with colleagues within primary care and in conjunction with neighbouring secondary care organisations.

4.2.9.3 A major issue which will be addressed jointly between Primary Care and the hospital is the ongoing support and management of patients with chronic disease. The emphasis on extensive support at home, to recognise the signs of "crisis", and support care and treatment at home, is acknowledged to have a significant impact on hospital based services.

4.2.9.4 The ongoing development of this model does not impact on the viability of the remaining models of care outlined above, and the establishment of an appropriate physical solution, but will compliment the final solution. The development of the emergency care model is recognised as having an impact on the working practices within the acute hospital, and also within intermediate care. However, the impact on the functional content required within the Manor Hospital and Goscote Hospital has already been acknowledged in the development of this case.

4.3 Education and Development

The Health Economy has developed a three year Workforce Plan that forms an integral part of the Local Delivery Plan and contributes to the Birmingham and Black Country Strategic Health Authority (BBC SHA) Workforce Plan. The plan highlights

significant staffing deficiencies and the requirement to provide a positive response in order to protect local services

An assessment of education and training facilities within the Walsall Health Community was carried out and the available facilities were confirmed as totally inadequate.

- The only formal teaching accommodation within the Acute Trust is the Postgraduate Medical Centre built in the 1960's of a lightweight wooden construction, which is now in a poor condition, with inadequate space even to provide postgraduate medical services with no capacity to meet the increasing demand from other professional groups such as; nurses, PCS staff and the increasing number of undergraduate doctors receiving their training at the hospital;
- The Trust has consequently had to restrict undergraduate numbers as it is impossible to find a large enough venue for them to meet daily;
- Suitable training facilities within the wider health community are virtually non-existent with the exception of a library facility at the Dorothy Pattison Hospital, the Training Room at Bloxwich Hospital and IT training at Jubilee House. Any large events organised by the health community must be based at the Walsall Football Club Bescot Stadium, as this is the only venue within the locality to cater for the numbers of personnel involved;
- Currently approximately 30% of the training and continuing professional development (CPD) for General Practice staff, including Practice Nurses is provided in commercial venues across Walsall, such as community Centres and hotels due to the lack of facilities within the tPCT.

4.4 Quality of Capital Stock

4.4.1 Within the sections outlining the revised models of care which the Trust is seeking to introduce a number of limitations in terms of the existing building stock have been identified.

4.4.2 The provision of effective and efficient facilities to support thenew models of care is clear in terms of the changes required for East Wing and Sister Dora. However the facilities available to support episodes of care over 48 hours must also be addressed.

4.4.3 The facilities within West Wing are generally of a reasonable standard but do not meet the latest guidance issued by NHS Estates in terms of consumerism, and in particular, the need to maintain improved levels of privacy and dignity for patients. The situation within the existing South Wing has the further problem of inflexibility in terms of providing appropriate ward and support accommodation to deliver the new models of care, especially the

delivery of therapy services within the ward or bed bays, and the lack of facilities for multidisciplinary team working.

4.5 Current Functional Locations

Included as part of ***Appendix C*** is a table setting out the location of facilities within both the Manor and Goscote sites as at 2004 and as anticipated at Financial Close of the Private Finance Initiative.

FUTURE REQUIREMENTS FOR SERVICES AND FACILITIES

4.6 Clinical Planning Process

4.6.1 Having established the need for change the Trust set about the planning process to determine the future clinical and physical configuration of the site.

4.6.2 The process involved the full engagement of clinical staff across all specialties within the Trust and confirmed the following key drivers in terms of identifying a preferred solution:

- The need to improve the management of the elective activity to minimise delays in treatment and avoid cancellations. This required the clear differentiation of elective, emergency and day case pathways and resources;
- The need to review the clinical pathways in order to improve access to diagnosis and treatment through multidisciplinary clinics; one stop diagnosis and treatment; reduced attendance at hospital; involvement of primary care;
- Standards identified within the NHS Plan; Cancer plan; NSFs and NICE guidance;
- Recognition of greater interdependence of services and the benefits of integration from a patient care delivery perspective, and long term professional support, recruitment and retention;
- Continued growth in demand for services across all specialties requiring improved access in terms of timing and management of patient expectations in terms of minimal attendance/residence in hospital; use of minimally invasive techniques; access to highest standards of facilities.

4.6.3 **Approach**

In order to complete the planning process and ensure the full involvement of the relevant clinicians the Trust established four clinical working groups:

- Children & Younger People;
- Women's Services;

- Elective Capacity/Diagnostic and Treatment Centre;
- Pathology.

4.6.4 Each of the Working Groups identified:

- Revised model of care;
- Changes in clinical practices;
- Implications of external influences e.g. NSFs; changes in technology;
- Implications of changing clinical models in terms of primary and Secondary care;
- Proposed standards of performance.

These findings were then linked with the key growth assumptions to identify the levels of activity and therefore facilities which needed to be provided to meet the future hospital based healthcare need. Although the Trust's working groups were in place before the establishment of the Black Country Review, the key stakeholders of each group participated in the Review in order to ensure that planning assumptions and models of care developed in conjunction with Black Country colleagues were appropriately reflected within the Walsall proposals. The approach of the Black Country Review (to ensure that all planned diagnostics and treatment were addressed in parallel to emergency models of care) resulted in the introduction of a fifth working group within Walsall which specifically addressed the needs of patients with a length of stay in excess of 48 hours.

The approach to planning for the multi professional education centre although influenced by the clinical models, has been directed by the requirement to meet new curriculum and teaching methods. A parallel working group was therefore established within the planning process in order to ensure consistency of approach and integration with the wider project.

4.7 Assessment of Future Activity

4.7.1 The Trust and its Commissioners, Walsall PCT have in place a 3 year Local Development Plan (LDP) which has outlined the expected growth in activity across all of the Acute Hospital services.

4.7.2 In drawing together the proposals contained in this OBC, the LDP has formed the basis of the activity assumptions.

4.7.3 In projecting the likely levels of activity at the end of the planning period (in order to ensure that the need to address the planning needs of a population of 500,000 were addressed) the exercise was undertaken in conjunction with both Walsall and Wolverhampton PCTs and colleagues at Royal Wolverhampton Hospitals Trust.

4.7.4 The following key factors have been brought into account in assessing the future requirements:

- Impact of national targets for patient access to services including maximum waiting times;
- Impact of National Service Frameworks;
- Development of cancer screening services;
- Impact of changes in referral pattern, including potential for repatriation;
- Changes in clinical practice in both Hospital and Primary Care settings;
- Improvements in chronic disease management particularly admission avoidance;
- Impact of developments in Intermediate Care;
- Impact of developments in reforming emergency care;
- Transfers of care between secondary care facilities and also between hospital and primary care;
- Demographic changes;
- Improvements in day case rates;
- Improvements in efficiency including reductions in length of stay.

The agreed baseline upon which the projected activity would be based was the outturn activity level for 2002/3, and would be based upon the utilisation of First FCEs. A full listing of the planning assumptions for each service is attached at ***Appendix D.*** The overall growth assumptions during the planning period and revised levels of activity are outlined in the table below. It should be noted that non-elective patient data is a combination of both admissions and assessments.

Appendix D also incorporates the planning assumptions which underpin the educational elements of the development.

Table 23. Total Growth Levels and Projected Activity Levels 2010/2011

Specialty	Day Case		Elective IP		Non Electives	
	Total Assumed Growth	Projected Activity	Total Assumed Growth	Projected Activity	Total Assumed Growth	Projected Activity
100 - General Surgery	4%	3,733	-51%	744	17%	5,577
101 – Urology	-2%	1,718	-36%	385	17%	64
110 - Trauma & Orthopaedics	63%	2,182	2%	1,018	4%	1,669
120 – ENT	173%	1,805	-87%	155	4%	327
130- Ophthalmology		1,212		0	n/a	0
143 - Orthodontics	8%	41	n/a	0	n/a	0
190 – Anaesthetics	12%	120	n/a	0	4%	1
303 - Haematology (clinical)	21%	1,157	-25%	47	4%	35

Specialty	Day Case		Elective IP		Non Electives	
	Total Assumed Growth	Projected Activity	Total Assumed Growth	Projected Activity	Total Assumed Growth	Projected Activity
400 – Neurology	25%	7	n/a	0	4%	1
420 – Paediatrics	56%	83	-58%	16	4%	3,344
180 - Accident and Emergency	6%	81	n/a	0	4%	1
All Medical	24%	5,177	-26%	236	11%	12,599
370 - Medical Oncology	29%	3,345	-85%	21	4%	1
Maternity		0		0	4%	6,873
502 – Obs & Gyn (Gynaecology)	3%	2,129	-36%	495	4%	1,416
140 - Oral surgery	5%	224	n/a	0	n/a	0
330 - Dermatology		3	-33%	5	4%	20
Total	**30%**	**23,016**	**-45%**	**3,122**	**9%**	**31,929**

4.7.5 It was clearly recognised that the changes in models of care were a fundamental requirement of the Project. Should these new ways of working not be introduced the inpatient bed requirement within Walsall would rise from the projected number of 749 at Stage 1 of the Black Country Review to 863.

4.8 Facility requirements

4.8.1 For each service an assessment was then undertaken of the facilities required to deliver the activity and related models of care.

4.8.2 **Children & Younger People**

The Trust's baseline activity for all admission categories and all services was reviewed in terms of the percentage of patients who fell into the two age categories of below 16 years and 16-19 years. This percentage was then applied to the projected activity for 2010/2011 to forecast the number of beds required for children and adolescents.

The assumed average length of stay used was that which had been included in the LDP.

The following assumptions were made in planning the number of Children & Younger People's Unit beds:

- Bed numbers reflect projected activity for Children and Younger People in all specialties not just Paediatrics;
- 72% bed occupancy;
- 365 days availability for inpatient beds;
- 250 days availability for daycase beds;
- patient turnover of 1.5 patients per bed for day case beds;
- All elective admissions aged16-19 year olds with a LOS of <3 days will be accommodated in the DTC;
- Paediatric Assessment Unit (PAU) beds are out with the

inpatient beds and are available throughout the 24 hour period, 365 days per annum;

- Outpatient clinics accommodate all children and younger people up to age 19;
- Outpatients function two sessions per day and 250 days per annum;
- Theatres function two sessions per day and 250 days per annum, and accommodate emergency cases. The hospital activity data was interrogated to determine, by HRG, the numbers of children and younger people whose admission involved an operative procedure. The proportion of spells that involved a procedure in the base year was assumed to be a proxy for the percentage in 2010/11.

The number of Children's and Younger People's service beds required is shown in the table below.

Table 24. Children and Younger People's Service Requirements

Facility	Quantum	Comment
Inpatient Beds	32	Includes day case beds
Neonatal Intensive Care/SCBU	12	Not included in the PFI Project
Adolescent beds	5	
Assessment spaces	6	Plus Resuscitation Trolley
Outpatient Consulting Rooms	7	Audiology; Orthoptic; Therapy rooms not included
Operating Theatres	1	Dedicated facility provided as part of a suite with Women's Services

In addition to the above facilities the proposed provision for Children and Younger People in order to meet the required standards in terms of child friendly environment and meet the proposed models of care will also include dedicated facilities for:

- Audiology;
- Orthoptics;
- Therapies;
- Parent/carer overnight stay.

For those services which are not provided via dedicated facilities (e.g. Fracture Clinic, Oral Surgery) appropriate provision will be made to ensure a child friendly environment is achieved.

4.8.3 Women's Services

The Trust's projected activity for Gynaecology was extracted and separated into the normal admission categories. In order to assess the impact of the Breast cases an analysis was undertaken of the HRG based activity within General Surgery to identify the key procedures. In view of the very low numbers of male patients it was

assumed all breast cases would be extracted with no separation of male patients.

The length of stay was adjusted to reflect the impact of the new models of care.

The percentage of 2002/03 out-turn episodes relating to patients aged up to 19 has been applied to the projected 2010/11 episodes to identify the bed requirements for Women's services

The following assumptions were made in planning the number of Women's Unit beds:

- 85 % bed occupancy;
- 365 days availability for inpatient beds;
- 250 days availability for daycase beds;
- Patient turnover of 1.5 patients per bed for day case beds;
- 16-19 year old Gynaecology and Breast cases would be managed in the Women's Unit;
- Theatre requirements were calculated based upon known theatre time by procedure, and assuming a two session day, 250 days per annum and all emergency activity; the hospital activity data was interrogated to determine, by HRG, the numbers of Gynaecology and Breast patients whose admission involved an operative procedure. The proportion of spells that involved a procedure in the base year was assumed to be a proxy for the percentage in 2010/11
- Outpatient requirements were based upon estimated time for the utilisation of all clinic facilities (not waiting) assuming a proportion of one stop/ treatment clinics, two session working and 250 days per annum.

The facilities required to support the revised model of care in Women's services are detailed in the table below:

Table 25. Women's Service Requirements

Facility	Gynaecology	Breast	Maternity	Total	Comment
Inpatient beds	15	3	50	68	
Day Case Beds	5	3	0	8	Day case beds based on turnover alongside Gynaecology
Critical Care	1	0	0	1	
Outpatient Consulting Rooms	6	3& 3	6	18	Antenatal excludes Fetomaternal Assessment Unit.
Operating Theatres	2		1	3	Non-maternity Theatres part of a shared suite with

Facility	Gynaecology	Breast	Maternity	Total	Comment
					Children & Younger People

4.8.4 General Acute Services Bed Requirements

The models of care developed for all of the remaining specialties within the Trust including the agreed reductions in length of stay and expansion of day case rates were brought together to identify the total requirements for beds, by specialty, by type and by location.

The following general assumptions were made in establishing the bed requirement:

- 84% bed occupancy;
- Day case beds operational 250 days per year;
- Turnover of 1.5 patients per day for day case beds with the exception of Medicine and Opthalmology where turnover has been assumed to be 4;
- Length of stay assumptions as outlined in ***Appendix D***;
- Beds continue to be distributed between the Manor and Goscote sites based upon the new clinical models;
- Numbers include Women, Children and Younger People.

4.8.5 Overall Bed Requirement

The total requirement for the Trust is identified in the table below:

Table 26. Overall bed requirement 2010/11

Specialty		Non-Elective	Elective	Day Case/47 hour	Ass'ment	Critical Care	Total
100	General Surgery	90	20	11	10	3	134
101	Urology	1	6	4	0	1	12
110	Trauma & Orthopaedics	55	21	7	0	4	87
120	ENT	2	1	8	1	0	12
130	Ophthalmology	0	0	3	0	0	3
303	Haematology (clinical)	1	1	5	0	0	7
420	Paediatrics	27	0	0	7	12	46
All Medical		*308*	*10*	*6*	*22*	*12*	*358*
370	Medical Oncology	0	0	12	0	0	12
	Maternity	49	0	0	0	0	49
502	Obs & Gyn (Gynaecology)	5	7	6	3	1	22
140	Oral surgery	0	0	1	0	0	1
330	Dermatology	0	0	1	0	0	1

Specialty	Non-Elective	Elective	Day Case/47 hour	Ass'ment	Critical Care	Total
Other	**0**	**2**	**1**	**1**	**0**	**4**
Grand Total	**538**	**68**	**65**	**44**	**33**	**748**
Total – Acute beds on Manor site	463	68	65	44	33	673
Total – Sub acute beds on Goscote site	75	0	0	0	0	75

The assessment of the most appropriate location for the beds in terms of the distribution of beds between the Manor Hospital site and the Goscote site identified the need for 75 beds at Goscote Hospital (a reduction of 28 over existing) and 673 on the Manor Hospital site an increase of 33 over the existing baseline. The basis of the distribution of beds included an assessment of the likely length of stay in excess of 10 days, of which a significant proportion would have moved into a sub-acute phase of their treatment.

The achievement of the activity levels and length of stay assumptions of Stage 2 of the Black Country Review would remove the requirement for any acute or sub acute beds on the Goscote Hospital site.

4.8.6 **Theatres**

Separate calculations were undertaken to identify the requirements for each specialty and the requirements for Women, Children & Younger People are summarised in Tables 19 and 20. The requirements for all of the remaining specialties are outlined in the table below, which also identifies the requirement in terms of proposed location, based upon the proposed models of care and agreed case mix for management through the DTC.

The hospital activity data was interrogated to determine, by actual HRG, the numbers of patients whose admission involved an operative procedure. The proportion of spells that involved a procedure in the base year was assumed to be a proxy for the percentage in 2010/11.

The following throughput and availability assumptions were made:

- 3.5 hours per session for all specialties;
- 2 sessions per day;
- 46 weeks per year to take into account Bank Holidays and sickness;
- 80% utilisation of scheduled time;
- All elective work is assumed to go through theatres during scheduled sessions;
- Theatre time required for each procedure was built up using actual operating time data.

Based upon actual numbers of procedures and actual theatre time per procedure the projected number of theatre sessions required for each specialty was confirmed as follows:

Table 27. Theatre Sessions

Speciality	Non-elective sessions	Elective Sessions	Day Case Sessions	Total
General Surgery	7.3	5.6	11.8	24.7
Urology	0	2.3	3.6	5.9
Trauma & Orthopaedics	6.4	9.9	9.3	25.6
ENT	0.1	0.9	9.1	19.1
Ophthalmology	0	0	5.5	5.5
Oral Surgery	0	0	1.0	1.0
Medicine	0.7	0.1	0.4	1.2
Anaesthetics	0	0	0.3	0.3
Haematology	0	0	0.2	0.2
Orthodontics	0	0	0.3	0.3
Gynaecology	0.4	3.5	6.2	10.1
Breast	0	0.7	2.1	2.8

With the exclusion of Women, Children's and Younger People's Services whose requirements have been indicated within the designated sections, the Adult Acute requirements indicate a need for 4 theatres to support day case activity, a further 5 for inpatients plus a CEPOD Theatre to support inpatient activity. The Table below outlines the theatre provision for the whole site and the proposed changes in distribution.

Table 28. Theatre Provision Changes

Theatre Location	Current	Proposed	Change
East Wing	2	0	-2
West Wing	6	6	0
Maternity	1	1	0
Surgical Day Unit	2	0	-2
Women, Children & Younger People Unit	0	3	+3
Diagnostic and Treatment Centre	0	4	+4
Total	**11**	**14**	**+3**

4.8.7 Outpatients

The growth projections assumed a significant transfer of Outpatient activity to Primary Care based on new models of care in terms of chronic disease management (e.g. diabetes, cardiac failure) plus a transfer of services to reflect the need for provision at a point closer to the patients (sexual health, ENT). Having taken account of these proposals the level of consulting rooms required, to be provided is summarised in the table below;

The following throughput and availability assumptions were made:

- 3.5 hours per session for all specialties;
- 2 sessions per day;
- 50 weeks per year to take into account Bank Holidays and sickness;
- 85% utilisation of scheduled time;
- For standard outpatient attendances each patient will be utilising the consultation room or related clinical facility e.g. treatment room for 20 minutes, with increased time allocations to account for the development of one-stop/ treatment clinics etc.;
- A throughput of 3,000 patients per room per annum has been assumed.

Table 29. Outpatient Clinic Requirements

Specialty	Consulting Rooms	Comments
100 - General Surgery	6.3	
101 - Urology	2.4	
110 - Trauma & Orthopaedics	5.5	Excludes Fracture Clinic
190 - Anaesthetics	0.5	
303 - Haematology (clinical)	4.6	
400 - Neurology	0.6	
All Medical	10.3	
370 - Medical Oncology	1.3	Excludes treatment reviews in Chemotherapy Unit
330 - Dermatology	1.8	
Joint Clinics	0.2	
Chemical Pathology	0.3	
Cardiac Surgery	0.1	
Total generic room requirement	**33.9**	
120 - ENT	3.0	Specialist room requirement
130- Ophthalmology	6.0	Specialist room requirement
143 – Orthodontics	4.0	Linked to Dental Surgery provision. Specialist room requirement.

The Table below summarises the outpatient clinic room provision for the whole site and the proposed redistribution.

Table 30. Outpatient Clinic Room Provision

Clinic Location	Generic Room Provision- Current	Generic Room Provision- proposed	Change
Sister Dora Outpatients	38	0	-38
Gynaecology Outpatients	3	0	-3
Paediatric Outpatients	4	0	-4
Ante Natal Clinic	4	0	-4
Women's Unit	0	18	+18
Children & Younger People	0	7	+7
Diagnostic & Treatment Centre	0	36	+36
Total	**49**	**61**	**+12**

4.8.8 Endoscopy

There are a number of issues which will impact on the requirements for Endoscopy facilities including the establishment of the Colorectal Screening programme. However it is anticipated that with changing working practices (including performing Flexible Sigmoidoscopy in the Outpatient clinic, and potential transfer of activity to Primary Care) the total requirement for dedicated Endoscopy facilities will remain unchanged, although an ability to expand within the adjacent area should be anticipated.

4.8.9 Imaging

The future requirement for Imaging services has been calculated on the basis of the overall activity projections and establishment of revised models of care including one stop clinics and 'see and treat' services. It is anticipated that the range of facilities which will be required to support the new developments and the existing services within the West Wing will be as follows:

Table 31. Imaging Modality Distribution

Modality	Women Children & Younger People	Main Department/ Inpatient support	DTC
CT	0	1	1
Fluoroscopy	0	1	0
MRI	0	1	0
Non-obstetric Ultrasound	1	2	2
Radioisotopes	0	1	0
General/ screening	1	5	4

4.8.10 Diagnostic and Treatment Centre

The model of care proposed for the Diagnostic and Treatment Centre supports the need to provide Outpatient, diagnostic and intervention facilities together with appropriate recovery capacity.

Based upon the specific specialty requirements as outlined in the sections above the interrogation of the models of care confirmed the overall bed, theatre and outpatient consulting room facilities which should be provided within the DTC:

Table 32. DTC Functional Content

Function	Quantum
Beds	52
Theatre Suites	4
Endoscopy Rooms	3
Imaging Rooms	6
Generic Consulting Rooms (clusters of 6)	36
Specialist Clinic Areas	3
Therapy Facilities	1
Clinical Measurement Facilities	1
Medical Photography Department	1

4.9 Impact of further changes to the models of care

4.9.1 The facility requirements outlined in the previous sections reflect the outcome of Stage 1 of the planning assumptions process. It is recognised that throughout the planning and implementation process there will be further changes to the models of care to reflect more radical developments within primary and intermediate care, changes in technology, improved techniques and establishment of greater levels of shared care management and identification of further examples of good practice.

4.9.2 It is to be anticipated that further progress will be made in the development of community based rehabilitation and intermediate care.

4.9.3 In undertaking Stage 2 of the planning process a wide range of potential areas for improved practice have been highlighted and debated at length within the Trust and with the wider health community.

4.9.4 The Trust is fully committed to developing these more radical models of care alongside partners within the Health Economy. Having assessed the potential for delivering the changes in clinical practice the health economy predicts that a further reduction of 80 beds could be achieved.

4.9.5 It is anticipated that with the reductions in length of stay and levels of admission avoidance the impact on the remaining beds would be a further increase in acuity of patients and therefore demand on the acute hospital resources. It has therefore been accepted that any further reductions in beds will be focused on the Goscote Hospital site. The impact of the potential changes on the capital solution outlined within this business case would therefore be nil. The future role for Goscote hospital therefore evolve to reflect the

provision of community services for older people increasing levels of Intermediate Care

4.9.6 In the event that further significant improvements can be achieved beyond the 2010/2011 planning period the Trust would welcome the potential flexibility which this would provide as this would enable the organisation to address the outstanding qualitative issues within the West Wing in terms of privacy, dignity and the wider consumerism agenda including the need to increase the proportion of single bedrooms, introduce ensuite facilities, reduce the multiple bed bays to a maximum of 4 beds and address the size of individual bed spaces.

4.10 Multi Professional Education Centre

4.10.1 In establishing the functional content required within the new, integrated, education centre account was taken of the projected increase in staff numbers, plus the enhanced training requirements to deliver improvements in services, productivity and staff working lives all add to the demand for training resource and thereby facilities.

4.10.2 A full review was undertaken of all the education and training courses that the Trusts will be required to provide and consequently an assessment made of the amount and type of facility required. In summary however the following services must be catered for:

- Walsall Health Library and Information Service including all activities connected with information retrieval and personal study e.g. periodicals reading area, reference section, general reading area and computers for training and one-to-one teaching;
- Generic Training courses for both Trusts;
- Multi agency learning time/PCT training including protected learning time;
- Resuscitation training including CPR and Advanced Life Support;
- Statutory/Mandatory Update sessions for all staff in both Trusts;
- Induction Training for both Trusts;
- IM&T Training including EPR;
- Undergraduate and Post Graduate Medical Education and Training in small specialist groups of 3-8 plus larger groups of 20-30;
- Clinical Skills areas to provide basis training for students plus enhance skills for nurses and other professions;
- National Vocational Qualifications;

- Continuous Professional Development;
- Regional Conferences for all professions.

4.10.3 The outcome of the assessment identified the following functional content for the educational facility.

Table 33. MPEC Functional Content

Function	Quantum
Library (including all activities connected with information retrieval and personal study)	1
Lecture Theatre (maximum capacity 150)	1
Seminar Room for up to 10 people	6
Seminar Room for 11-18 people	3
Seminar Room for 19-28	3
Seminar Room for 29-36	1
Clinical Skills Laboratory	2
IT Skills Training Room	2
Student Common Room	1
Student Locker Facilities	1
Buffet/ Breakout Space	1

SECTION 5

FORMULATION OF OPTIONS

PROJECT OBJECTIVES AND SCOPE

5.1 Overall Project Objective

5.1.1 In agreeing its Strategic Direction, the Trust has identified a number of Corporate Objectives relating to the access to and delivery of responsive patient care, and the efficient and effective use of resources. The Trust has also recognized the need to redesign its models of care across all of the services, taking the opportunity to reassess the patterns of delivery, and therefore identify the changes needed in working practice and facilities in order to meet the standards and targets identified within the modernization agenda and guidance documents.

5.1.2 A fundamental difference in approach to the design of the service has been the involvement in the assessment and planning, of colleagues across the Trust and from external partners including the PCT, social care and neighbouring care providers, with whom strategic clinical networks have been established, and with whom further such developments could underpin the ongoing viability of service provision to the local population.

5.1.3 The needs assessment work undertaken has identified the requirement for major changes in the following services as a priority:

- Children & Younger People;
- Gynaecology and Breast;
- Routine Elective diagnosis and Treatment;
- Management of episodes in excess of 48 hours;
- Emergency Care;
- Delivery of multi professional education.

5.1.4 In addressing the above priorities the Trust is aiming to achieve a number of service redesign objectives particularly:

- The establishment of a fully integrated Children & Younger People's Service with a single facility providing beds, theatres, routine diagnostic and outpatient facilities, together with the relevant support needs for children and young people up to their 19th birthday;
- The establishment of a fully integrated Women's Service to include all Gynaecology, Obstetric and Breast services within a single location;
- Creation of a Diagnostic and Treatment Centre which will be the focus for the management of the majority of elective

activity within the Trust including Outpatients, Diagnostics, Day Cases and routine, short stay inpatients;

- The redevelopment of key inpatient facilities to ensure that the requirements of privacy and dignity are addressed and the ward facilities provided are those which are needed to address better management of the patient pathway and multi- disciplinary multi-agency models of care;
- The establishment of a single 'Hospital Street' thereby minimizing patient journeys and ensuring that all care can be delivered within a 'single building';
- Provision of a centralised training and teaching facility incorporating an integrated library and designed to support competency based training methods.

5.1.5 The service redesign objectives must also be viewed within the context of the major review of the Trust's estate updated in 2004 which identified the urgent requirements to address the following Estate issues:

- Replacement of East Wing, Manor Hospital;
- Reprovision of improved day case facilities;
- Reprovision of improved Outpatient Clinic facilities;
- Replacement of the Main Pathology Department;
- Addressing the inadequacies of South Wing;
- Replacement of the Post Graduate Medical Centre and teaching facilities within St John's Block.

5.2 The Scope of the Project

5.2.1 In order to address the key objectives the following facilities will be brought within the scope of the project:

5.2.1.1 **Replacement of East Wing**

Current building is of Victorian stock, of inadequate standard to provide modern clinical services, cannot provide appropriate accommodation to national standards particularly the specific needs for Paediatric Care and the wider Consumerism Agenda.

There are also significant issues outstanding regarding the fire safety within the building. In spite of an investment of in excess of £3m the building does not meet the fire regulation standards and must be replaced.

5.2.1.2 **Improved/Expanded Day Case Facilities**

The dedicated day case unit on site operates effectively but has insufficient capacity to enable all day case activity to be provided in modern dedicated accommodation which is both clinically and cost effective. This is accentuated by the positive shift which the Trust has made and will continue to make between Inpatient and Day Case management. Unfortunately due to the restrictions of space, in order to achieve the required service patterns there is a need to

abuse other facilities on site including inpatient accommodation and Theatre capacity. In view of its current location and the difficulties within the inflexible design a full replacement is needed.

5.2.1.3 **Outpatients**

Although the existing main outpatient department only constructed in the 1970s, the design/layout is very inflexible and cannot be reconfigured to meet the current standards of ambulatory care, particularly the need to establish larger, multidisciplinary clinics and the establishment of true one stop clinics in which patients need to access consultation, diagnostic and potentially treatment facilities in the same visit. A full replacement is therefore required.

5.2.1.4 **Pathology**

The departments of Haematology, Biochemistry and Microbiology are housed within the buildings as Outpatients therefore suffer from many of the same difficulties. Increased automation requires a radical rethink of pathology service provision.

Replacement of the building is therefore required. Histopathology and associated mortuary accommodation is housed in separate good quality accommodation. It is therefore not proposed to relocate this service.

5.2.1.5 **St. Johns Block**

This facility accommodates a range of teaching and administrative services and provides office accommodation for some clinical services. The building is again of Victorian stock and has significant issues in terms of backlog maintenance and inflexibility in terms of meeting modern standards and fire regulations.

5.2.1.6 **South Wing**

As with the Outpatient Department this building was constructed in the 1970s. The ward design is based on 6 bedded bays which are increasingly inflexible in terms of addressing new models of care and the requirements to improve the patient experience in terms of privacy and dignity within the care environment.

In bringing these facilities within the scope of the project there is a need to recognise the range of services and facilities which are affected.

5.2.1.7 **Post Graduate Medical Centre**

Built in 1960's of a lightweight wooden construction the building is now in a poor condition, with inadequate space even to provide postgraduate medical services let alone the increasing demand from other professional groups such as; nurses, PCS staff and the increasing number of undergraduate doctors receiving their training at the hospital. The Estates Condition Survey classified the present building in Category D: the building is in extremely poor condition and is not functionally suitable to meet modern education and training needs. It has long been considered that any expenditure, other than to keep the building weatherproof, secure

and usable is not justified. The floor area and the configuration of the space in the library does not meet the requirements of the Helicon accreditation or HBN42 as there are an inadequate number of reader places, no areas for group study, no quiet reading area, impaired access to IT facilities, and no separate office, workroom or photocopier space. Library staff work in cramped and hazardous conditions and there is no space for archiving purposes

5.2.2 In addition to the key structural reprovision required by the Project there are other service element which need to be drawn in if the service redesign objectives are to be delivered:

5.2.2.1 **Women's Services**

In redesigning the delivery of Women's services the Trust is seeking a solution which reprovides an integrated facility and will therefore bring together other services not currently located within the East Wing.

There are two significant elements, the Breast Screening Service including the administrative support function (other than that provided within the Community) and the Antenatal Service including Ultrasound and a Fetomaternal Unit.

5.2.2.2 **Children and Younger People**

Although Paediatric Medicine is located within East Wing the surgical facilities for children are located within the West Wing, including theatre facilities. Many young outpatients are also still examined and treated in the main outpatient department. The project therefore seeks to transfer these clinics to the integrated unit and include these elements of care and service delivery together with dedicated Audiology, Orthoptic and Therapy services.

In addition, the National Service Framework for Children and Younger people seeks to ensure that the management of the care of young people up to their 19th birthday is managed within a more appropriate environment. The Trust is therefore seeking to create an Adolescent Unit for the management of all young people from all specialties.

Under existing services the Child Protection Suite is located in a property in 2 Ida Road, and is not easily accessible to all of the care professionals. The relocation to the new Children and Younger People will provide a state of the art, accessible unit which has immediate access to key support facilities.

5.2.2.3 **Diagnostic & Treatment Centre**

The models of care which have been developed by the Trust seek to include within the Diagnostic & Treatment Centre (DTC) the diagnostic, treatment and nursing support for adult patients whose episode of care within the hospital will be less than 47 hours. Consequently, in addition to the replacement requirements outlined above for Day Case and Outpatient services there will be a need for additional Theatre and Imaging capacity and facilities for patients requiring an overnight stay.

5.2.2.4 **Inpatient Services**

The reprovision of the generic acute beds must support the improved management of the inpatient episode in terms of the support provision including dedicated inpatient therapy services but also address the environmental standards established by NHS Estates in terms of the proportion of single bedrooms, provision of en-suite WC/shower rooms and the maximum multi bed size of 4.

KEY BENEFITS OF THE PROJECT

The delivery of the key objectives of the Project will bring a range of benefits both clinical and organisational.

Table 34. Project Benefits

Service	Benefit
Women's Services Integrated Gynaecology	▪ Better utilisation of a wide range of clinical skills; ▪ Improved medical cover to key areas; ▪ Ability to meet new medical cover requirements (junior & Consultant); ▪ Reduced patient journeys; ▪ Better access to specialist care; ▪ Ability to share diagnostic facilities.
Replacement of Antenatal facilities	▪ Better management of the complex pregnancy; ▪ Redesign of the patient journey to reduce hospital visits; ▪ Improved diagnostic facilities to enable better use of technology.
Integration of Breast Services	▪ Delivery of care within a female friendly environment; ▪ Access to specialist support services.
Children & Younger People	▪ All children receive their care within a child friendly environment; ▪ Specialist skills are concentrated in a single location; ▪ The need for children to travel to services is reduced; ▪ Parent facilities can be provided in line with latest standards; ▪ Adolescents are no longer managed in Adult Acute beds; ▪ Dedicated child protection suite on site.

Service	Benefit
Pathology Services	▪ Services are provided in an environment suitable for the maximum utilization of automated analysers; ▪ Access to key areas of the hospital are via an appropriate specimen transportation system; ▪ All Microbiology services are accommodated together; ▪ Sufficient access is provided for staff CPD.
Diagnostic & Treatment Centre	▪ Ability to reduce patient journeys; ▪ Separation of the majority of elective activity from non-elective; ▪ Increased capacity for the management of elective treatment especially Day Cases; ▪ Facility to establish true one stop clinics therefore reducing patient attendance at hospital; ▪ Ability to operate multidisciplinary clinics more readily.
Generic Acute Beds/ Replacement for South Wing	▪ Improved patient environment with increase availability of single bed rooms and en-suite WC/showers; ▪ Provision of dedicated inpatient therapy facilities; ▪ Co-location with Assessment/ Emergency/ Critical Care services; ▪ Support facilities available to support multi-disciplinary/ multi-agency working; ▪ Provision of all inpatient facilities in a single building; ▪ Flexibility in bed utilisation between specialties to reflect changes in working patterns/ models of care.
Multi Professional Education Centre	▪ Establishment of an integrated education facility supporting all the professions across the whole health economy; ▪ Creation of a modern teaching facility to support competency based training methods; • Provision of sufficient training and education capacity to support increasing staff and student numbers.

Service	Benefit
Whole Hospital Benefits	▪ Creation of a single hospital street improves the management of patient movements and deliveries as they remain internal; ▪ Separation of elective and non – elective activity will support the delivery of Modernisation Agenda; ▪ Reprovision of oldest elements of the estate will ensure that future care delivery is within appropriately designed and built facilities.

OUTPUT SPECIFICATION

5.4 The Trust has undertaken an extensive consultation exercise with the key stakeholders linked to each of each of the services to be affected by the project - the outcome of the discussions being confirmation of the revised models of care delivery, and related functional content of each facility. This has then been set against the projected activity levels for each service (as outlined in Section 4), from which the minimum accommodation requirements have been derived.

In order to foster the development of Integrated services for Women and in recognition of the close clinical and social relationships with the Children and Younger people's Services, the need for a discreet entrance leading to differentiated reception facilities for the three different services has been identified.

Service Specific requirements have been identified for the different service areas and set out in ***Appendix E***.

DEVELOPMENT OF OPTIONS

5.5 **Long-list of Options**

The long-list of options from the Strategic Outline Case has been taken as a starting point for the consideration of options within the OBC. Further evaluation has been undertaken on a service basis as set out below:

Women's Services

- Do Nothing;
- Transfer service to West Wing;
- Transfer Service in whole or in part to the Maternity Unit;
- Provision of a new build integrated unit co located with Children's Services and linked to the existing Maternity Unit;

- Provision of a new build stand-alone unit co located with Children and Younger People's Services;
- Partial upgrade of the existing East Wing;
- Full upgrade of the Existing East Wing;
- Cease provision of service.

Children and Younger People Services

- Do Nothing;
- Transfer service to existing accommodation in West Wing;
- Provision of an integrated Unit in West Wing;
- New integrated block co-located with Women's Services and attached to the existing Maternity Unit;
- Upgrade of current accommodation in East Wing;
- Cease Provision of service.

Diagnostic & Treatment Centre

- Do Nothing;
- Do minimum (Backlog maintenance only);
- New Build – all Services on the DGH site;
- New Build – partial services on DGH site partial services developed within the community;
- All Services undertaken within the Community;
- Greenfield (Brownfield) site development;
- Cease provision of service.

Pathology

- Do Nothing;
- Do minimum (Backlog maintenance only);
- New Build – all services on the Manor Site;
- Refurbishment 'Hot laboratory' only;
- Services provided by an external supplier;
- Greenfield Site Provision;
- Cease provision of service;

This evaluation took into account the Estates Strategy for the Manor Hospital site, and discounted a number of the long-list of options for the following reasons:

- Do Nothing – The Trust would be unable to deliver the Local Delivery Plan and would in addition have to cease the provision of services from East Wing from 2007;
- Transfer of Services (in part or in whole) to West Wing – Unachievable, West Wing is extremely well utilised and there is no space available for occupation or modification to accommodate either Women or Children's Services;

- Transfer of Services (in part or in whole) to Maternity – It is unachievable to transfer either Women or Children's Services in whole to the Maternity Unit, but scope exists to transfer / relocate up to 2000 m2 of Clinical Accommodation into the under utilized in patient provision (circa 20 beds) and the re-location of whole hospital support facilities. This spare capacity has been carried forward into the short list of Options to be evaluated;
- Upgrade (in whole or in part) of East Wing – The Trust has recently undertaken a major capital project, which partially addressed the safe and lawful issues. This building has exceeded it useful life and will not be permitted to deliver Clinical Service from 2007 by the West Midlands Fire & Rescue Service;
- Cease Provision of Service – Children's, Women's and Ambulatory Care Services form the core of the local secondary health care provision and are of such a volume that other local providers are unable to accommodate these services without a major capital investment themselves;
- Transfer Services i.e. to be provided in a Primary Care setting – Unachievable these services cannot be provided in their entirety without the backup Clinical Support and Clinical Care;
- Greenfield (Brownfield) Site – Unachievable; these services cannot be provided in their entirety without the backup Clinical Support and Clinical Care;
- Pathology 'Hot Lab' The Trust have defined a 'Hot Lab: as providing tests within a 2 hour turnaround for immediate management of the patient, or review for discharge etc;

  The Hot Lab would provide testing for acute services on-site to e.g. to all Emergency and Assessment and Critical Care facilities. Because of the nature of the work it would be necessary to have back-up equipment in the event of breakdown. This would make the service very inefficient in terms of capital outlay, maintenance agreements and staffing, particularly if the equipment and staff was not used to full capacity. In addition the Hot Lab would require additional capacity off site to process all routine work. As such the Evaluation Team discounted this option;
- Pathology – External Provider – Much of the specialised work is already sent to Regional Centres and other laboratories. Transfer of all routine and urgent testing to an external provider would create concerns in terms of increased turnaround times and cost and ensuring that systems are in place to ensure the quality of the work. Logistically there would be problems in co-ordinating transfer of samples, particularly in the case of urgent work. There would also be significant costs for transport of

samples to other laboratories. As such the Evaluation Team discounted this option.

5.6 Short-list of Options

Based on the initial analysis described above, the Project Team and its external advisors developed the following options that respond to the requirements from the long-list developed as part of the SOC:

Table 35. Description of Options

Option Number	Option Name	Brief Description
Option 1	Do Minimum	A minimised Estates solution, which would allow the Trust to deliver services in a safe & lawful manner. This option does not address any capacity or models of care issues.
Option 2	Interim OBC updated	The provision in two phases of an integrated Women, Children & Younger People's facility centred upon the existing Maternity block, linked back to the existing Hospital Street Network and also linked to a new DTC on the former East Wing Site.
Option 3	CABE / Design Exemplar updated	Based upon the CABE proposals for the hospital redevelopment, this option provides a single phase, deep plan block in the centre of the site, and links the existing West Wing and Maternity blocks.
Option 4	Two Centre Option	In this option, the existing Laundry is relocated off site and replaced by a DTC linked directly to the existing West Wing. In addition, an integrated Women, Children & Younger People's facility centred upon the existing Maternity block is linked back to the existing Hospital Street Network. The two blocks can be delivered in parallel.
Option 5	The Tower Solution	This option aims to minimise both land-take and site infrastructure and provides all the new accommodation in a five storey tower block, linked back to both the existing West Wing and Maternity unit.
Option 5a	The Tower Solution and South Wing	In addition to the tower block described in Option 5 above, the existing Laundry is relocated off site and replaced by 135 generic beds and associated therapy services, allowing the subsequent demolition of South Wing.
Option 6	Radical Laundry &	This option is delivered in two phases.

Option Number	Option Name	Brief Description
	South Wing	The existing Laundry is relocated off site and replaced by 135 generic beds and associated therapy services, allowing the subsequent demolition of South Wing. The South Wing site is utilized to provide a DTC linked back to the existing West Wing. The integrated Women, Children & Younger People's facility is centred upon the existing Maternity block linked back to the existing Hospital Street Network.

The options aim to incorporate the key service redesign objectives set out under section 5.1.5. They also aim to address the significant estates issues by reducing the quantum of inappropriate accommodation (for example the original Victorian Poor Law stock and by releasing any overcapacity for example within the Maternity block.

5.6.2 All the short listed options (other than Option One: Do Minimum) are capable of delivering the same functional content in terms of the Clinical Brief (see ***Appendix E*** for the schedule of accommodation) the differences are in the resultant departmental adjacencies, and extent of both vertical and horizontal communication space.

5.6.3 A detailed description of the options is included in ***Appendix F*** and sets out an estates technical evaluation for each option. This evaluation formed the basis of the assessment of on-costs within the Capital Cost section of the OBC.

5.6.4 In addition to the option appraisal undertaken by the Trust, advice and comment has been sought from the Local Authority in terms of both Planning and Highways issues. All the short-listed options are capable of meeting the requirements of the Local Authority and the technical evaluation described above documents the relative merits and concerns on each option.

5.6.5 The various alternative ways in which Pathology can be delivered under each of the options has been considered separately. As set out in ***Appendix F***, the preferred solution for Pathology is New Build Accommodation.

5.6.6 Whole Hospital Support

5.6.6.1 The Business case calls for the demolition of both the existing St. John's Block and East Wing (The two remaining Victorian buildings on the Manor Site) together with the demolition of Surgical Day / Endoscopy Unit, Sister Dora Out- Patients Department, The Pathology Department and the Ante Natal Clinic. In addition to those services, which form an integral part of both the Women Children and Younger People Centre and the Diagnostic &

Treatment Centre a number of clinical support and administration functions will require re-provision. The proposed solution is identical for all Options (other than Option One: Do Minimum) and is described as follows;

5.6.6.2 The brick built portions of both the Sister Dora OPD and Pathology block will be retained and refurbished.

5.6.6.3 The existing 'White House' I and 'White House' II (relatively new sectional buildings providing additional administrative support facilities) will be relocated on the site and supplemented with 'White House' III to provide the balance of support accommodation required under this Business Case.

5.7 Description of Short-listed options

This section of the OBC summarises the key features of each of the options short-listed for detailed evaluation. ***Appendix F*** provides a more detailed description of the short-listed options, and ***Appendix G*** provides overall site plans for the options.

5.7.1 OPTION 1: Do Minimum

This option aims to provide for the minimum Estates solution that will allow the Trust to deliver Healthcare from the Manor Hospital in a "safe & lawful" manner in the short to medium term.

This option does NOT address any of the capacity issues in terms of either models of care or the Local Delivery Plan. Any additional activity will require working extensively out-with the "normal" working day / week. This option does not address consumerism issues within either Women Children and Younger People Services or the DTC. The only capital Works other than backlog maintenance is the replacement of East Wing that will fail to receive a Fire Certificate after 2007:

- The Pathology Department remains as the current provision;
- Out-patient consultation remains a the current provision in Sister Dora OPD;
- The Surgical Day Unit remains in its current location;
- The Medical Day Unit remains in its current location within South Wing remote from other OPD / Day case facilities;
- In Patients – all activity above a 12 hour length of stay remains in West Wing;
- Gynaecology inpatients moves into Bluebell (to take up the current overcapacity within the Maternity Unit);
- The Ante Natal Clinic remains in its current location;
- Paediatric Surgery remains in West Wing remote from Paediatric Medicine;
- Replacement of East Wing gives a safer environment but

does not provide either increased functionality or improved clinical adjacencies. The Services accommodated include:

Paediatrics (Medical) Inpatients;

Children's OPD;

Paediatric Assessment Unit;

Gynaecology Inpatients;

Gynaecology Day Case;

Gynaecology Treatment & OPD;

Theatre Suite;

Imaging Suite (B);

Seminar Suite;

Administration including Trust Management.

- St John's block is retained to provide both clinical non clinical support accommodation.

5.7.2 **OPTION 2: Interim OBC updated**

This option is an update of the "preferred option" prepared for the Strategic Outline Case. The solution consists of a phased development.

Phase one is the provision of an integrated Women, Children and Younger People Centre and includes a part refurbishment of the first template of the Maternity Unit, the new build element is located on the amenity area in the centre of the site. This will allow for the demolition of East Wing, which will form the site for Phase two, the Diagnostic & Treatment Centre.

The Hospital Street network from West Wing will be continued through the Women, Children and Younger People Centre and the Diagnostic & Treatment Centre to enable access to all Clinical facilities on the Manor site.

External access and egress to the Women, Children and Younger People Centre and the Diagnostic & Treatment Centre is from the Pleck Road and associated car parks.

The key Clinical aspects of this option are summarised below:

- Gynaecology, Breast & Children linked to the existing Maternity Unit to provide an integrated Women, Children and Younger People Centre;
- Links Maternity Unit to West Wing. (The Diagnostic & Treatment Centre may compromise the 'Secure By Design' boundaries in that access between the DTC and West Wing will be through the Maternity Block). This link is therefore potentially sub-optimal;
- The Diagnostic & Treatment Centre and Women &

Children's Theatres can be co-located effecting clinical efficiencies;

- Elective Components split by the Women, Children and Younger People Centre resulting in reduced opportunities to integrate clinical activities;
- Duplication of emergency Endoscopy is required in west wing theatres due to excessive distance to new Diagnostic & Treatment Centre;
- Dedicated entrances facing Pleck Road for both the Women & Children's Centre and Diagnostic & Treatment Centre;
- The available footprint for Women, Children & Younger People's services will facilitate the building being stacked with like facilities (for example Theatre Suite and associated support) co-located to ensure that the key clinical adjacencies within each block are maximised.

5.7.3 **OPTION 3: CABE / Design Exemplar updated**

This option is an update of the CABE (Commission for Architecture & the Built Environment) scheme prepared for NHS Estates and Walsall Hospitals NHS Trust. The solution has been modified to reflect the concerns of the Local Authority Planning Department (proximity to the Board of Guardians) and Highways Engineers (Access and egress from the site).

This solution consists of a deep plan single block in the centre of the site on the amenity area and links together the Maternity Unit and West Wing. The key Clinical aspects of this option are summarised below:

- Gynaecology, Breast & Children linked to the existing Maternity Unit to provide an integrated Women, Children and Younger People Centre;
- Links the existing Hospital Street network in West Wing to the existing Maternity Unit;
- The Diagnostic & Treatment Centre and Women Children and Younger People Centre Theatres can be co-located effecting clinical efficiencies;
- Elective components not fully integrated (although better than option 2) resulting in reduced opportunities to integrate all clinical support services and inpatient facilities;
- Duplication of emergency Endoscopy may be required in West Wing theatres due to excessive distance to new Diagnostic & Treatment Centre;
- A single shared entrance from Pleck Road serving both the Women & Children's Centre and the Diagnostic & Treatment Centre;
- The available footprint for this single block is limited by the

proximity of adjacent buildings, which would present challenges in achieving key clinical adjacencies within each floor level.

5.7.4 **OPTION 4: Two Centre Option**

In this option the existing Laundry (a facility which is operated by Mid Staffordshire NHS Trust) is relocated off site, this realises a significant area of site in the heart of the hospital. The solution adopted is to construct two separate blocks, one serving Women, Children and Younger People, one serving the Diagnostic and Treatment Centre.

Block one is the provision of a dedicated Diagnostic & Treatment Centre on the laundry site, linked at two levels to the existing West Wing Hospital Street network.

Block two is the provision of an integrated Women, Children and Younger People Centre and includes a part refurbishment of the first template of the Maternity Unit; the new build element is located on the amenity area in the centre of the site linked to the West Wing Hospital Street network.

It is assumed that access and egress from the Diagnostic & Treatment Centre will be from the North car park either via the existing main entrance or a new entrance through the dining room area. External access to the Women & Children's Centre will be afforded from the Pleck Road.

The key Clinical aspects of this option are summarised below:

- Women & Children linked to the existing Maternity Unit to provide an integrated unit;
- Elective components co-located resulting in opportunities to better integrate all clinical support services and inpatient facilities;
- No duplication of Endoscopy required;
- Theatres (neither Diagnostic & Treatment Centre nor Women & Children's can be co located with either each other or the existing West Wing provision;
- Links the Diagnostic & Treatment Centre to West Wing & Women, Children and Younger People Centre via the hospital street network;
- Patient access to the Diagnostic & Treatment Centre not simple (via new entrance in dining room);
- The available footprint for the Women, Children & Younger People's facilities would allow an optimal layout in respect of key clinical adjacencies. The DTC however is limited by the proximity of adjacent buildings at would present challenges in achieving key clinical adjacencies.

5.7.5 **OPTION 5: The Tower Solution**

This option aims to minimize the land-take required to accommodate the functional content and maximise the amenity site between the Maternity Unit and West Wing. The built form will be a five-storey tower block and upper ground floor podium.

Two linked but separate concourses will be accommodated on the lower ground floor to serve the Women, Children and Younger People Centre and the Diagnostic & Treatment Centre.

The integrated Women, Children and Younger People Centre will be accommodated on the lower ground, ground and first floor levels and includes a refurbishment of the first template of the Maternity Unit.

The Diagnostic & Treatment Centre will be accommodated on the first floor (part) second third and fourth floor levels.

The layout of the first floor allows the Diagnostic & Treatment Centre and Women & Children's Centre theatre suites to be co-terminus.

External access and egress to both the Women & Children's Centre and the Diagnostic & Treatment Centre is from the Pleck Road and associated car parks

The key Clinical aspects of this option are summarised below:

- Women & Children linked to the existing Maternity Unit to provide an integrated unit;
- Links to West Wing & Women, Children and Younger People Centre with the Diagnostic & Treatment Centre;
- Diagnostic & Treatment Centre & Women, Children and Younger People Centre theatres can be co-located;
- Elective components not fully integrated (though better than option 2) resulting in reduced opportunities to integrate all clinical support services;
- Duplication of emergency Endoscopy may be required in west wing theatres due to excessive distance to new Diagnostic & Treatment Centre;
- Clinical build housed within a five storey building relying on lift provision for vertical movement;
- The available footprint for this single tower block is limited by the proximity of adjacent buildings and the very limited site options sufficient to support a single-phase development. It would not achieve key clinical adjacencies on each floor level, and would rely on vertical communications to achieve these adjacencies.

5.7.6 **OPTION 5a: The Tower & South Wing**

In this option, a variant of Option 5, the existing Laundry (a facility which is operated by Mid Staffordshire NHS Trust) is relocated off

site, this realises a significant area of site in the heart of the Hospital. The solution adopted is to construct two separate blocks, one serving the Women, Children and Younger People and the Diagnostic & Treatment Centres. The other providing a replacement for South Wing

The Women, Children and Younger People and the Diagnostic & Treatment Centres, provides the functionality identical to that described in Option 5 above.

The laundry site is utilized to provide a bed tower on an area providing 135 generic acute beds and Therapy facilities to replace the current South Wing. This will be a physical extension to West Wing co-locating emergency and elective in patient accommodation above a 47-hour length of stay in a single location.

External access and egress to both the Women, Children and Younger People Centre and the Diagnostic & Treatment Centre is from the Pleck Road and associated car parks

The key Clinical aspects of this option are summarised below:

- Women & Children linked to the existing Maternity Unit to provide an integrated unit;
- Links to West Wing & Women, Children and Younger People Centre with the Diagnostic & Treatment Centre;
- Diagnostic & Treatment Centre & Women, Children and Younger People Centre theatres can be co-located;
- Elective components not fully integrated (though better than option 2) resulting in reduced opportunities to integrate all clinical support services;
- Duplication of emergency Endoscopy may be required in west wing theatres due to excessive distance to new Diagnostic & Treatment Centre;
- Clinical build housed within a five storey building relying on lift provision for vertical movement;
- Requires replacement of Medical component currently located on South Wing;
- Allows for the South Wing replacement to address Clinical appropriateness / Functionality issues;
- The available footprint for this single tower block is limited by the proximity of adjacent buildings and the very limited site options sufficient to support a single-phase development. It would not achieve key clinical adjacencies on each floor level, and would rely on vertical communications to achieve these adjacencies.

5.7.7 **OPTION 6: Radical laundry & South Wing**

In this option, the existing Laundry (a facility which is operated by Mid Staffordshire NHS Trust) is relocated off site, this realises a

significant area of site in the heart of the hospital. The solution adopted is to construct three separate blocks, one serving the Women, Children and Younger People Centre, one the Diagnostic & Treatment Centre, the other providing a replacement for South Wing.

The Women, Children and Younger People Centre, similar to Phase One of Option Two above provides an integrated Women, Children and Younger People Centre and includes a part refurbishment of the first template of the Maternity Unit, the new build element is located on the amenity area in the centre of the site, and physically links this Centre to West Wing.

The laundry site is utilized to provide a bed tower on an area providing 135 generic acute beds and Therapy facilities to replace the current South Wing. This will be a physical extension to West Wing co-locating emergency and elective in patient accommodation above a 47-hour length of stay in a single location.

Once the laundry site has been commissioned and South Wing demolished this site will be utilised to provide the new Treatment and Diagnostic Centre. This will have two separate links to West wing, one an extension of the Hospital Street network allowing access to all other Clinical departments. The other a dedicated operating theatre link connecting the DTC and West Wing theatres as a single unit.

External access and egress to both the Women, Children and Younger People Centre and the Diagnostic & Treatment Centre is from the Pleck Road and associated car parks.

The key Clinical aspects of this option are summarised below:

- Women & Children linked to the existing Maternity Unit to provide an integrated unit;
- Elective components relatively close resulting in opportunities to better integrate clinical support services;
- No duplication of Endoscopy required;
- DTC Theatres can be co-located (via bridge) to existing west wing theatres;
- Links West Wing to the Women, Children and Younger People Centre and the Diagnostic & Treatment Centre;
- Requires replacement of Medical component currently located on South Wing;
- Allows for the South Wing replacement to address Clinical appropriateness / Functionality issues.
- The available footprint for each of the clinical blocks (South Wing Replacement, DTC and the Women, Children & Younger People's Centre) is sufficiently large enough to accommodate key clinical adjacencies on a floor by floor basis, thus reducing the dependence of vertical communication with each clinical zone.

Table 36. Summary of Options

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 5a	Option 6
West Wing	Retained (as is)	Retained (limited works)	Retained (limited works)	Retained (limited works)	Retained (limited works)	Retained (limited works)	Retained (limited works)
South Wing	Retained (as is)	Retained (as is)	Retained (as is)	Retained (as is)	Retained (as is)	Demolish	Demolish
St John's Block	Retained (as is)	Demolish	Demolish	Demolish	Demolish	Demolish	Demolish
East Wing	Replaced	Demolish	Demolish	Demolish	Demolish	Demolish	Demolish
S. Dora SDU & OPD	Retained (as is)	Replaced	Replaced	Replaced	Replaced	Replaced	Replaced
Laundry	Retained (as is)	Retained (as is)	Retained (as is)	Demolish	Retained (as is)	Demolish	Demolish
Maternity	Retained (as is)	Retained (limited works)	Retained (limited works)	Retained (limited works)	Retained (limited works)	Retained (limited works)	Retained (limited works)
Integrated clinical block	-	-	W, C & YP plus DTC	-	W, C & YP plus DTC	W, C & YP plus DTC	-
DTC	-	New Block	-	New Block	-	-	New Block
W, C & YP	-	New Block	-	New Block	-	-	New Block
Generic In patients	-	-	-	-	-	New Block	New Block

SECTION 6

NON-FINANCIAL APPRAISAL OF OPTIONS

APPROACH TO NON-FINANCIAL APPRAISAL

6.1 The Trust has followed a structured and sequential process to ensure a robust approach to the non-financial appraisal of the short-listed options, this involved:

- The definition of benefit criteria;
- Weighting of criteria;
- Scoring of Options;
- Sensitivity Analysis;
- Selection of the Preferred Option.

6.2 The appraisal has involved a wide cross-section of interests throughout the process including:

- Trust Managers;
- Clinicians;
- PCT Representatives;
- GPs;
- Patient Representatives;
- Staff Interests.

BENEFIT CRITERIA

6.3 From previous work as part of developing the SOC and the national criteria established by the CPAG prioritization of schemes the following 9 criteria have been identified:

- Better access to services;
- Improved clinical quality of services;
- Improved environmental quality of services;
- Developing existing services and / or providing new services;
- Improved strategic fit of services;
- Meeting national, regional and local policy imperatives;
- Meeting training, teaching and research needs;

- Making more effective use of resources;
- Ease of Delivery.

6.4 Further details on each of the criteria are included in ***Appendix H.***

6.5 In order to reflect the relative importance of these criteria, workshops were held to consider views on the most appropriate weightings to be used. Whilst there were considerable consistencies in views, there were some notable differences. Consequently it was agreed to examine the impact of two different sets of weightings as set out in the table below:

Table 37. Criteria Weightings

Criteria	Weighting 1	Weighting 2
	%	%
Better access to services	18	6
Improved clinical quality of services	20	15
Improved environmental quality of services	6	17
Developing existing services and / or providing new services	10	15
Improved strategic fit of services	6	10
Meeting national, regional and local policy imperatives	14	10
Meeting training, teaching and research needs	6	15
Making more effective use of resources	14	6
Ease of Delivery	6	6
Total	**100**	**100**

OPTION SCORING AND SENSITIVITY

6.6 A series of workshops were held with all interested parties to review and score the options. The following 10 point scoring system was used to score each of the options against the agreed criteria:

- 0: Option makes no contribution towards the criteria;
- 1 - 2: Weak;
- 3 - 4: Below average;
- 5: Satisfactory;
- 6 - 7: Good fit;
- 8 - 9: Outstanding fit;
- 10: Ideal, option perfectly meets the criteria.

6.7 The results of the detailed scoring exercise are set out in ***Appendix H,*** and can be summarised as set out in the following tables, based on the average scores of the participants involved in the workshops:

Table 38. Option Scores

Option	Weighted Score	Rank	Difference
			%
Option 1: Do Minimum	167	7	-75.9
Option 2: SOC Option	487	5	-29.4
Option 3: CABE Option	540	4	-21.8
Option 4: Two Centre Option	484	6	-29.9
Option 5: Tower Option	581	3	-15.9
Option 5a: Tower Option with South Wing	583	2	-15.5
Option 6: Radical Option with South Wing	690	1	-

6.8 Option 6 (The Radical Option) was clearly preferred, with Options 5 (The Tower Option) and Option 5a (The Tower Option with South Wing) being the next preferred options. Option 1 scored significantly below all other options.

6.9 The criteria used for the scoring of options within the Non-financial appraisal are those set out by the Department of Health in SOC Guidance. There are a significant number of factors affecting the specific scores assigned to the various options. Having said this, 5 key factors underpin the overall analysis:

- Access to the site / buildings;
- Co-terminosity of theatres;
- Availability of the planned footprint to achieve optimum clinical adjacencies;
- Interdepartmental linkages and the ability to maintain / develop the principles of 'Secure by Design';
- Future Flexibility (without major rebuilding or reducing Clinical functionality).

The following table shows the relative delivery of the options against these factors, demonstrating the benefits of the preferred option.

Table 39. Key factors affecting the Non-financial Appraisal

Key Factors	Option 1	Option 2	Option 3	Option 4	Option 5	Option 5a	Option 6
Access to the site / buildings	Low	Medium	Medium	Low	High	High	High
Co-terminosity of theatres	Not provided	Low	Medium	Medium	Medium	Medium	High
Availability of plan footprint to achieve optimum clinical adjacencies	Not provided	High	Medium	Medium	Medium	Medium	High
Interdepartmental linkages and the ability to maintain / develop the principles of 'Secure by Design'	Low	Low	Medium	High / Medium	Medium	Medium	High
Future Flexibility (without major rebuilding or reducing Clinical functionality)	Low	Medium / Low	Medium / Low	Low	Low	Low	Medium

6.10 Sensitivity Analysis

Detailed analysis of the scores has been undertaken and the following summarises the findings:

- As an alternative to taking the average score, using the mode (the most common score) and median (the central score from the range given) scores produces the same preference for the options ranked 1st to 3rd, and the same 6th ranked option;
- Using the Alternative weighting similarly produces the same preference for the options ranked 1st to 3rd, and the same 6th ranked option, with some minor changes in the relative differences between options;
- Option 6 was the preferred option (or equal 1st option) of 20 of the 30 participants, with only Option 5 or 5a (9 1st preferences) and Option 3 (2 1st preferences) being preferred by any participant;
- Option 1 was seen as the least favoured option by all participants.

The conclusion drawn from this analysis is that:

- The preference for Option 6 from a non-financial perspective is robust under any of the scenarios considered, and Option 6 can therefore be seen as clearly the most favoured of the 6 options;

This outcome will require consideration alongside the results of the financial and economic analysis of options set out in the next

section of the OBC to determine the overall preferred option for the re-development of the Manor Hospital site.

SECTION 7

FINANCIAL AND ECONOMIC APPRAISAL OF OPTIONS

FINANCIAL APPRAISAL

7.1 A detailed financial and economic appraisal of the identified options has been undertaken as part of the development of this OBC as set out below. Details of all calculations are set out in ***Appendix I.***

CAPITAL COSTINGS

7.2 The initial capital costs (including VAT) of the options have been assessed using a MIPS 385 VOP index level for approvals purposes as outlined below:

Table 40. Capital Costs of Options

Capital Costs at MIPS 385 VOP	Option 1 £000s	Option 2 £000s	Option 3 £000s	Option 4 £000s	Option 5 £000s	Option 5a £000s	Option 6 £000s
Works	14,958	62,470	64,503	64,163	63,165	81,353	80,283
Fees	1,962	7,901	8,155	8,113	7,988	10,262	10,128
Equipment	1,105	8,660	8,660	8,720	8,660	9,086	9,086
Non-Works	155	305	305	805	305	1,305	1,305
Contingencies	2,727	11,900	12,243	12,270	12,018	15,301	15,120
VAT	3,264	14,377	14,786	14,830	14,517	18,464	18,248
Total at MIPS 385 VOP	**24,171**	**105,613**	**108,652**	**108,901**	**106,653**	**135,770**	**134,171**
Total at Forecast Outturn	**29,682**	**129,608**	**133,351**	**133,540**	**130,888**	**166,507**	**164,536**
Total at current cost levels	**26,889**	**117,216**	**120,614**	**120,782**	**118,379**	**150,684**	**148,986**

7.3 These capital costs have been calculated by Quantity Surveyors and follow standard NHS Estates costing guidelines. Estimates incorporate:

- Quarterly MIPS Update 13.2;
- A base approvals index of MIPS 385 VOP;
- Outturn costs assume a Q2 2006 start on site (at MIPS 448 VOP), with annual cash flows uplifted by the appropriate MIPS, APSAB and Equipment indices thereafter;
- Capital costs at "current" (2003/04) values – used for the purposes of assessing affordability and value for money –

derived by discounting outturn cash flows by 2.5% per annum compound;

- Professional Fees at 12.5%;
- New equipment provision has generally been made at 30% of the full replacement value; for Radiology, PACS, Telephone and Computer Installations, new provision is included for all options with the exception of Option 1;
- Optimism Bias is acknowledged through the inclusion of general capital contingencies at 15% for all works and equipment elements. This provision is over and above the standard 2% contingency allowance embedded within DCAGs. Subsequent to the initial analysis undertaken by the Trust, a draft methodology (which seeks to codify the criteria and quantify the judgements made by Trusts on a project-specific basis) has been made available to the Trust. The analysis undertaken confirms that the 15% contingency provision made represents a realistic assessment of:

  Potential bias; and

  Mitigation applicable to this Project;

- Non-Works Costs provision has been made as follows:

  Options 5A and 6 (£1.2m) include for: the re-location of laundry equipment; the provision of a temporary Medical Assessment Unit; and a £200,000 general provision;

  Option 4 (£700,000) includes for the re-location of laundry equipment and a £200,000 general provision;

  Options 1, 2, 3 and 5 include a general provision of £200,000.

- Options 5a and 6 include for the full costs of replacing the existing South Wing – under the other options, South Wing replacement is included only in the economic analysis and is assumed to take place between 2013 and 2015;
- All options (other than Option 1) include capital provision for new pathology facilities;
- On-costs include for demolition and site preparation and, reflecting the varying site configurations under each design solution, have been assessed at:

  Option 1 - 80%

  Option 2 - 87%

  Option 3 - 93%

  Option 4 - 88%

  Option 5 - 89%

  Option 5A - 84%

  Option 6 - 82%

7.4 A breakdown of costs for each option prepared in accordance with NHS Executive guidance is contained within ***Appendix I.***

LIFECYCLE COSTS

7.5 The cost of maintaining the assets during the anticipated 60-year life of the Project has been assessed in conjunction with professional advisers as follows:

- All figures are at 2003/04 cost levels, exclusive of VAT and no assessment has been made of the impact of future inflation on cost levels;
- The lifecycle cost driver for each option is based on the value of the initial new works, fees and contingencies, excluding VAT. Under Options 5A and 6, these costs include for the replacement of the existing South Wing facilities, whilst for Options 1 to 5 it is assumed that South Wing would be replaced between 2013 and 2015. The lifecycle provision for this element of Options 1 to 5 has been re-profiled accordingly;
- Under Option, 1 initial capital costs also include for the removal of backlog maintenance liability on existing assets that would be retained;
- No provision has been made for the lifecycle impact of the current West Wing and Maternity Blocks, which are to be retained under and assumed to be common to all options;
- The assessment is based on standard building component lives expressed as a proportion of initial building and engineering costs, with replacement banded into 5 yearly cycles. The following underlying assumptions have been used;
- For each option cyclical "refurbishment" is assumed to be some 8.5% more expensive than the initial capital costs, as a result of the need to decant and the higher on-costs attributable to refurbishment work;
- 60% of new build cost works relate to building fabric, with the remaining 40% relating to engineering plant;
- Building asset lives have been forecast as follows:

60 years	*75%*
30 years	*1%*
25 years	*1%*
20 years	*15%*
15 years	*2%*
10 years	*5%*

5 years *1%*

- Engineering asset lives have been forecast as follows:

  60 years *38%*

  30 years *20%*

  25 years *15%*

  20 years *13%*

  15 years *7%*

  10 years *7%*

  5 years *0%*

- The resulting building life cycle costs have then been allocated to the relevant time period;
- In addition, an allowance has been included for annual spends on irregular maintenance based on an average cost of £2 per m2;
- For equipment, a 10-year replacement cycle has been incorporated into the economic analysis for all options, using the full replacement value of the new equipment provision included in capital costs above.

7.6 Details of the life cycle analysis can be found at ***Appendix I.***

CURRENT REVENUE BUDGETS

7.7 The current revenue budget of the Trust is summarised in the table below:

Table 41. Summary of Revenue Budget 2003/04

Cost Heading	Pay	Non-Pay	Total
	£000s	£000s	£000s
Clinical Services	63,228	13,546	76,774
Non Clinical Services:			
Services to be provided by a PFI Partner	6,120	6,429	12,549
Trust Retained Services	6,084	4,138	10,222
Total Revenue Costs (excluding capital charges)	75,432	24,113	99,545
Capital Charges (including Target Return at 3.5%)		9,222	9,222
Gross Revenue Budget	75,432	33,335	108,767
Category C Income		(8,101)	(8,101)
Net Revenue Budget	75,432	25,234	100,666

FORECAST IMPACT ON REVENUE BUDGETS

7.8 In assessing the potential impact on revenue budgets under each of the options, a 2003/04 price has been used and the following methodology adopted:

7.9 **Capital charge estimates**

- All new capital expenditure is deemed to add value to the Trust's asset base;
- For capital charges (and value for money) purposes, capital costs at "current" values have been used, namely outturn costs discounted by GDP compounded at 2.5% per annum;
- Target return on assets at 3.5%;
- Depreciation on new building and related assets assumes an average asset life of 40 years;
- Depreciation on new equipment assumes a 10 year average life;
- Savings on current capital charges, reflecting the demolition of existing assets (the majority of which relate to East Wing and the Outpatients Department and are common to all options), have been incorporated at: £1.2m for Option1, £1.4m for Options 2 to 5 and £1.6m for Option 5a and 6.

7.10 Activity Projections

Appendix D provides details of the forecast (FFCE) activity for 2010/11, which underpins the financial estimates. The methodology used to establish the FFCE change cost drivers can be summarised as follows:

Establish base activity for 2002/03 (split elective, day case and emergency and consolidate into total);

Split forecast for 2010 as per base to establish % activity growth over base, applied annually on a straight line basis;

These percentages have then been applied to the variable and semi-fixed cost elements of budget heads as described below to derive forecast annual revenue costs.

7.11 **Clinical and Non-Clinical Costs**

A simple costing methodology has been adopted, whereby at main budget head level, judgements have been made as to the proportion of the budget deemed to be variable;

The variable proportion of each budget head has then been attributed a 'cost driver' – mostly FFCEs as a general proxy - but Outpatients or Space where specifically appropriate. The 2010/11 full year effects of cost driver changes incorporated are shown in the table below:

Table 42. Summary of Cost Driver Changes

Cost Driver	Change
FFCEs	Additional 7.48%
Outpatients	Additional 10.98%
Space (Option 6)	Additional 20% (14,010 m2)

- Base Clinical and Non-Clinical costs have been flexed similarly across all options for cost driver changes. A further review has been undertaken to assess the potential for clinical and operational savings under each of the options. As noted below, the scope for savings is deemed to be limited;
- It should be noted that cost provision has only been made for the activity to be undertaken within the Walsall hospitals setting: the cost impact of activity to be undertaken in primary care or intermediate care is the subject of separate review by the PCT, and is excluded from this analysis;
- In assessing the cost impact of the activity change above, activity growth has been netted off the efficiency gain of clinical efficiencies planned.

7.12 Other Savings

Options have been reviewed to assess the likely change in clinical and operational practice required, specifically as a function of delivering the Project (a) compared to current practice and (b) to assess potential differences between options. This review has confirmed that change is likely to be restricted to specific areas as described below:

- Children's Inpatients: Currently beds provided in 3 wards (Christopher Robin, Canterbury and Salisbury). In future beds to be provided in two inpatient areas. No change in general staffing levels (as bed reductions offset by higher dependency), except for Grade F and G Sisters, where there should be a 25% saving;
- Day Case Area: No change to staffing levels (better efficiency offset by increases in staffing to oversee more single rooms);
- Outpatients: No change in nurse staffing levels. Better efficiency in admin staffing through better design, leading to a 25% reduction in reception staff in outpatients;
- Phlebotomy: Currently provided in a single location for outpatients (plus a ward visiting service). In future to be provided in two locations (plus ward visiting). Increase in staffing by 1 wte;

- Breast Care: Currently provided in 3 locations. In future to be integrated, leading to a 0.25 wte saving in admin support staff;
- Portering: New Facilities to include a pneumatic tube for the delivery of specimens and drugs, etc. This will lead to a 5% reduction in portering requests. A saving of 5% in pharmacy portering staff and some elements of the site courier service has been assumed.

Additional savings Option 5A and 6

- In addition to the above, the improvements in functional relationships arising from the design solution will reduce travel distances and times within the hospital, and obviate the need for internal transport to be provided. A saving on the Internal Ambulance has been assumed as other transport will still be needed for Goscote etc. There will be an equivalent saving in Healthcare Assistants (in respect of current East Wing, South Wing and Outpatients) who in future will need to spend less time accompanying patients;
- Co-location of theatres will lead to saving in senior staff within theatres / endoscopy, estimated at 1 wte Grade G nurse.

7.13 On the basis of the assumptions outlined above, Options 1 to 5 are expected to produce potential savings of £104,000 per annum (at 2003/04 prices), whilst for Options 5A and 6 a saving of £212,000 is expected. Savings are assumed deliverable in 2010/11.

7.14 The full running costs of the options at 2010/11 project activity levels are therefore forecast (at 2003/04 pay and prices levels) to be as follows:

Table 43. Forecast 2010/11 Revenue Costs (at 2003/04 prices)

Running Costs	Option 1 £000s	Option 2 £000s	Option 3 £000s	Option 4 £000s	Option 5 £000s	Option 5A £000s	Option 6 £000s
Clinical Costs	76,891	76,891	76,891	76,891	76,891	76,803	76,803
Non-Clinical Costs:							
PFI Services	12,417	12,988	12,893	12,965	12,950	13,081	13,105
Trust Retained Services	9,896	9,896	9,896	9,896	9,896	9,896	9,896
Total Revenue Costs (excluding capital charges)	**99,204**	**99,775**	**99,680**	**99,752**	**99,737**	**99,780**	**99,804**
Capital Charges (including Target Return at 3.5%)	8,808	14,763	14,965	14,982	14,832	16,602	16,495
Gross Revenue Budget	**108,012**	**114,538**	**114,645**	**114,734**	**114,569**	**116,382**	**116,299**
Category C Income	(8,349)	(8,349)	(8,349)	(8,349)	(8,349)	(8,349)	(8,349)

Running Costs	Option 1 £000s	Option 2 £000s	Option 3 £000s	Option 4 £000s	Option 5 £000s	Option 5A £000s	Option 6 £000s
Net Revenue Budget	**99,663**	**106,189**	**106,296**	**106,385**	**106,220**	**108,033**	**107,950**
Affordability Rank	**1**	**2**	**4**	**5**	**3**	**7**	**6**
Affordability Switch Value over Option 2		**0**	**(107)**	**(196)**	**(31)**	**(1,844)**	**(1,761)**

7.15 Noting that Option 1 cannot deliver the outputs sought, and is included as a required comparator only, in terms of revenue affordability:

- Option 2 represents marginally the cheapest development option but, as with Options 3 to 5, does not include for the replacement of South Wing;
- Of the two options that include for South Wing replacement, Option 6 is marginally preferred over Option 5A, in financial terms;
- The marginal revenue impact of replacing South Wing "now" is thus approximately £1.7m.

AFFORDABILITY OF OPTION 6

7.16 In order to provide a context for assessing the affordability of Option 6, a further analysis has been undertaken in order to:

- Quantify the impact of cost change over the main change drivers; and,
- Profile the change annually up to 2010/11.

Table 44. Option 6 Forecast Revenue Cost Changes

Running Costs	2003/04 £000s	2010/11 £000s	Increase £000s
Clinical Costs	76,774	76,803	29
Non-Clinical Costs:			
PFI Services	12,549	13,105	556
Trust Retained Services	10,222	9,896	(326)
Total Revenue Costs (excluding capital charges)	**99,545**	**99,803**	**258**
Capital Charges	9,222	16,496	7,274
Gross Revenue Budget	**108,767**	**116,299**	**7,532**
Category C Income	(8,101)	(8,349)	(248)
Net Revenue Budget	**100,666**	**107,950**	**7,284**

7.17 The following tables provide a profile of the annual build-up in revenue costs over the period 2004/05 to 2010/11. They highlight the cost impact of delivering the activity sought under the LDP and also the estimated forecast in capital charges, which now reflect the requirement to include liability in respect of assets under construction. The first table presents figures in line with the summary revenue analysis headings, whilst the second provides an attribution of cost increases between the main change drivers:

Capital Charges, split:

- 'New for Old';
- Consumerism;
- Activity;
- South Wing Increase;
- Savings on demolished assets.

Other, split:

- Activity;
- Space;
- Efficiencies.

Table 45. Option 6 Annual Profile of Cost Changes

Running Costs	04 /05 £000s	05/06 £000s	06/07 £000s	07/08 £000s	08/09 £000'	09/10 £000s	10/11 £000s	Total £000s
Clinical Costs	337	337	(94)	(94)	(94)	(94)	(268)	29
Non-Clinical Costs:								
PFI Services	36	36	(37)	(37)	(37)	(37)	632	555
Trust Retained Services	4	4	(67)	(67)	(67)	(67)	(67)	(326)
Total Revenue Costs (excluding capital charges)	**376**	**376**	**(198)**	**(198)**	**(198)**	**(198)**	**297**	**258**
Capital Charges	113	550	2,374	2,395	3,263	925	(2,345)	7,274
Gross Revenue Budget	**489**	**926**	**2,176**	**2,197**	**3,065**	**727**	**(2,048)**	**7,532**
Category C Income	(7)	(7)	(47)	(47)	(47)	(47)	(47)	(248)
Net Annual Increase	**482**	**919**	**2,129**	**2,150**	**3,018**	**680**	**(2,094)**	**7,284**
Cumulative Increase	**482**	**1,401**	**3,530**	**5,681**	**8,699**	**9,379**	**7,284**	

Table 46. Option 6 Attribution of Annual Change

Running Costs	04 /05 £000s	05/06 £000s	06/07 £000s	07/08 £000s	08/09 £000'	09/10 £000s	10/11 £000s	Total £000s
Capital Charges								
New for Old	69	336	1,448	1,461	2,112	564	0	5,989
Consumerism	11	55	237	239	346	92	0	982
Activity	12	61	261	263	381	102	0	1,080
South Wing Increase	20	99	427	431	623	166	0	1,767
Savings on demolished / disposed assets	0	0	0	0	(199)	0	(2,345)	(2,544)
Total Capital Charges	**113**	**550**	**2,374**	**2,395**	**3,263**	**925**	**(2,345)**	**7,274**
Other								
Activity	369	369	(245)	(245)	(245)	(245)	(245)	(485)
Space	0	0	0	0	0	0	708	708
Efficiencies	0	0	0	0	0	0	(213)	(213)
Total Other	**369**	**369**	**(245)**	**(245)**	**(245)**	**(245)**	**251**	**10**
Total Change	**482**	**919**	**2,129**	**2,150**	**3,018**	**680**	**(2,094)**	**7,284**
Cumulative Change	**482**	**1,401**	**3,530**	**5,681**	**8,699**	**9,379**	**7,284**	

COST IMPACT BY COMMISSIONER

7.18 Table 47 below provides a summary analysis of the additional cost impact, by Commissioner. Facilities-related costs have been apportioned on the basis of 2002/03 recurrent income, whilst activity-related costs are split on the basis of baseline Occupied Bed Days (assuming a 1 day length of stay for day case activity).

Table 47. Cost Impact of Option 6 by Commissioner

PCT	%	2010/11 £000s
Walsall	87.2	6,353
South Staffs – Cannock Chase	4.9	356
South Staffs – Burntwood, Lichfield & Tamworth	2.1	155
Sandwell – Wednesbury & West Bromwich	3.0	220
Wolverhampton	0.7	52
Dudley – Beacon Castle	0.1	5
Dudley – South	0.1	5
Other	1.9	138
Total	**100.0**	**7,284**

ECONOMIC ANALYSIS

7.19 All options have been evaluated in line with the requirements of the NHS Capital Investment Manual, HM Treasury's Green Book Guidance and the guidance contained in the Generic Economic Model published by the NHS Executive in August 2001, using a 3.5% discount factor. VAT has been excluded from the discounting in line with the Capital Investment Manual guidance.

7.20 A 66-year period has been used for the evaluation (reflecting 60 full years of "new" operation) and in calculating the Net Present Value (NPV and Equivalent Annual Cost (EAC), the following assumptions have been made:

- Capital cash flows are taken from capital cost forms, and the capital costs have been inflated from MIPS index 385 to forecast out-turn levels and then discounted by 2.5% per annum (forecast GDP deflator) to represent current (2003/04) cost levels;
- Life-cycle costs have been based on the breakdown of age of assets used in calculating capital charges and applied to all options over the full economic period;
- Options 1 to 5 include for the replacement of the existing South Wing in the period 2013 to 2015. Under Options 5A and 6, such provision is made within the initial capital costs;
- A review of Opportunity Costs has been undertaken and the conclusions can be summarised as follows:

  All options allow for the retention of West Wing and Maternity. However, since these blocks are integral to maintaining clinical viability on the site and represent no realistic alternative development potential, no opportunity costs have been included for these elements;

  All options include capital costs for either replacing or major upgrade of the remaining facilities on the site and (effectively) deliver the same economic outputs. Under options 5A and 6, all other facilities are replaced as new build; Options 2 to 5 mirror this principle, save for the later (2013) re-provision of South Wing. Option 1 provides for a minimum new build but full removal of backlog maintenance liability;

  In view of the low value of the existing South Wing and the small time differential between it's demise under Options 5A and 6 (say 2009) and other options (say 2015), no opportunity cost provision has been made for this block under any option;

  Since Option 1 costs include for bringing existing facilities up to statutorily required functional levels, no further (opportunity) cost has been ascribed to this option.

- Equipment is assumed to require replacement every 10

years;

- Residual values at the end of the economic analysis period have been calculated taking account of depreciation and life-cycle replacements.

7.21 Detailed calculations are shown for each option in ***Appendix I,*** with the following overall results.

Table 48. Summary Economic Analysis of options

Economic Cost 60 Year Analysis	Option 1 £000s	Option 2 £000s	Option 3 £000s	Option 4 £000s	Option 5 £000s	Option 5A £000s	Option 6 £000s
Net Present Value	2,553,297	2,651,759	2,653,117	2,655,066	2,652,110	2,671,515	2,670,240
Equivalent Annual Cost	93,973	97,597	97,647	97,719	97,610	98,324	98,278
EAC switch value over lowest development option		13	(50)	(122)	(13)	(727)	(681)
RANK	**1**	**2**	**4**	**5**	**3**	**7**	**6**

7.22 The analysis indicates that Option 1 has the lowest economic cost, and whilst the development options represent potentially broadly similar value for money solutions, Option 2 is marginally preferred. Nonetheless, Option 6:

- Delivers the significant non-financial benefits at a relatively low economic cost, equivalent to an additional EAC of £681,000 against Option 2;
- Represents a (marginally) better economic solution than the other "full" development Option 5.

ECONOMIC SENSITIVITY ANALYSIS

7.23 The results of the overall economic appraisal were then subjected to a specific sensitivity test to assess the level of differential cost driver change (switch values) required to make Option 6 preferred over Option 2.

Table 49. EAC Switching Values

Economic Cost (after Risk Adjustment)	Option 2 £000s	Option 6 £000s
Base EAC	97,597	98,278
EAC Switching Values between these Options	681	(681)

7.24 Three key scenarios have been examined to assess the level of change necessary in key cost drivers to trigger these switching values. The following provides a summary of the analysis.

Table 50. Scenario Summary

Scenario 1: Change in Capital Costs
Option 2 costs would have to increase by £22m (18%)
Option 6 costs would have to reduce by £21m (16%)
Scenario 2: Change in Lifecycle Costs
Option 2 costs would have to increase by £62m (63%)
Option 6 costs would have to reduce by £62m (48%)
Scenario 3: Change in Annual Revenue Costs
Option 2 costs would have to increase by £678,000 (0.7%)
Option 6 costs would have to reduce by £678,000 (0.7%)

7.25 In terms of value for money there are unlikely to be circumstances in which capital or lifecycle cost drivers might change differentially in favour of Option 6. Revenue cost switch values are more likely to be triggered in favour of Option 6, but on the basis of the level of cost analysis undertaken would be difficult to justify.

7.26 Option 2 is therefore confirmed as the marginally preferred option in economic terms.

THE IMPACT OF *PAYMENT BY RESULTS*

7.27 A framework is currently being established to assess the potential financial impact of the project under the proposed *Payment by Results*, which if implemented to timetable, will be well established before this project is completed. In view of the outstanding issues remaining to be addressed and the lack of definitive guidance currently available, it has been necessary to use national Reference Cost data as a basis for the current analysis. The approach being adopted is as follows:

- Cost the Trust's base HRG activity using 2003 national Reference Costs and compare with existing income streams;
- Cost the Trust's forecast HRG activity for 2010/11 using 2003 national Reference Costs and compare with forecast revenue quantum.

7.28 The analysis undertaken indicates that compared with current baselines, the Trust is likely to generate additional income of £9m:

- An extra £4.4m through delivering agreed forecast activity:
- A further £4.6m as a result of the introduction of Payment by Results.

CONCLUSION TO THE FINANCIAL AND ECONOMIC ANALYSIS OF THE DEVELOPMENT OPTIONS

7.29 Whilst Option 2 is marginally preferred overall in terms of both affordability and value for money, Option 6 is the preferred "full" development option. It is considered that the additional cost impact realistically reflects the major clinical and other non-financial benefits of replacing South Wing as part of the main hospital re-development. Option 6 is thus preferred and forms the Trust's *Public Sector Comparator.*

SECTION 8

THE PREFERRED OPTION

SELECTION OF THE OVERALL PREFERRED OPTION

8.1 It can be seen from Sections 6 and 7 that the Non-financial and Financial / Economic evaluation of options show different preferences in terms of the options. From a Non-financial perspective Option 6 is clearly preferred, whilst from an Economic perspective Option 2 is marginally preferred.

8.2 It is therefore necessary to consider the overall preferred option taking both of these analyses into account.

Table 51. Overall Evaluation Summary

Option	Weighted Score	Equivalent Annual Cost	Benefit Score / £m	Difference
		£m		%
Option 1: Do Minimum	167	94.0	1.78	-74.7
Option 2: SOC Option	487	97.6	4.99	-28.9
Option 3: CABE Option	540	97.7	5.53	-21.2
Option 4: Two Centre Option	484	97.7	4.95	-29.5
Option 5: Tower Option	581	97.6	5.95	-15.2
Option 5a: Tower Option with South Wing	583	98.3	5.93	-15.5
Option 6: Radical Option with South Wing	690	98.3	7.02	

8.3 From the combined analysis there is a clear preference for Option 6, the Radical Option with replacement of South Wing, and this is therefore selected as the Preferred Option for implementation. Outline Floor Plans showing the way in which the services will be provided under this option are included in ***Appendix J.***

DELIVERY OF PREFERRED OPTION

8.4 In developing the preferred option a detailed appraisal has been undertaken on how the facilities could be procured, this appraisal underpins the public sector comparator but is not the only way of

delivering this scheme, which will be determined by the successful PFI partner.

- **STAGE 0**
  Laundry to move off site (Pre PFI)
  Provision of Multi Professional Education Centre (Pre PFI)
  Nurse Education available of temporary non clinical decants (Pre PFI)
- **STAGE 1**
  Infrastructure Rationalisation to the whole site
  Rationalisation of the RDS / Service Centre
  Demolition of Laundry
  Minor Works to existing Maternity
  Rationalisation of West Wing Concourse
  Demolition of the HSDU Site Education and training block
  Provision of relocated Ambulance Facilities
  Temporary relocation of office facilities
- **STAGE 2**
  Provision of South Wing Replacement
  Provision of Women, Children & Younger Persons
  Development Provision of a temporary MDU
- **STAGE 3**
  Demolition of South Wing
  Demolition of East Wing
  Demolition St John's Block
- **STAGE 4**
  Provision of the Diagnostic & Treatment Centre
  Provision of Assessment Beds within West Wing
- **STAGE 5**
  Demolition of Sister Dora Outpatients / Surgical Day
- **STAGE 6**
  Provision of the new Pathology Block
  Rationalisation of West Wing
- **STAGE 7**
  Demolition of Pathology
  Relocation of section office complex
  Re provision of office facilities
- Timescale for Construction of Public Sector Comparator follows is included at ***Appendix K.***

BENEFITS OF THE PREFERRED OPTION

8.5 The redevelopment of the Hospital site in line with Option 6 provides a great many benefits in terms of achieving the clinical and service delivery objectives set out within the scope of the project, whilst also providing a much improved strategic fit in terms of the longer term vision for the delivery of care across the spectrum of services including Emergency and Intermediate Care.

8.6 In establishing the Project the Trust outlined the key benefits which it was seeking to achieve. The table below outlines in italics the degree of success, which Option 6 offers

Table 52. Benefits of Preferred Option

Service	Benefit and *Extent to which it is addressed*
Women's Services Integrated Gynaecology	❑ Better utilisation of a wide range of clinical skills *The option brings all of the Gynaecology Services into a single location and therefore provides the potential for great sharing of skills and experience* Improved medical cover to key areas *The delivery of services in a single location ensures that cover is not distributed too thinly and therefore provides improved levels of care and cover* ❑ Ability to meet new medical cover requirements (junior & Consultant) *The co-location with Maternity services ensures that the ability to meet the new targets is enhanced* Reduced patient journeys *Although many of the diagnostic facilities to be provided are in the West Wing or DTC these are rarely used by Gynaecology. The frequently used facilities are within easy reach and within a single building* ❑ Better access to specialist care *Improved access to medical cover and the range of specialist skills is highlighted above. There is also significant benefit to be gained in terms of the ready access to Critical care, via the Hospital Street rather than resorting to the use of external transport* Ability to share diagnostic facilities *There is commonality with the Obstetric service and this can be maximized within this option, although the final design of the adjacencies will be critical*
Replacement of Antenatal facilities	❑ Better management of the complex pregnancy *The adjacency to the Obstetric Unit provides ready*

Service	Benefit and *Extent to which it is addressed*
	access to the specialist skills. ❑ Redesign of the patient journey to reduce hospital visits *More integrated services will support the development of "one stop" services ".* ❑ Improved diagnostic facilities to enable better use of technology *Purpose designed facilities will support maximum use of technology in situ*
Integration of Breast Services	❑ Delivery of care within a female friendly environment *The service will be delivered within an environment designed specifically for the needs of Women, and will be supported by a sympathetic infrastructure. The specialist skills developed by Gynaecology nurses will support the psychological as well as physical needs of this very vulnerable group of patients* ❑ Access to specialist support services *Provision of all services within a single Building will ensure access to medical and nursing skills is maximised*
Children & Younger People	❑ All children receive their care within a child friendly environment *The Option provides the vast majority of children's care within a single location. Consequently the achievement of the appropriate environment whatever the child's needs can be achieved* ❑ Specialist skills are concentrated in a single location *The provision of a single, integrated facility for all elements of the service ensures that skills are available at the level required* ❑ The need for children to travel to services is reduced *The provision of both Diagnostic and Treatment facilities for Children in a single location, including Theatres ensures that Children would only leave their unique environment in the most exceptional circumstances* ❑ Parent facilities can be provided in line with latest standards *The correct standards can be achieved and within*

Service	Benefit and *Extent to which it is addressed*
	"dressing gown" distance from the ward facilities Adolescents are no longer managed in Adult Acute beds *Provision of specific accommodation will ensure that the specialist needs of this small but complex group of patients can be delivered by staff with the appropriate skills and a more socially relevant environment*
Pathology Services	❑ Services are provided in an environment suitable for the maximum utilization of automated analysers *Sufficient space and an appropriate environment are deliverable* ❑ Access to key areas of the Hospital are via an appropriate specimen transportation system *Although the solutions are widespread the transportation mechanism can achieve the required standards* ❑ All Microbiology services are accommodated together *Achieved with the ability to link the clinical and laboratory functions* ❑ Sufficient access is provided for staff CPD *Capability for multidisciplinary CDP is also delivered*
Diagnostic & Treatment Centre	❑ Ability to reduce patient journeys. *The available footprint will allow the building to be stacked with like facilities and key clinical links co-located on a single floor, further reducing patient journeys* *The provision of the key diagnostic and treatment facilities in a single building will ensure patients have minimum need to dress/undress, and can also benefit from the development of true "one-stop" services* ❑ Separation of the majority of elective activity from non-elective *The requirements of elective patients in terms of diagnostic and treatment needs are delivered in distinct locations. Therefore the requirements for scheduling elective activity in order to maximize capacity, achieve waiting time targets and avoid wasted patient visits/ admissions can be addressed*

Service	Benefit and *Extent to which it is addressed*
	❑ Increased capacity for the management of elective treatment especially Day Cases *Access to Theatre facilities is key to delivering much of the Elective activity. This option provides more Theatres plus the option for the delivery of some services, currently inappropriately using Theatres, within a safe clinical environment* ❑ Facility to establish true one stop clinics therefore reducing patient attendance at hospital *The location of the key diagnostic services and treatment facilities will facilitate better scheduling and the ability to support patients attending for multiple investigations.* ❑ Ability to operate multidisciplinary clinics more readily *Appropriate clustering of Consulting Rooms and provision of diagnostic and treatment facilities in a single location will ensure that clinical skills can be drawn together more readily*
Generic Acute Beds/ Replacement for South Wing	❑ Improved patient environment with increase availability of single bed rooms and en-suite WC/showers *The new facilities will provide the target 50% single rooms with en-suite WC/ shower. The maximum multi-bed room size will be 4 beds and each room will have an adjacent en-suite WC/shower* ❑ Provision of dedicated inpatient therapy facilities *An integrated Therapy Centre will be built within the new build accommodating Physiotherapy Treatment, Occupational Therapy ADL Assessment and Speech & Language Therapy facilities* ❑ Co-location with Assessment/ Emergency/ Critical Care services *The preferred option provides the new building at the rear of the A&E Department with corridor link access on a level with Critical Care* ❑ Support facilities available to support multi-disciplinary/ multi-agency working *Assessment and MDT facilities will be available in the ward areas for use by all health partners* ❑ Provision of all inpatient facilities in a single

Service	Benefit and *Extent to which it is addressed*
	building *All of the buildings will be linked by a single hospital street therefore there is ease of patient and staff flow between buildings, and there is immediate access to full diagnostic and treatment facilities for the new generic acute beds* ❑ Flexibility in bed utilisation between specialties to reflect changes in working patterns/ models of care *Both the location of the beds and their overall generic design will ensure that the facility can be used by any acute specialty (with the exception of Critical Care) and will therefore facilitate flexible use in the future including shared specialty wards; provision of acute assessment; early rehabilitation or initial inputs from intermediate care services*
Multi Professional Education Centre	❑ Establishment of an integrated education facility supporting all the professions across the whole health economy; *The preferred solution provides a focal point for training and education which is accessible to all professionals and all agencies, with an integrated library and information service.* ❑ Creation of a modern teaching facility to support competency based training methods; *The provision of clinical skills laboratories and IT training facilities in addition to the wide range of seminar and library facilities ensures the ability to meet modern day training needs. The provision of AV links to operational facilities and the medical school also enhances the access to on-line training and education* ❑ Provision of sufficient training and education capacity to support increasing staff and student numbers. *The MPEC facility provides a substantial capacity for the delivery of different teaching methods to a range of group sizes. In addition to the centralised facility there is also provision of teaching/seminar facilities within each of the new clinical developments to support teaching within the clinical environment.*
Whole Hospital Benefits	❑ Creation of a single hospital street improves the management of patient movements and deliveries as they remain internal

Service	Benefit and *Extent to which it is addressed*
	This option delivers this with the added benefit that key clinical services are more appropriately linked via the Street e.g. Medical Wards are adjacent to the A&E Department ❑ Separation of elective and non –elective activity will support the delivery of Modernisation Agenda *The requirements of elective patients in terms of diagnostic and treatment needs are delivered in distinct locations. Therefore the requirements for scheduling elective activity in order to maximize capacity; achieve waiting time targets and avoid wasted patient visits/ admissions can be addressed.* *The needs of Non-elective patients also begin to be addressed through the reprovision of South Wing* ❑ Reprovision of oldest elements of the estate will ensure that future care delivery is within appropriately designed and built facilities *The delivery of this solution would bring the overall estate to a much higher standard addressing the key issues of poor accommodation in South Wing*

8.7 Operational Benefits

8.7.1 The development of Option 6 provides a number of Operational benefits which the Trust believes are significant

8.7.2 *Theatre Configuration*- the Trust's operating theatres are currently distributed across four locations on the Manor site. It has long been recognised that significant benefits are achieved through the clustering of Theatres over fewer locations. The preferred option in effect reduces the number of Theatre blocks to 3, with the ability to manage the existing West Wing Theatres and the Diagnostic & Treatment Centre as a single Theatre facility. This option facilities the collocation of the West Wing and DTC theatres, creating a single managed unit and opportunities to provide integrated support and staff facilities.

8.7.3 In addition the location of the West Wing and DTC Theatres as a single facility will support increased flexibility of use of both total Theatre capacity and individual Theatre lists, with the ability to integrate routine and complex surgery through one Theatre whilst the patients receive their nursing and rehabilitation support in either the DTC or Acute Inpatient Ward, whichever is clinically appropriate.

8.7.4 *Co-location of Women & Children's Services*- it has long been acknowledged that the needs of these two disparate patient groups can be best addressed through co-locating services and therefore

minimising the perceived barriers to care delivery. The patient and carer support mechanisms both clinical and social can be provided with minimal duplication and provide a single access point to the broader healthcare networks.

8.7.5 *Movement of Staff and Goods* - The proximity of the DTC to West Wing will allow for the transfer of staff and goods between the DTC and the long stay elective / emergency facilities in an optimum fashion, whilst maintaining its separate identity / philosophy of service.

THE CONSULTATION PROCESS

8.8 The Trust has been extremely committed to the involvement of all of the key stakeholders in the development of both the Models of Care delivery and the identification of the preferred capital solution.

8.9 The Trust has actively participated in the Black Country Review process and has embraced many of the key principles through the clinical working groups, and has built in a number of assumptions in terms of efficiency and transfers of care which pass beyond earlier considerations regarding the likelihood of changes in practice. All of the planning assumptions and changes in practice have been agreed with the both Walsall and Wolverhampton PCTs and are fully supported by the clinical body within the Trust

8.10 In addition to the formal Project structure including Project Board and Team established with representation from both the Acute and Primary Care Trusts, with the commencement of the planning process in January 2003, a number of Clinical Working Groups were established, involving Medical, Nursing and management representatives of the key functions, again from both the Acute and Primary Care Trusts.

8.11 All of the Clinical Working Groups met at least weekly to identify and resolve the issues arising from their preferred model of service delivery and develop the relevant functional content and related schedules of accommodation.

8.12 In developing the models of care the focus has been on the achievement of the highest standards and delivery of best practice. Reference has been made to external expertise including Royal Colleges, the Modernisation Agency, and patient support groups such as Action for Sick Children.

8.13 The development of the Diagnostic and Treatment Centre is recognised as a significant change in the direction of care delivery which has significant implications for the whole of the local health economy. In addition it was acknowledged that there was a strategic vision within the Primary Care Trust to develop DTCs within the local community. The objective for the Acute Trust therefore reflected the need to ensure that the facilities developed on the Manor Hospital site complimented those anticipated within the community. The planning process therefore began with two workshops involving Hospital Consultants, General Practitioners,

and clinical staff from both Trusts to identify the remit of the two different DTCs. The range of services which were anticipated to be delivered within the hospital and in a community/ primary care facility were identified and agreed, and therefore formed the basis of the detailed planning for the Acute Hospital facility.

8.14 Having established the clinical models and functional content of the key service areas the completion of the Option Appraisal process was widened to ensure that stakeholders across the whole health economy were able to participate.

8.15 The Trust has also recognised that the improvements proposed for the Manor Hospital site are a unique opportunity to provide a landmark development for Walsall itself. Regular discussions have therefore taken place with colleagues within the local council in order to understand their concerns and priorities relating to this proposal.

8.16 In order to widen the consultation process as part of the wider communication strategy within the project a website has been designed which will provide details of the models of care, the detailed discussions which have taken place within the working groups, and the development of the proposed solutions. This site will be available via the Trust's intranet and will therefore enable all staff to participate in and contribute to the ongoing planning process.

8.17 As part of the selection of the Options, from the review of the long list through the development of the Short List and selection of the preferred option and preparation of the Public Sector Comparator the Trust have worked closely with the Walsall Metropolitan Borough Council (WMBC). The Director of the Built Environment represents the Borough Council on the Project Board for this Project.

8.18 A Development Team has jointly been set up in-order that consensus can be achieved with a wide range of Professions within the Borough Council throughout the procurement process. This consultation process includes:

- WMBC Planning Policy Department;
- WMBC Planning and Development Control;
- WMBC Landscape and Nature Conservation;
- WMBC Building Control;
- WMBC Environmental Health;
- WMBC Highways and Transportation;
- WMBC Design and Conservation;
- WMBC Property and Development.

8.19 In addition, liaison has been carried out with Centro and WMBC Highways and Transportation in connection with the current proposals for the 5 W's Metro Route. Presentations on the proposals have also been made to the Walsall Regeneration

Company who is currently overseeing the development of the proposals for the Walsall Waterfront and Pleck Road regeneration.

8.20 The Outline Planning Application reference BC58026P was accepted on 3rd August 2001 and approved 12 March 2003 and further clarification / development has been documented as follows.

- Gill & Russell, HSDU Site & Pleck Road
  Application – 02/0537/FL/W2
  Accepted 22nd August 2002
  Approved 25th November 2002

- Manor Quays, Brineton Street
  Application – 03/2199/FL/WZ
  Accepted 7th November 2003
  Approved 11th February 2004

An application, currently in the process of being approved, has been lodged in respect of the Multi Professional Education Centre.

SECTION 9

THE PRIVATE FINANCE INITIATIVE

INTRODUCTION

9.1 Detailed consideration has been given to the delivery of the project through the Government's Private Finance Initiative. This section of the OBC sets out the details of this component of the overall plans.

SHADOW PFI COST MODEL

9.2 KPMG, as Corporate Finance Advisors to the Trust, have developed a Shadow PFI Cost Model to examine the potential PFI Tariff that would arise for the development in comparison to the costs included in Section 7 for the Public Sector Comparator (PSC).

9.3 The Trust has provided KPMG with information extracted from the PSC in order for KPMG to prepare a Shadow Model that calculates a potential private sector tariff should the new hospital facilities be funded under the PFI. The model has been prepared on a traditional project finance structure basis. The funding assumptions adopted are in line with current banking conditions and requirements and as such should be broadly acceptable to potential funding institutions, subject to their own funding and credit robustness criteria being satisfied.

9.4 The private sector tariff (or unitary charge) is based on funding the capital costs exclusive of VAT since it is assumed that all VAT on construction costs is recoverable by the private sector. If the public sector was to fund the project then VAT would not normally be recoverable on substantial elements of the project.

PFI AFFORDABILITY AND VALUE FOR MONEY

9.5 **AFFORDABILITY**

A comparison has been undertaken to determine the relative affordability of the PFI Solution on the basis of the indicative tariff. The analysis undertaken confirms that, taking due account of the amortisation of the residual interest, the PFI solution will be affordable to commissioners within the resources expected to be available under NHS Payment by Results tariffs.

9.6 **VALUE FOR MONEY**

In terms of Value for Money (VFM), the analysis undertaken reflects the impact of the new Treasury Green Book guidance, as follows:

- A discount rate of 3.5% (for the first 30-years, 3% thereafter) is used;
- Appraisals have made over the full 66-year economic period and also the 36-year period (to cover just the full 30 year operating concession);
- PSC optimism bias has been ameliorated by the inclusion therein of capital cost contingencies at 15% - previously a 6% allowance was typical;
- The potential tax advantages of undertaking the project under PFI, relative to a public sector procurement, has been reflected by applying a 3% weighting to all cash flows within the PSC, with the exception of Trust-retained clinical and support services;
- A full risk assessment of the PFI solution and PSC has been carried out. Analysis follows the guidance on risk transfer as set out in the Private Finance Panel's *Risk and Reward in PFI Contracts*.

9.7 A widely accepted, 3-point probability approach to risk assessment has been adopted and the methodology applied can be summarised as follows:

- Assess minimum, likely and maximum impact of risk to apply as a % to cost driver, thus deriving potential risk values;
- Apply probabilities to each of those potential risk values, using an expected distribution curve as the likely impact (but also skewing for minimum and maximum scenarios) to derive expected values for each risk;
- Apply a probability to each risk event occurring at all;
- Apply a percentage for the proportion of each risk to be retained by the Trust;
- For each risk retained value derived above, apply a discount factor for the period of risk exposure, to generate an NPV and EAC for each individual risk.

9.8 The economic analysis confirms that over both 66-year and 36-year appraisal periods, the PFI Solution represents better value for money than the PSC.

CONCLUSION TO THE PFI AFFORDABILITY AND VALUE FOR MONEY ANALYSIS

9.9 On the basis of the analysis undertaken, the PFI solution:

- Represents potentially better value for money than the PSC, after allowing for the impact of risk and is affordable within the resources expected to be available to the Trust, for planned activity levels within the Payment by Results framework.

SECTION 10

PROJECT ARRANGEMENTS

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INTRODUCTION

10.1 This section covers the arrangements for the control and management of the following phases of the project:

- PFI Procurement;
- Full Business Case preparation;
- Implementation;
- Post implementation evaluation.

PROJECT MANAGEMENT

10.2 The Trust places particular importance on effective project management arrangements across a wide spectrum of activities, and has significant in-house experience. The definitions and responsibilities contained in the Capital Investment Manual are fully endorsed. The Chairman and Chief Executive fully accept that they are respectively accountable and responsible for the effective delivery of all capital investment projects.

10.3 The Trust Board have taken an active role in the overall Site Development Programme since the inception of The Trust and fully accept their responsibilities as the Investment Decision Maker (as defined by the Capital Investment Manual). They have received regular progress reports on the progress of the project since its inception.

10.4 The overall organisation, including the Project Board is already in existence and reflects the blend of background and skills proposed in the Capital Investment Manual. The project sponsor is the Chief Executive. Membership of the Project Board and overall project management structure is listed in ***Appendix M.***

10.5 In addition to the project Board, a number of multi-professional project teams will oversee day to day progress on the scheme. The project team membership is listed in ***Appendix M.***

10.6 The Trust has also appointed a team of advisors, experienced in the delivery of large-scale acute hospital developments and PFI Projects, as follows

Legal Advisors:	Pinsent Masons
Corporate Financial Advisors:	KPMG
Healthcare Business Advisors: (including Project Management)	Strategic Healthcare Planning

10.7 The Project Director for this project is David Lawson, Director of Estates and Support Services for the Walsall Hospitals NHS Trust who had delegated authority from the Chief Executive. The following Trust resources are also assigned to this Project:

Project Director	Full time
Project Manager	Full time
Project Administrator	Fulltime
Assistant Administration	Full time
Project Assistant	Full time
Project Nurse	Fulltime
Human Resources	Fulltime

Financial support is provided by the Director of Finance as required.

10.8 Regular contact between the PCT and the Trust and the close involvement of the PCT in the project structures will ensure the sharing of the common agenda and that plans are mutually agreed. Cross membership between the various project Boards and Teams ensures a cohesive approach to implementation across the Borough.

RISK MANAGEMENT

10.9 In line with Department of Health guidance, a Risk Management Strategy and Risk Register have been developed for the project, based on an assessment of the risks to the Trust given the status of the Project. The Risk Register is included at ***Appendix L.***

10.10 **Principles**

The overall aim has been to:

- Identify the key risks inherent within the project;
- From the viewpoint of the Trust, determine the impact that the risk could have, and the likelihood that the risk will emerge;
- Allocate responsibility for managing each risk;
- For those risks that are judged to be significant, develop a risk action plan to ensure that the risk is minimised.

Risks have been categorised into the various stages of the project, and a simple 5-point scoring system has been used to assess both the impact that the risk may have and the likelihood that it will emerge (in line with the overall Risk Management approach of the Trust). This has resulted in a 'Red, Amber, Green' (RAG) rating being assigned to each risk. For those risks accorded "Red Light" or "Amber Light" status a specific risk mitigation plan has been identified.

10.11 **Risk Register**

Initial work has identified the specific risks for the project for both the Approvals and Procurement Phase of the Project.

It is proposed to formally review and update the Risk Register prior to the commencement of each Stage of the Procurement Phase of the Project (MOI, PITN, FITN, Preferred Bidder).

In addition the generic risks associated with PFI Projects for subsequent Phases have been assessed. These will be reviewed during the Procurement Phase of the project to develop a detailed Project Specific Risk Register to enable the continued monitoring and management of the risks.

PROJECT APPRAISAL, MONITORING AND EVALUATION

10.12 Project evaluation is part of the total quality process, and the Trust acknowledges its contribution towards a successful outcome in terms of:

- greater assurance of total performance in terms of cost, time and quality;
- clearer definitions of responsibilities;
- reduced exposure to risk;
- improved value for money.

10.13 The Trust is committed to undertaking a formal Post Project Evaluation (PPE) of the project including Benefits Realisation. The Project Director will be responsible for ensuring that a three stage appraisal system is in place covering the following elements:

- the evaluation of the capital development, to ensure desired functionality has been achieved;
- the subsequent evaluation with commissioners of achievement against outputs in clinical terms;
- an evaluation of the project processes to ensure that lessons are learnt for future projects.

Stage 1 Project Appraisal

The purpose of this stage is to ensure that the process for Post Project Evaluation and Benefits Realisation is robust, has the necessary resources and is well focussed.

The Trust has expressed the project objectives clearly against quantifiable measures of change. A Project Evaluation Matrix has been developed as part of the OBC, and will be refined during the FBC stage of the project. This identifies measures, assumptions and risks against the objectives defined for the project and will form the baseline against which the remaining stages can be undertaken.

The Project Board has designated the Project Director as Project Evaluation Manager, who will lead an Evaluation Team consisting of:

- Project Team members;

- Representatives of Commissioners;
- External interests and advisers as relevant.

Detailed records will be maintained on Project Files in formats approved by the Project Board.

Stage 2 Project Monitoring & Evaluation

The purpose of this stage is to assess the effectiveness of the project as it is delivered, so that lessons can be learnt for future projects.

The Project Director will take responsibility for managing project monitoring from FBC approval, through procurement and up to post-completion. Monitoring reports will be prepared quarterly and summarised for all Project Board meetings.

Regular reviews of the original option appraisal will take place at key decision points to confirm or modify future plans.

For monitoring and evaluation purposes, the scope of the project will comprise the following elements:

- Changes in clinical practice;
- New Build Works monitoring;
- Refurbishment Works monitoring;
- Commissioning;
- Service transfers;
- Overall Capital completion.
- Post Completion, the construction record and functional suitability will be reviewed, to address:
- Completion against schedule;
- Achievement of forecast costs;
- Rationale for any variations, and mitigating action taken;
- Recommendations for future projects;
- Functional suitability of the facility.

Stage 3 Review of Objectives

The purpose of this stage is to assess whether the project has achieved the objectives set.

The Trust will review the costs and benefits of the Project on a phased timescale, starting 12 months after handover of the completed development.

Performance will be monitored against baselines as defined in Stage 1, and against approved, modified baselines. The original non-monetary evaluation will be repeated, and results compared with the original exercise conducted in the option appraisal. It is anticipated that benefits should be realised within a year of the handover of the final capital element, but soundings will be taken as to whether it is appropriate to establish a further review after a longer time period has elapsed, in order to obtain a clear picture of

any trends over time.

BENEFITS REALISATION PLANS

10.14 An outline Benefits Realisation Matrix has been developed as part of the OBC to demonstrate that the process outlined above is already well founded and thought through.

Benefits for the project have been considered under the following 9 headings:

- A: Improved Clinical Quality;
- B: Improved Customer Care;
- C: Improved Staff Resourcing;
- D: Improved Patient Flow and Throughput;
- E: Accessibility of Services to Local Population;
- F: Flexibility of Accommodation;
- G: Improved Quality of Accommodation;
- H: Ability to Respond to Commissioner's Current and Future Strategy and Commissioning Intentions;
- I : Financial Benefits.

Attached at ***Appendix N*** is a copy of the draft Benefits Realisation Matrix.

SECTION 11

TIMETABLE AND DELIVERY

INTRODUCTION

11.1 A detailed project plan has been developed for the delivery of both the PFI Project and the completion of the Full Business Case. Details are included within ***Appendix M.*** The overall project timetable will ensure completion of the project by the earliest practical date, and can be summarised as follows:

Table 53. Summary Project Plan

Main Project Stage	Date
Outline Planning Permission granted	July 2001
Draft OBC Submission	March 2004
Final agreement of OBC	August 2004
Placement of OJEU Advert	August 2004
Open day for Bidders	October 2004
Selection of shortlist of Bidders	December 2004
Selection of final 2 Bidders	March 2005
Selection of Preferred Bidder	November 2005
Financial Close	November 2006
Start on site	December 2006

11.2 The precise timescales for completion of the Capital Works is dependant on the design solution of the preferred partner. However it is anticipated that the new facilities will be available for the operation of Clinical Services by 2009.

SECTION 12

CONCLUSION AND RECOMMENDATIONS

CONCLUSION

12.1 This Outline Business Case has set out the way in which the project to re-develop the Walsall Manor Hospital site has been developed. The plans are robust, demonstrate value for money and delivers substantial service benefits to the health community of Walsall, including:

- Provision of a fully integrated Women and Children's Unit meeting the needs of the local community;
- Integration of the Diagnostic & Treatment Centre with a range of existing diagnostic and other clinical support services will allow the concept of fast, convenient services to be realised;
- The overall development will support the Trust in its effort to continue to meet the key NHS targets in relation to waiting times for routine treatment;
- Rationalisation of the site's infrastructure, meeting the aspirations of the Trust and the requirements of local planners and highways department;
- Improvement to the physical stock of the Trust removing a significant backlog maintenance liability and providing modern consumer friendly facilities for the delivery of quality modern healthcare.

RECOMMENDATION

12.2 Following approval by the Trust Board and confirmation of the affordability of the proposed solution by the main commissioners of Trust services, the Strategic Health Authority and Department of Health are recommended to approve the OBC to permit the completion of the development of much needed new infrastructure for the Trust.

Signed:

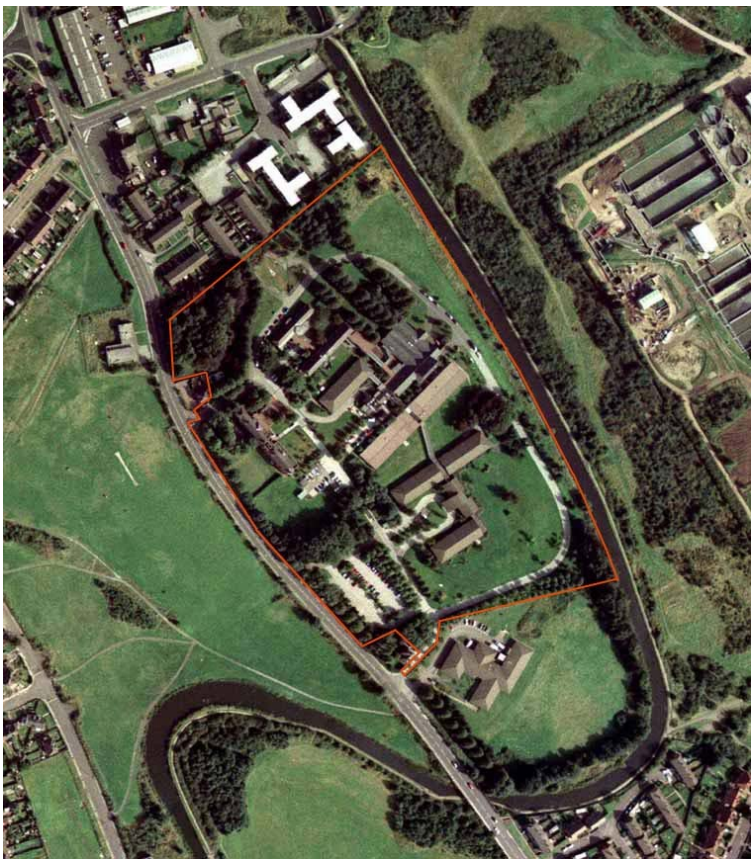
.....	.....
Chief Executive	Finance Director

APPENDIX A

AERIAL PHOTOS OF HOSPITALS SITES

1. AERIAL PHOTO OF THE MANOR HOSPITAL

2. AERIAL PHOTO OF THE GOSCOTE HOSPITAL SITE



APPENDIX B

ACTIVITY 2002/03, 2003/04 & CONTRACTED 2004/05

1. INPATIENTS AND DAYCASES

The contracted activity for the Trust has not yet migrated to the use of First FCEs. Consequently the Non-elective Inpatient and Elective Inpatient figures contained in the tables below are in a currency of FCEs.

	2002/03 Out-turn			2003/04 Out-turn		
	Non Elective Inpatients	Elective Inpatients	Day Cases	Non Elective Inpatients	Elective Inpatients	Day Cases
General Surgery	5,330	1563	3588	5191	1268	2859
Urology	483	616	1757	458	522	1444
Trauma & Orthopaedics	1,799	1009	1338	1739	860	872
Accident & Emergency	1	0	77	0	0	105
Ear, Nose & Throat	339	1165	661	324	783	424
Oral Surgery & Dental	1	2	213	0	1	139
Orthodontics	0	0	38	0	0	43
Anaesthetics	2	5	107	3	1	113
General Medicine	12,104	277	4159	12489	236	4505
Clinical Haematology	74	68	956	108	48	1019
Dermatology	28	8	0	17	8	0
Medical Oncology	1	137	2602	2	128	3300
Neurology	1	1	2	0	0	17
Paediatric Medicine	2,986	38	51	3148	25	65
Special Care Babies	262	-	-	294	-	-
Elderly Care	5,797	76	22	6274	55	33
Obstetrics	5,731	0	0	6316	0	0
Gynaecology	1,402	774	2071	1392	609	1711
GP Maternity	1,019	-	-	240	-	-
GP Medicine	8	65	0	12	40	0
TOTAL	37,368	5804	17642	38,008	4583	16648

INPATIENTS AND DAYCASES (continued)

	2004/05 Contracted		
	Non Elective Inpatients	Elective Inpatients	Day Cases
General Surgery	5320	1483	3218
Urology	470	561	1513
Trauma & Orthopaedics	1782	1329	1284
Accident & Emergency	0	0	105
Ear, Nose & Throat	332	1069	565
Oral Surgery & Dental	0	2	191
Orthodontics	0	0	43
Anaesthetics	3	1	117
General Medicine	12801	235	4491
Clinical Haematology	111	47	1026
Dermatology	17	8	0
Medical Oncology	2	128	3301
Neurology	0	0	17
Paediatric Medicine	3227	26	72
Special Care Babies	301	-	-
Elderly Care	6337	56	33
Obstetrics	6473	0	0
Gynaecology	1427	683	1857
GP Maternity	247	-	-
GP Medicine	12	40	0
TOTAL	38,863	5667	17836

2. OUTPATIENTS

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	2002/2003 Out-turn		2003/2004 Out-turn	
	New	Return	New	Return
General Surgery	7103	17412	6479	16987
Urology	1295	3521	1149	3239
Trauma & Orthopaedics	8009	20077	8435	20779
Accident & Emergency		192	8	303
Ear, Nose & Throat	4742	8926	4790	9376
Oral Surgery & Dental	949	2015	1253	2059
Orthodontics	737	4340	704	4109
Thoracic Surgery	82	193	62	191
Anaesthetics	619	682	634	536
General Medicine	6192	21263	6381	22901
Clinical Haematology	1034	19499	1239	21872
Dermatology	3298	4161	4019	5117
Medical Oncology	794	3087	913	3286
Neurology	800	1278	1391	1341
Paediatric Medicine	7653	5196	7783	5095
Special Care Babies	-	-	-	-
Elderly Care	537	3284	444	3470
Obstetrics	3662	9502	3636	9550
Gynaecology	3927	11139	4288	11501
GP Maternity	-	-	-	-
GP Medicine	0	0	0	0
Clinical Biochemistry	629	307	736	333
ENT/Oncology	30	440	19	371
GUM	4482	5158	6030	5466
TOTAL	56581	141672	60391	147883

OUTPATIENTS (continued)

	2004/2005 Contracted Activity	
	New	Return
General Surgery	6562	17205
Urology	1128	3184
Trauma & Orthopaedics	9072	22326
Accident & Emergency	8	304
Ear, Nose & Throat	5200	10171
Oral Surgery & Dental	1325	2188
Orthodontics	713	4162
Thoracic Surgery	63	195
Anaesthetics	658	557
General Medicine	6339	22752
Clinical Haematology	1248	22032
Dermatology	3845	4897
Medical Oncology	917	3303
Neurology	1461	1412
Paediatric Medicine	7894	5173
Special Care Babies	-	-
Elderly Care	449	3507
Obstetrics	3691	9716
Gynaecology	4331	11615
GP Maternity	-	-
GP Medicine	0	0
Clinical Biochemistry	739	335
ENT/Oncology	19	372
GUM	6120	5549
TOTAL	61783	150955

APPENDIX C

DETAILS OF CURRENT SITE AND ACCOMMODATION

Description of Existing Estate

The Walsall Hospitals NHS Trust was established in April 1991 and provides a range of acute secondary care services for the diagnosis, treatment and care of patients whose healthcare needs cannot be met within the community / primary care. The Trust provides a full range of 'District General Hospital' type services.
Walsall Hospitals NHS Trust estate is split between two main sites:

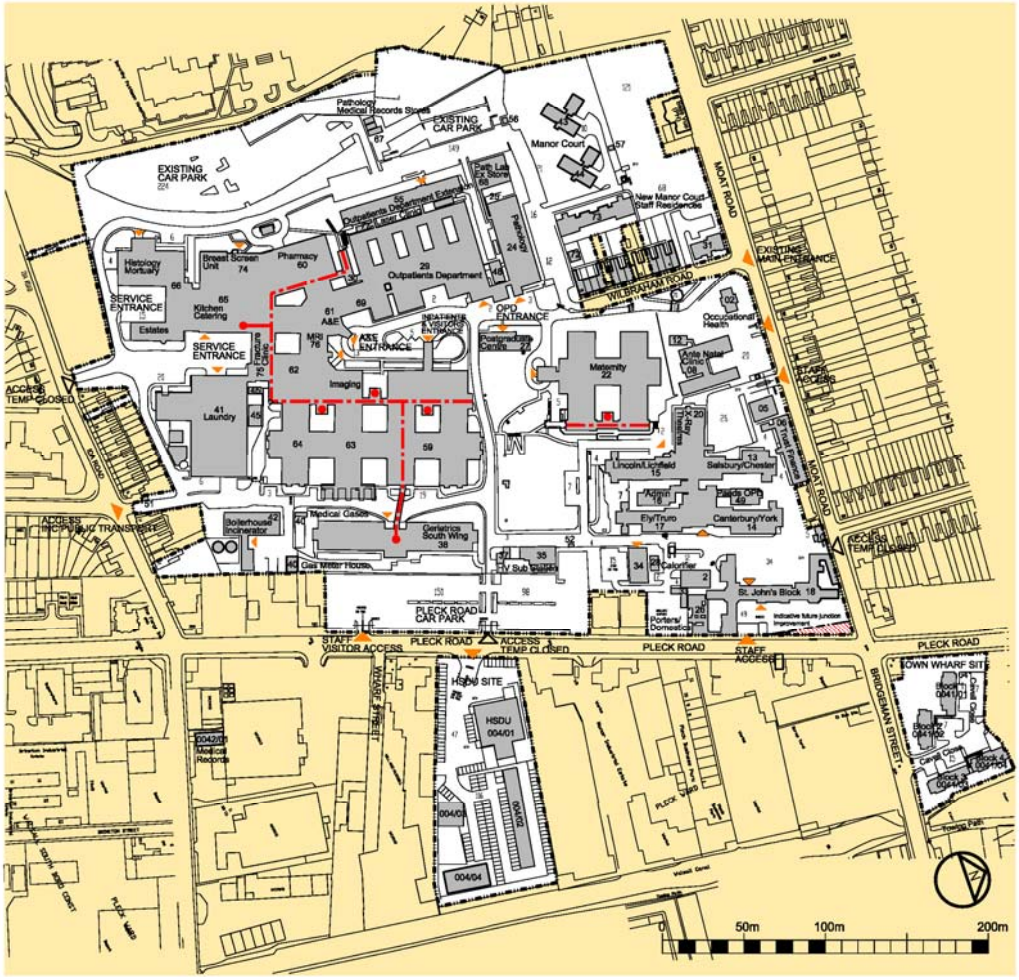
- Walsall Manor Hospital
- Goscote Hospital

The Manor Hospital is the main District General Hospital site, consisting of some 11.45 hectares catering for all general acute specialities. All support services are located on the Manor site with the exception of HSDU which is adjacent.
Goscote Hospital is situated three miles from the main site and consists of 6.96 hectares providing services primarily for the rehabilitation of the elderly along with a central catering facility for the whole of the Trust.

The total site area totals some 18.41 hectares with 15% (7 hectares) of building stock which is made up of a diversity of building styles ranging from east wing which is a Victorian 'H' block construction, south wing which is of 1970's construction, west wing 1980's nucleus build and the relatively new maternity wing completed in 1994. The Goscote site has a mix of buildings ranging from the 1928 nurses home to the 1980 ward block.

The Trust estates strategy has been utilised in the preparation of the outline business case proposals and has been supplemented with additional information prepared to support the development of the outline business case. This information includes a detailed review of functional content for the Manor site and preparation of site infrastructure drawings .
Copies of this information can be made available on request.

Following are copies of site plans for both the Manor Hospital and Goscote Hospital sites.



EXISTING SITE PLAN

EXISTING BUILDING ACCOMMODATION SCHEDULE

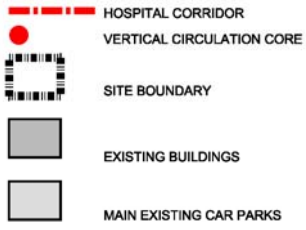
PLECK ROAD SITE	
BLOCK No	BLOCK DEPARTMENT
01	CAR PARKS
02	OCCUPATIONAL HEALTH
05	DIABETIC RESOURCE CENTRE
06	TRUST FINANCE DEPARTMENT
08	ANTE NATAL CLINIC
13	SALISBURY/CHESTER
14	CANTERBURY/YORK
15	LINCOLN/LICHFIELD
16	ADMIN. BLOCK
17	ELY/TRURO
18	ST. JOHN`S BLOCK
20	X-RAY DEPARTMENT/THEATRES
22	MATERNITY
24	PATHOLOGY DEPARTMENT
26	PORTERS/DOMESTICS
27	POSTGRADUATE CENTRE
28	PLANT ROOM CALORIFIER
29	OUTPATIENTS DEPARTMENT
31	WILBRAHAM COURT. MEDICAL RESIDENCES
34	WHITEHOUSE
35	TUG GARAGE
37	SUB STATION AND GENERATOR ROOMS ETC
38	SOUTH WING
40	MEDICAL GAS STORE
41	LAUNDRY
42	BOILERHOUSE STORE AND INCINERATOR
43	MANOR COURT Nos 1-9
44	MANOR COURT Nos 10-18
45	GENERATOR HOUSE
48	PORTACABIN (OPD)
49	CHILDRENS PAEDIATRIC OUTPATIENTS
51	GAS METER HOUSE
55	OPD EXTENSION
56	FLAMMABLE LIQUIDS STORE
57	ELEC SUB STATION
58	DISTRICT GENERAL (west wing)
59	DISTRICT GENERAL (west wing)
60	DISTRICT GENERAL (west wing)
61	DISTRICT GENERAL (west wing)
62	DISTRICT GENERAL (west wing)
63	DISTRICT GENERAL (west wing)
64	DISTRICT GENERAL (west wing)
65	DISTRICT GENERAL (west wing)
66	DISTRICT GENERAL (west wing)
67	PATHOLOGY/MED RECS STORES
68	PATH LAB EXT-STORE
73	NEW MANOR COURT(STAFF RESIDENCES)
74	BREAST SCREEN UNIT
75	FRACTURE CLINIC
76	MRI SCANNER
77	LASER CLINIC
80	2 WILBRAHAM ROAD
81	4 WILBRAHAM ROAD
82	6 WILBRAHAM ROAD
83	8 WILBRAHAM ROAD
84	14 WILBRAHAM ROAD
85	16 WILBRAHAM ROAD
86	18 WILBRAHAM ROAD
87	22 WILBRAHAM ROAD
88	24 WILBRAHAM ROAD
89	26 WILBRAHAM ROAD
90	28 WILBRAHAM ROAD
92	2 IDA ROAD
93	42 IDA ROAD
94	68 IDA ROAD

HSDU SITE	
BLOCK No	BLOCK DEPARTMENT
01	HSDU
03	CRECHE (TEDDY'S NUSERY)

TOWN WHARF SITE	
BLOCK No	BLOCK DEPARTMENT
01	TOWN WHARF BLOCK 1
02	TOWN WHARF BLOCK 2
03	TOWN WHARF BLOCK 3
04	TOWN WHARF BLOCK 4
01	MEDICAL RECORDS

BLOCK NUMBERS RELATE TO EXISTING SITE PLAN

KEY



Walsall Hospitals NHS Trust
Goscote Hospital
Schedule of Existing Buildings
04 CAERNARVON WARD
05 WINDSOR WARD
06 GENERATOR HOUSE
09 WARWICK WARD
10 CONWAY LINK CORRIDOR
11 NURSES HOME
14 BOTTOM LODGE
15 BALMORAL
16 HARLECH
17 LINK BLOCK
18 LUDLOW
19 CATERING/AUTOVALET
20 EDINGBURGH

APPENDIX D

FORECASTS OF ACTIVITY AND BED REQUIREMENTS

1. Introduction

1.1 The requirement to modernise the NHS as identified with in the NHS Plan – Modern and Dependable, has had a significant impact on Health Services in Walsall and has resulted in significantly greater emphasis on the modernisation of models of care and the facilities in which care is delivered. This has been reflected in a range of National Guidance Documents, and service development initiatives which have clearly influenced the review of local provision within the Black Country, and specifically within Walsall.

1.2 This Appendix will identify the key National and Local initiatives which have influenced the planning assumptions adopted by the Trust and Primary Care Trust and consequently formed the basis of the activity projections and resource requirements

2. National Policies and Initiatives

The modernisation focus is described in a range of documents which have shaped the development of the local care delivery strategies and consequently identified the need for local investment. The following documents in particular have proven of significant influence:

- The NHS Plan – Modern and Dependable
- National Service Frameworks
- Reforming Emergency Care
- Intermediate Care
- Patient Access and Choice

2.1 The NHS Plan- Modern and Dependable

2.1.1 The NHS Plan published in 1999 outlined the government's vision for the modernisation of health services in order to ensure their fitness for the future. The fundamental elements of the plan include:

- Improved access to care in terms of local delivery of care close to patient's homes and the reduction in waiting times to access treatment in both primary and secondary care;
- Development of services within Primary Care in order to reduce the need for patients to access hospital based services;
- Establishment of national standards to ensure equality of services delivered to patients;
- Adoption of modern techniques in the design and delivery of healthcare including the improved provision of facilities and equipment;

- Establishment of key delivery targets;
- Breaking down of traditional demarcation lines between and within organisations;
- Emphasis on prevention and self care;
- Development Information Technology.

2.1.2 The establishment of the Modernisation Agency has supported the development of a range of service planning and redesign processes which have provided a serious challenge to the historic patterns of care delivery, with increasing emphasis on the establishment of streamlined processes and procedures and the development of whole systems approaches, which bring together the skills and resources of all elements of the health care community to target the key needs of the individual patient.

2.1.3 The NHS Plan outlined key targets for the improvement in access to care including maximum waiting times the achievement and maintenance of which require the provision of different models of care involving multidisciplinary diagnostic and treatment programmes which span the interface between primary and secondary as well as social care.

2.1.4 A clear objective within the NHS Plan is the establishment of "joined up" planning across the health and social care community, to ensure that planning of healthcare provision is taken as a system wide rather than organisational solution.

2.2 National Service Frameworks

2.2.1 Since the publication of the NHS Plan six National Service Frameworks (NSFs) have been published with further plans in preparation. Those issued to date are:

- Cancer (Not formally called an NSF)
- Coronary Heart Disease
- Mental Health
- Older Peoples' Services
- Diabetes
- Children & Younger People

2.2.2 The key principle behind the NSFs is the establishment of core standards for the delivery of care to key patient groups. The standards are linked to key performance and access targets which are the responsibility of the Health Economy and are central to the commissioning and delivery of healthcare provision. Achievement of many of the standards requires close working between agencies particularly primary and secondary care, and increasingly social care and the independent sector.

2.2.3 In establishing the healthcare provision for the future, the achievement of these care standards is key and heavily influences the pattern of service provision and the models of care which need to be established and implemented. All of the NSFs impact on the delivery

of acute services and challenge the traditional relationships and treatment methodologies.

2.2.4 Local implementation of the various NSFs has sought to bring together the key stakeholders within each of the relevant services to address the programme of action required thus avoiding the "isolationist" approach to services. An important focus of all of the NSFs is the emphasis on the approach to healthcare, and models of care, with the physical facilities required for delivery being derived from the redesigned service model, rather than care models being influenced by physical capacity and resource distribution.

2.3 Reforming Emergency Care

2.3.1 The pressures of service delivery have been a major source of concern in planning health services. The key source of the pressure has been historically from the level and management of emergency in view of the perceived unpredictable nature of the demand.

2.3.2 The proposals for a radically different approach to delivering emergency care arose as a response to inappropriate delays in accessing care and clear evidence of the improved outcomes when prompt appropriate care is available.

2.3.3 A major issue for the Health Service has been the need to ensure that patients receive the right treatment, from the right professional, in the right place. In the case of emergency care delivery a major issue has been the role of the patient in accessing the services.

2.3.4 The national initiative "Reforming Emergency Care" addresses the issues facing emergency services through reform of the totality of the service including:

- The separation of elective and emergency activity in order to ensure that the unpredictability and urgency of emergency activity does not disrupt the delivery of planned care;
- Reduction in delays in discharging patient from hospital;
- Identification of increased capacity for delivery of planned care capacity both within the NHS and within the Independent sector;
- Redesign of diagnostic and other support services to ensure their availability at all times;
- Removal of demarcation of working practices both within the hospital service and between the various health organisations and the establishment of integrated service delivery models;
- Provision of appropriate consistent assessment processes;
- Establishment of consistent emergency care standards;
- Establishment of a co-ordinated approach to emergency care.

2.3.5 The effective management of emergency activity is core to the success of all healthcare organisations and is central to the planning process in terms of establishing radical approaches to the models of care and the implementation of new working patterns and physical solutions. A

joint approach to planning and delivery involving primary and secondary care is vital, but cannot be undertaken in isolation from colleagues in neighbouring health districts and the local authority services.

2.3.6 The establishment of a whole systems approach to emergency care planning will provide a sound basis upon which all models of care can be established as a complimentary process.

2.4 Intermediate Care

2.4.1 The management of patients with ongoing care needs has been an issue for many years and is one which has often resulted in patients, particularly older people, remaining within a hospital environment which is wholly inappropriate and adversely affects the overall outcome of their care, through reduced independence or the creation of increased dependence on continuous care and support.

2.4.2 The need to maximise ongoing independence and ensuring access to appropriate care as close to home as practical, was highlighted within the National Bed Enquiry, and is a one of the core standards within the NSF for Older People. The standard establishes a range of new services to help older people avoid unnecessary hospital admissions; to speed recovery, and rehabilitation and to prevent premature or unnecessary admission to long-term residential care. Promoting independence grants enable councils to support more people to retain their independence longer, and works together with Supporting People, an initiative to help vulnerable people to live independently in the community, by providing a wide range of housing support services.

2.4.3 An essential requirement of intermediate care services is that they should be integrated within a whole system of care including primary and secondary health care, health and social care, the statutory and independent sectors. This creates challenges for the commissioning, management and provision of care entailing, through a range of complex multi-sartorial work (but intermediate care cannot be the responsibility of only one) professional groups or agencies. However the model must ensure that clinical and managerial accountability should be clear at all times, especially when the service user moves form one setting to another.

2.4.4 In establishing their model, intermediate care services must focus on three key points in the overall pathway of care:

- Responding to or averting a crisis including step up care and intensive support within the home linked as appropriate to focused diagnostic and assessment facilities/services and ambulatory care services;
- Active rehabilitation following an acute hospital stay to maximise a person's physical functioning, build confidence and re-equip them with the skills they need to live safely and independently at home;
- The nature and purpose of any long term care planning to avoid unnecessary admission to either residential or nursing home accommodation.

2.4.5 A fundamental benefit of the establishment of good intermediate care models and services is the ability to support vulnerable people and avoid multiple admissions to hospital, whilst also improving recovery rates, which will reduce the impact upon primary care services confused by unplanned discharges.

2.4.6 In line with the principle of "care closer to home", intermediate care models should generally identify the delivery of care in service users' own homes or in community-based settings, but sight should not be lost of the need for discrete facilities on acute hospital sites.

2.5 Service and Planning Networks

2.5.1 A fundamental impact of the national approaches to NSFs, Reforming Emergency Care and Intermediate Care has been the establishment of clinical care and planning networks covering groups of health and social care organisations.

2.5.2 The impact and role of the networks has varied dependent on the needs of the specific service, but has fostered a degree of joint working including joint staff appointments across networking organizations; redistribution of activity to reflect the availability of appropriate skills and support; development of standardised care protocols; and the development of joint learning and planning forums.

2.6 Patient Access and Choice

2.6.1 Improving patient access to diagnosis and treatment was a central theme of the NHS Plan. The provision of choice is central to the government's vision for the NHS. Greater choice for all patients will help to ensure that all patients experience an NHS that is centred on their needs. Some patients have been informed and articulate enough to seek choices not routinely available within the NHS, but the government believes that all patients should have the advantages of choice in their healthcare. Increases in capacity and diversity go hand in hand with patient choice. A wider range of services and providers will allow patients to choose services that best meet their needs.

2.6.2 Alternative providers including NHS Trusts, Diagnostic and Treatment Centres and the independent sector (including overseas) will need to be identified. It will be the responsibility of PCT's to commission the appropriate capacity to treat those patients who choose to move provider. In order to ensure the clinical safety of the patients, all of the receiving and originating providers must agree the clinical pathways needed to allow patient transfer, providing quality assured process for the patients.

2.6.3 By the summer of 2004 all patients waiting 6 months for elective surgery are to be offered choice. This will extend to choice at referral by December 2005, and will require the ability of GPs, when referring a patient for an elective procedure to provide options of up to 4 or 5 alternative hospitals.

2.3 **Local Policy Initiatives**

Having identified the key National Strategic drivers it is essential to recognise the position of Acute Services in terms of the local Walsall

Health and Social Care Economy and the approach to service planning and delivery.

3. Local Initiatives

3.1 Black Country Review

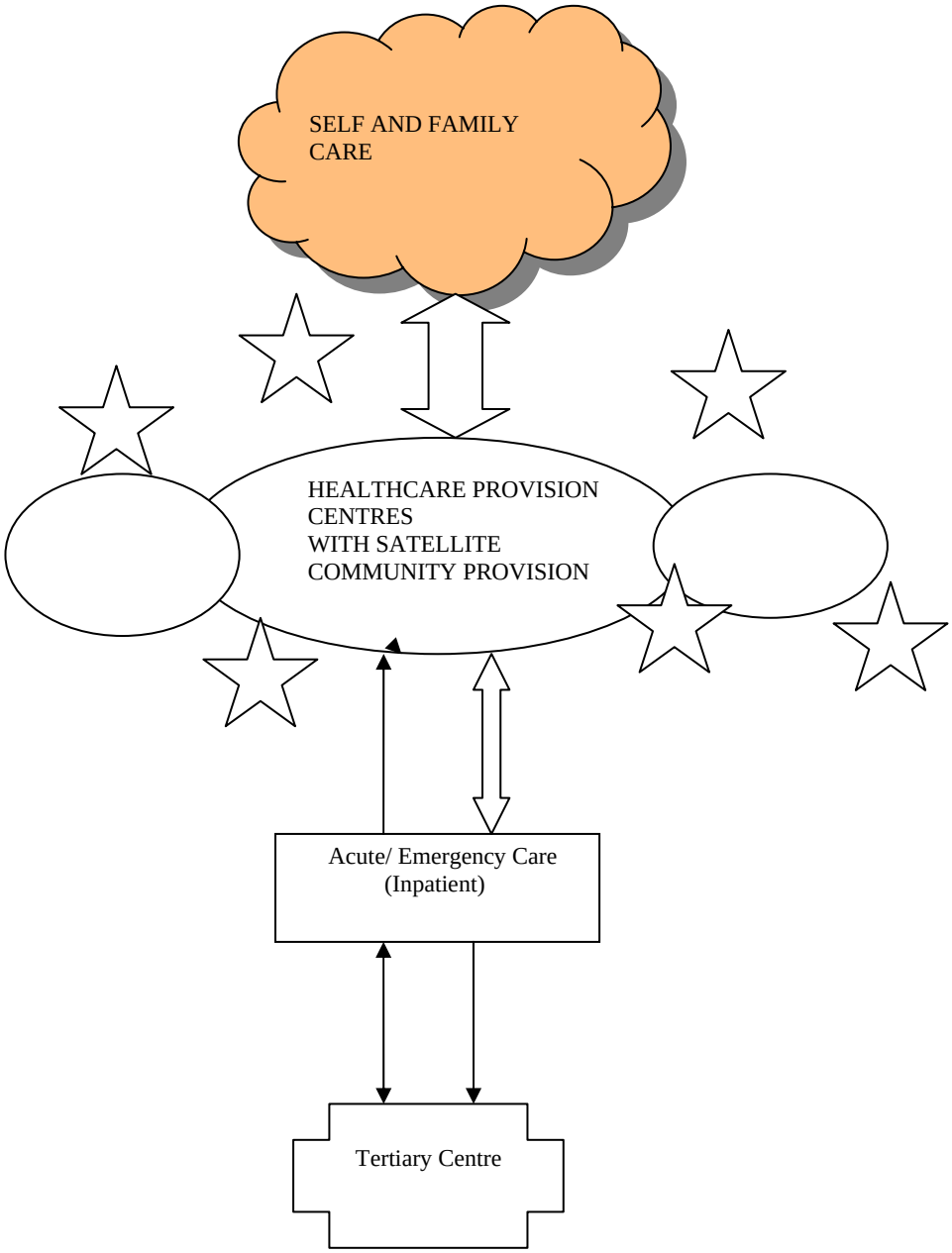
3.1.1 The local planning population for Walsall is in the region of 253,000, and shares many similar traits/features as the neighbouring Black Country boroughs such as Wolverhampton. However, in spite of the similarities which exist between the two populations there has be little joint planning for provision of health or social care. In 2002 the newly formed Birmingham and Black Country Strategic Health Authority sought to address this shortfall and established the Black Country Review. One of the key objectives of the review was to assess the implications of key national initiatives on the hospital and primary care services within the Black Country areas of Walsall, Wolverhampton and Dudley, and identify alterations to the models of care delivery which would ensure that the aspirations of a modernised NHS could be achieved equitably across those patient populations.

3.1.2 A key factor in identifying the potential models centred on the need to ensure an adequate size of planning population. On the basis of advice received it was identified that the minimum population against which services should be planned is in the region of 500,000. Planning has therefore proceeded on a joint basis between the Walsall and Wolverhampton PCTs together with the two acute Trusts.

3.1.3 The proposed models of care identify significant changes in terms of the interface between secondary and primary care, and build upon the aspiration of providing the majority of patient care as close to their home as possible, and the development of service networks to ensure the ongoing viability of clinical services.

3.1.4 The model identified by the review builds upon a “reverse pyramid”, with a focus on self help and self/family care, using community based services when required, emergency centre/acute care available for times of acute/emergency need and tertiary care for highly specialised care only and is portrayed in the following schematic:-

Figure 1. Models of Care Schematic



3.1.5 It has been indicated that for a population of 500,000 up to 4 community care centres each serving a population of 100,000-175,000 would be established providing a wide range of services including outpatient consultation; maternity care; therapy support; diagnostics including Endoscopy, laboratory tests and imaging with technician reporting; day surgery and day care assessment; dental, optical and Audiology services together with nurse led chronic disease management including cardiac disease, respiratory disease, diabetes, anticoagulation and cancer care. Access would also be available to

social care; health promotion and advice services (e.g. housing; benefits).

3.1.6 In support of the community care centres there would be a network of 5-10 primary care centres each supporting a population of 15,000-20,000.

3.1.7 The model assumes services are provided on an integrated, multi-disciplinary team basis with prompt access to care and a single point of access. The emphasis is on the provision of care in the most effective and convenient place for the patient, rather than care being "site based". This may mean care in the patient's home or through the primary care centres with some more specialised services available at the healthcare provision centre.

3.2 Intermediate Care and Chronic Disease Management

3.2.1 The local health and social care economy has established an Older People's Programme Board to facilitate the truly multi agency planning required to support the development of appropriate and sustainable services for this vulnerable client group.

3.2.2 A core objective of the Board has been the development and implementation of a multi-agency/profession Intermediate Care Strategy.

3.2.3 A detailed assessment of the current services and the needs of the population has been undertaken and highlights the need for significant changes in the model of care and range of facilities, particularly in the health sector to embrace the values of Intermediate Care.

3.2.4 Within the current system there is significant use made of Goscote Hospital for the ongoing care and support of older patients, once the initial acute episode is resolved. Points prevalence audits undertaken by Public Health clinicians have indicated that in a great many cases the admission to Goscote could have been avoided (and potentially those to the Manor), and of those admissions which were initially appropriate, the care needs could be addressed differently in order to support an earlier discharge .

3.2.5 The whole systems approach to establishing a more appropriate strategic direction in terms of Intermediate Care has resulted in the development of a joint vision and service strategy and proposed model of care. Key themes of the service strategy for intermediate include:

- A single point of access to Intermediate Care Services;
- The single assessment process;
- The prevention of avoidable admission to hospital or long term care through a 'family' of services;
- Reduction in the number of older people being readmitted to hospital with shorter lengths of stay for those people whose admission is not avoidable;
- Working smarter in partnership with other agencies, including pooled budget arrangements.

3.2.6 In establishing the strategic direction of acute services, the impact of elements of the admission avoidance and bed based provision are of particular relevance

3.2.7 In developing the Hospital Admission Avoidance "family" of schemes will include:

- Accident and Emergency diversion, Clinical Decision Unit and Medical Assessment Unit based at the hospital working through agreed protocols;
- Community physician or GP with special interests;
- Elderly care physicians outreach to nursing and residential homes;
- Rapid response schemes including domiciliary stroke service, hospital at home, rapid access outpatient provision.

3.2.8 A high proportion of older people who will be eligible for intermediate care are acknowledged to have chronic disease. A revised model for the management of chronic disease and particularly the support of those patients experiencing multiple admissions to hospital is anticipated to have a fundamental impact on secondary care services.

3.2.9 Within Walsall, a pilot of the "Evercare" scheme, which provides targeted support to those most vulnerable and at risk of requiring significant primary or secondary care intervention, has been operating for a number of months. Early indications show that the impact on overall patient well-being is significant. The full consequences of the wider adoption of the scheme have yet to be identified, but the need to remodel hospital and primary care services to, reflect the changes in approach to the benefit of all patients is central to the future planning of services.

3.3 Reforming Emergency Care

3.3.1 The local response to the "Reforming Emergency Care" initiative has a very clear emphasis on the development of strong prevention/ monitoring systems within the community and improvement in access through a single point of entry to assessment without the necessity for admission, and Diagnostic facilities. The development of a Clinical Decision Unit and Primary Care Assessment facilities is a central theme of the Health Economy response. There is clearly a requirement for focused assessment capability within the Acute Hospital setting in the form of beds and consultation facilities.

3.3.2 The development of the correct model for the longer term is the subject of further debate but the assumption for the immediate future will provide sufficient space for assessment and diagnosis to take place but with maximum flexibility to support further significant changes in the agreed model of care.

3.4 LIFT

Walsall and Wolverhampton PCTs have jointly established a LIFT procurement to support capital developments for the two primary care populations. The initial developments are specifically linked to Wolverhampton PCT, with the facilities to be provided within Walsall

to be finalised with the interpretation of the primary care models of service delivery.

3.5 IM&T Strategy

3.5.1 The IM&T Strategic Plan is underpinned by six key principles to ensure that the implementation of the strategy addresses National and Strategic Health Authority priorities.

- The IM&T strategy ensures and promotes equitable access to information infrastructure, services and support;
- The IM&T strategy is underpinned by a collaborative borough wide approach between the Department and Health Services resourcing IM&T programs;
- The IM&T strategy identifies an expected level of IM&T service to all health care workers, health facilities, Area and other Health Services and consumers across Walsall, supported by service level agreements determined by the Department and Services;
- A framework that will foster collaboration across Walsall Health to enhance its capacity to achieve goals and priorities supports the IM&T Strategy;
- The IM&T strategy will operate within a governance structure that:
  - *positions the health economy to provide leadership in IM&T;*
  - *clearly identifies accountabilities for implementation of key strategies and priorities; and*
  - *expands clinician participation.*
- The IM&T strategy will provide a transparent framework to reduce fragmentation and implement a consistent development approach to IM&T across Walsall Health.

3.5.2 The overarching goal of the IM&T Strategic Plan is to provide the basis for improved information management and technology systems to support patient and client care and more informed decision-making across all levels of the Walsall health economy.

3.5.3 The seven goals of the IM&T Strategic Plan are to:

- Provide tools to improve the quality of, and responsiveness to, patient / client care and health service management;
- Enable hospitals, community health and GPs to work towards delivering a continuity of health care services;
- Provide consumers with better access to information about their health care, and greater control over security and privacy issues;
- Provide the basis for a boroughwide improvement in, and standardisation of, information management practices;

- Support innovation and improvement in health service delivery and quality patient / care;
- Provide an Information, Technology and Telecommunications infrastructure to link all parts of Walsall Health system to achieve an integrated health care system**;**
- Provide the health workforce with the training and education required to be able to use information technology as a core component of decision making in clinical practice.

3.6 Modernisation Plan and Service Development Reviews

3.6.1 As already identified the Trust is facing a wide range of strategic care planning and development issues. As part of the response to the need to address the service improvement agenda, including the remodelling/redesign of service delivery, the Trust has established a Modernisation Plan. As an early element to this, wide ranging service reviews were undertaken, to establish the current position in comparison to the key standards and targets to be achieved. Each service has subsequently identified the key priorities for development or redesign including the interface with Primary Care and Social Care agencies.

3.6.2 The needs of the individual services identify specific timescales and in some case the need for major capital redevelopment. The requirements of those services whose proposed solution is linked to the proposed site redevelopment are highlighted in the section "The Case for Change". Other key priorities for the Trust which are not required to be addressed as part of the site redevelopment as a consequence of timing or links to other developments are identified in the following list:

3.6.3 ***Interventional Radiology*** - there are two aspects to this service; Cardiac Catheterisation and Vascular Intervention. The Trust has been successful in being awarded a New Opportunities Fund allocation for the provision of a fixed Cardiac Catheterisation Laboratory, the procurement of which indicates an arrival on site in the Autumn of 2004. In recognition of the service delivery interface with Vascular interventions the propose capital solution from the Cardiac facility will be sufficient to accommodate a Vascular Unit as resources allow.

3.6.4 ***Critical Care*** - Implementation of the recommendations of "Comprehensive Critical Care" is a core objective for the Trust, with the proposed establishment of a single, integrated Critical Care facility bringing together ITU and HDU beds; the extension of the outreach service to provide 24 hour support to include follow-up clinics for patient after discharge; the development of consistent protocols with the critical care network to deliver consistency of admission, management and transfer of patients. In view of the importance of the link between Critical Care, Theatres and A&E the proposed solution for the integrated facility is an expansion of the existing ITU area within the West Wing. The service priorities have confirmed that this

development must take place before the end of the 2005/6 financial year.

3.6.5 ***A&E / Clinical Decision Unit / Emergency Admissions*** - the full implications of a Health Economy wide approach to Reforming Emergency Care has yet to be fully measured. However, in the short term A&E Services will continue to restructure to reflect the core priorities of the guidance, including the streaming of patients and the provision of improved assessment facilities with the establishment of the Clinical Decision Unit. The future facility, as a redevelopment of the existing MAU, has yet to be identified, although the projected impacts on overall bed numbers of changes in models of care are being addressed by the Trust.

3.6.6 ***Health Records*** - the Trust has committed to the implementation of the full Electronic Patient Record by 2006. Proposals for the storage and retrieval of records to ensure consistent availability and the establishment of core standards of record keeping are established within an ongoing development to support the agreed EPR timescale.

3.6.7 ***Diabetes*** - in line with the National Service Framework, the implementation of the requirements is proposed to be on the basis of a whole health economy service. This will also ensure the service is structured and resourced to meet the projected increase in demand arising from an increase in the number of diagnosed diabetics as a result of the NSF. Shared care agreements and related clinical pathways will support the establishment of Diabetes as a mainly primary care based service, with the transfer of the management of the majority of Type 2 diabetics away from the hospital, and the reprovision of the Diabetic Resource Centre on a site physically separated from the main acute services at the Manor Hospital.

3.6.8 ***Imaging*** - the implementation of comprehensive, PACS complaint diagnostic service is a fundamental objective providing links to primary care, tertiary care and Consultants' homes.

3.6.7 ***Sexual Health Services*** - the provision of these services is increasingly acknowledged as having greater links with primary care, although links to secondary care facilities are essential. Current proposals by both the Trust and the PCT involve the establishment of facilities on a site physically separated from the main acute services at the Manor Hospital.

3.8 Older People with Mental Illness and Walsall Hospice

3.8.1 The provision of services for Older People with Mental Illness within Walsall has been the subject of a separate review by the PCT in view of the clinical concerns linked to the ongoing provision of services in isolation from other clinical facilities. Having identified the models of care, the preferred option for the relocation of the hospital-based facilities has been identified as the transfer from Bloxwich Hospital to a facility on the Goscote Hospital site.

3.8.2 It is anticipated that the changes of models of care between the Acute and Primary Care teams will release sufficient capacity within Goscote to accommodate the new service.

3.8.3 The relocation of services from Bloxwich is, in itself, critical to the establishment of a Hospice within Walsall. To date there has been no hospice provision within the borough, with the result that those

residents who can access such care must travel to Birmingham, Staffordshire or further afield. Unfortunately the majority of patients who would benefit from hospice care do not currently receive it and in fact remain within the hospital environment resulting, in abnormally high death rates in hospital and extended lengths of stay. The development of a hospice within Walsall has therefore been an acknowledged priority for the Trust, PCT and Strategic Health Authority, and is to be pursued through charitable sources.

3.9 Training and Education

Health Economy Workforce Plan

The Health Economy have developed a three year Workforce Plan that forms an integral part of the Local Delivery Plan and contributes to the Birmingham and Black Country Strategic Health Authority (BBC SHA) Workforce Plan.
This takes into account the capacity planning undertaken within the economy, and recognises the impact of planned service developments and re-design over the next 3 years. In particular it highlights the following implications for staffing:

- Across the health economy there are massive deficits in staffing in key professions:
  - 30% shortfall in GP numbers based on nationally recommended practice sizes;
  - Grossly inadequate Nursing and Medical staffing levels at Walsall Hospitals NHS Trust;
  - Low levels of Practice and Community Nursing services;
  - Recruitment difficulties in General Practice and some key acute medical specialities.

Application of the NHS plan requirements for increasing the workforce in each staff group to the economy's workforce numbers. Productivity increases will be secured within Walsall through the development of Integrated Care Pathways and through Walsall's modernisation programme. A range of Skill mix initiatives including: New nursing posts to support GPs in their growing role in Chronic Disease Management; New roles and posts for Intermediate Care Services; a pilot project to determine whether biomedical scientists could be involved in the dissection of specimens and selection of tissues, a procedure normally performed by Consultant Histopathologists; Consultant Therapist posts in Physiotherapy and Occupational Therapy; The extension of Nurse Prescribing; The development of the Advanced Practitioner grade in Imaging; Development of Support Workers in Dietetics, Imaging, Occupational Therapy & Physiotherapy

IM&T

The Information for Health strategy identifies the need for the WHT to work towards successful implementation of level 111 and above of the

Electronic Patient Record (EPR). In addition, the Walsall natural community is a pilot site for the ERDIP project. Implementation of these will lead WHT into developing more clinically based systems resulting in the need for training to be focussed on not only the administrative processes and staff, but also clinicians. Similarly the NHS requirement for all staff to have the opportunity to undertake the European Computer Driving Licence (ECDL) and Walsall's status as a test centre leads to the need for a comprehensive training programme.

Facilities

An assessment of education and training facilities within the Walsall Health Community was carried out and the available facilities were found to be totally inadequate:
Postgraduate Medical Centre: built in 1960's of a lightweight wooden construction the building is now in a poor condition, with inadequate space even to provide postgraduate medical services let alone the increasing demand from other professional groups such as; nurses, PCS staff and the increasing number of undergraduate doctors receiving their training at the hospital. The accreditation report (May 2003) recommended the following action prior to a revisit in 2004:

- Position the library as part of an organisational structure able to address the complexity and inequity issues
- Achieve an integrated healthcare library service across the two Trusts
- Replacement accommodation to cover the closure of the university site library

Suitable training facilities within the health community are virtually non-existent with the exception of a library facility at the Dorothy Pattison Hospital, the Training Room at Bloxwich Hospital and IT training at Jubilee House. Any large events organised by the health community must be based at the Walsall Football Club Bescot Stadium, as this is the only venue within the locality to cater for the numbers of personnel involved.
Currently approximately 30% of the training and continuing professional development (CPD) for General Practice staff, including Practice Nurses is provided in commercial venues across Walsall, such as community Centres and hotels due to the lack of facilities within WtPCT.

Professional Bodies Recommendations

An educational and training contract for the provision of postgraduate medical and dental education based at Walsall Hospitals NHS Trust exists between the Deanery and WHT, which requires that WHT provide facilities for Postgraduate and Continuing Medical and Dental Education. These facilities may be used on a multi-disciplinary basis. Where these facilities are shared with other non-medical disciplines, agreement as to the manner of sharing must be obtained from the relevant Education Committees. The provision of undergraduate training for medical students is also the subject of a Generic Framework Agreement, which contains clear stipulations as to the facilities that Trusts are required to provide for the undergraduates including:

- Maintain the agreed space requirements for academic accommodation and re-provide this accommodation should this be necessary as a result of changes in service provision
- Provide lecture theatre accommodation, seminar rooms and whenever required undergraduate tutorial rooms adjacent to clinical areas
- Provide a clinical skills centre able to accommodate up to 12 medical undergraduates at any one time and including at least 1 bed, 3 trolleys and 12 computer stations

The last two Educational monitoring visits by the Royal Colleges and West Midlands Deanery to WHT highlighted the poor provision of facilities at WHT by commenting:

- The development of the new postgraduate centre is desperately needed.
- The urgent need for the development of a skills room
- The poor provision of computer and internet access
- The poor provision of library services

Walsall Health Improvement and Modernisation Plan 2002/3

Walsall Health Improvement and Modernisation Plan 2002/3 re-emphasises support for the SOC and the development of facilities at the Trust. Further more it confirms that:

'the proposals for a much needed new education facility are being drawn up by a multi-agency steering group with the intention to build the centre on the boundary of the Manor Hospital and Dorothy Pattison Hospital.'

4. CLINICAL GROWTH AND PLANNING ASSUMPTIONS

4.1 In developing the planning assumptions the Trust worked closely with the Walsall Primary Care Trust and identified key service and practice changes which it was accepted would occur during the planning period.

4.2 These planning assumptions can be categorised as:

- Growth
- Improved efficiency including reduced length of stay and admission avoidance
- Improved performance including improvements in Day Case rates
- Transfers of care into and out of the Trust including changes in models of care/practice initiative such as Intermediate Care

4.3 The detailed planning assumptions are outlined in Annexe 1 to this Appendix.

4.4 The impact of the planning assumptions on the 2002/2003 baseline is summarised in Annexe 2 to this Appendix which provides an Audit Trail across the different planning categories and provides the overall impact in terms of cases and occupied bed days plus outpatient

attendances. Annexe 2 also provides a summary of the impact of achievement of Stage 2

4.5 Annexe 3 provides a detailed analysis for each specialty. It should be noted that applying the methodology adopted at the increased level of detail used within the individual specialty planning assumptions (e.g. turnover intervals), the bed numbers derived from Annexe 3 differ slightly from those in Annexe 2.

4.6 Within the Black Country review the potential for further, more radical changes in care models have been identified which could result in further reductions in length of stay and increased numbers of admissions avoided. The Trust is fully committed to working with the local health and social care community to deliver as many of these best practice targets as possible. It is not considered practical to assume that all of the targets can be delivered in full, but an assessment of the likelihood of introducing the changes successfully over a period of time has been undertaken and is summarised in the table below.

4.7 An assessment of the potential impact of the growth assumptions, without the introduction of the new models of care, has indicated that rather than an overall requirement of 748 beds there would be a requirement for 863 inpatient and 69 day case beds, a total of 932. A clear benefit of the new service provision is therefore the avoidance of investment in further facilities to accommodate this projected increase.

Assessment of Future Need for Training and Education

To deliver the service changes and developments over the next 5 years, the Health Economy must provide effective learning environments with manageable numbers for a range of workplace learners such as students, overseas nurses, returnees, and newly qualified and regional trainees. To help determine the requirements WHT's 'A Strategy for the 21st Century' includes a clear break down of the additional workforce requirements. (Appendix 2) Similarly WtPCT has identified the high priority posts required as a result of the capacity planning exercise and these are also listed in appendix 2. These requirements however will not be easily achieved as can be seen from the table below:

Table A: Staffing increases

	Walsall Proporation of the national target	Strategy requirement	Comment
Consultants	50	32	The lower strategy target reflects the difficulty in funding and recruiting to all these posts and

			hence prioritises the Trusts requirement
GPs	-	33	Only one third of this target represents development of services, as there is the need to recruit to the existing 7 vacancies and replace 14 GPs who are due to retire
Nurses	175	249.5	The higher strategy target for WHT reflects the existing shortfall of nursing posts to meet the current workload levels, as identified in the recent CHI visit
Doctors		90.5	In order to meet compliance requirements for junior doctor hours in 2004 WHT will need to recruit up to 52 Trust Grade doctors.
Therapists/scientists	150	67	WHT is experiencing significant recruitment and retention issues with this staff group and to help redress the problem have established NVQ programmes within Physiotherapy and OT, and is developing an advanced practitioner programme to aid retention in Imaging
Health care assistants (HCA)	135	84	WHT's current ward skill mix ratio is 50/50 qualified/unqualified. The recommendation (Wanless Report) is

			for a 60/40 split so the Trust is emphasising recruitment of qualified nursing staff not HCAs, in order to ensure progression to a skill mix of 60/40.

This level of increase in pure numbers, plus the enhanced training requirements to deliver improvements in services, productivity and staff working lives all add to the demand for training resource and thereby facilities.

Recognising this and in accordance with the SOC plans, the Trust, in collaboration with the Strategic Health Authority, WtPCT, General Practitioners Surgeries, West Midlands Workforce Confederation and the West Midlands Deanery established a project team to determine the education and training facilities that will meet the needs of all health professionals, working within the Walsall Health Economy for the present and foreseeable future. This process involved identifying all the education and training courses that are to be provided and an assessment of the amount and type of facility required. The outcome of this assessment is detailed in Annexe 4.

Possible Impact on Bed Requirements of Stage 2 of the Black Country Review							
		Probability Assessment			Impact on Beds		
		Minimum	Most Likely	Maximum	Minimum	Most Likely	Maximum
	Beds	%	%	%	Beds	Beds	Beds
Baseline Projection from Stage 1 of the Black Country Review	748				748	748	748
Possible Changes arising from							
Surgery Best Practice List	70	10%	30%	60%	-7	-21	-42
Medicine Best Practice	25	25%	50%	75%	-6	-13	-19
Chronic Disease Management assumed included in above best practice							
Final Bed Requirements	653				735	714	687
Beds on Manor Hospital proposed within the PFI Project	673				673	673	673
Residual Beds at Goscote / ("Spare" Beds at Manor Hospital)	(20)				62	41	14

ANNEXE 1 – SUMMARY OF PLANNING ASSUMPTIONS

Summary of Planning Assumptions
Activity

Baseline Activity

ActivityModelScenario	MainPCT	MainSite	Specialty	MainCategory

OP Equilibrium Adjustment

ActivityModelScenario	Input Stage	MainPCT	MainSite	Specialty
	> OP Equilibrium Adjustment			

IP Equilibrium Adjustment

ActivityModelScenario	Input Stage	MainPCT	MainSite	Specialty
	> IP Equilibrium Adjustment			

Scale to Plan

ActivityModelScenario	Input Stage	MainPCT	MainSite	Specialty
	> Scale to Plan			

Projected Baseline

ActivityModelScenario	Input Stage	MainPCT	MainSite	Specialty
	> Projected Baseline			

Demographic Change

ActivityModelScenario	Input Stage	MainPCT	MainSite	Specialty
	> Demographic Change			

OP Waiting List Cohorts

ActivityModelScenario	Input Stage	MainPCT	MainSite	Specialty
	> OP Waiting List Cohorts			
	> OP Waiting List Cohorts			
	> OP Waiting List Cohorts			
	> OP Waiting List Cohorts			

IP Waiting List Cohorts

ActivityModelScenario	Input Stage	MainPCT	MainSite	Specialty
	> IP Waiting List Cohorts			
	> IP Waiting List Cohorts			
	> IP Waiting List Cohorts			
	> IP Waiting List Cohorts			

Activity

Day Case Rate (Set Target Rate)

ActivityModelScenario	Input Stage	Old Category	New Category	MainPCT
Scenario 2	> Day Case Rate (Set Target Rate)	Elective IP	Day Cases	

Day Case Rate

ActivityModelScenario	Input Stage	Old Category	New Category	MainPCT
Scenario 1	> Day Case Rate	Elective IP	Day Cases	
Scenario 1	> Day Case Rate	Elective IP	Day Cases	
Scenario 1	> Day Case Rate	Elective IP	Day Cases	
Scenario 1	> Day Case Rate	Elective IP	Day Cases	

Outpatient Procedures

ActivityModelScenario	Input Stage	Old Category	New Category	MainPCT
	> Outpatient Procedures	Day Cases	Review OP - Proc	
	> Outpatient Procedures	Day Cases	Review OP - Proc	
	> Outpatient Procedures	Day Cases	Review OP - Proc	
	> Outpatient Procedures	Day Cases	Review OP - Proc	
	> Outpatient Procedures	Day Cases	Review OP - Proc	
	> Outpatient Procedures	Day Cases	Review OP - Proc	
	> Outpatient Procedures	Day Cases	Review OP - Proc	

Shift to Primary Care

ActivityModelScenario	Input Stage	Old Category	New Category	MainPCT
	> Shift to Primary Care	Review Appt - GP Referred	Primary Care	
	> Shift to Primary Care	Review Appt - GP Referred	Primary Care	
	> Shift to Primary Care	Review Appt - GP Referred	Primary Care	
	> Shift to Primary Care	Review Appt - GP Referred	Primary Care	
	> Shift to Primary Care	Review Appt - GP Referred	Primary Care	
	> Shift to Primary Care	Review Appt - GP Referred	Primary Care	
	> Shift to Primary Care	Review Appt - GP Referred	Primary Care	
	> Shift to Primary Care	Review Appt - GP Referred	Primary Care	
	> Shift to Primary Care	Review Appt - GP Referred	Primary Care	

Early Discharge to Primary Care No Assumptions for this Stage

ActivityModelScenario	Input Stage	Old Category	New Category	MainPCT

Activity

Intermediate Care

ActivityModelScenario	Input Stage	Old Category	New Category	MainPCT
	> Intermediate Care	Non Electives	Intermediate Care	
	> Intermediate Care	Non Electives	Intermediate Care	

Critical Care

ActivityModelScenario	Input Stage	Old Category	New Category	MainPCT
	> Critical Care	Elective IP	Critical Care	

Assessment Unit

ActivityModelScenario	Input Stage	Old Category	New Category	MainPCT
	> Assessment Unit	Non Electives	Assessment Unit	
	> Assessment Unit	Non Electives	Assessment Unit	
	> Assessment Unit	Non Electives	Assessment Unit	
	> Assessment Unit	Non Electives	Assessment Unit	
	> Assessment Unit	Non Electives	Assessment Unit	
	> Assessment Unit	Non Electives	Assessment Unit	
	> Assessment Unit	Non Electives	Assessment Unit	

Assessment / Admission

ActivityModelScenario	Input Stage	Old Category	New Category	MainPCT
	> Assessment / Admission	Non Electives	Assessment Unit	
	> Assessment / Admission	Non Electives	Assessment Unit	
	> Assessment / Admission	Non Electives	Assessment Unit	
	> Assessment / Admission	Non Electives	Assessment Unit	
	> Assessment / Admission	Non Electives	Assessment Unit	
	> Assessment / Admission	Non Electives	Assessment Unit	

Ambulatory Care No Assumptions for this Stage

ActivityModelScenario	Input Stage	Old Category	New Category	MainPCT

Service Shifts

ActivityModelScenario	Input Stage	Old Site	New Site	MainPCT
	> Service Shifts	WALSALL HOSPITALS NHS TRUST	Other	WALSALL TEACHING PCT
	> Service Shifts	WALSALL HOSPITALS NHS TRUST	Other	WALSALL TEACHING PCT
	> Service Shifts	WALSALL HOSPITALS NHS TRUST	Other	WALSALL TEACHING PCT
	> Service Shifts	WALSALL HOSPITALS NHS TRUST	Other	WALSALL TEACHING PCT

Change LOS

ActivityModelScenario	Input Stage	MainPCT	MainSite	Specialty
	> Change LOS			
	> Change LOS			
	> Change LOS			
	> Change LOS			
	> Change LOS			
	> Change LOS			
	> Change LOS			
	> Change LOS			
	> Change LOS			All Medical
	> Change LOS			All Medical
	> Change LOS			
	> Change LOS			
	> Change LOS			
	> Change LOS			

New Services

Input Stage	ActivityModelScenario	Recurring	MainPCT	MainSite
> New Services		Recurring	Walsall Teaching PCT	WALSALL HOSPITALS NHS TRUST
> New Services		Recurring	Walsall Teaching PCT	WALSALL HOSPITALS NHS TRUST
> New Services		Recurring	Walsall Teaching PCT	WALSALL HOSPITALS NHS TRUST
> New Services		Recurring	Walsall Teaching PCT	WALSALL HOSPITALS NHS TRUST
> New Services		Recurring	Walsall Teaching PCT	WALSALL HOSPITALS NHS TRUST
> New Services		Recurring	Walsall Teaching PCT	WALSALL HOSPITALS NHS TRUST

Non Elective Demand

ActivityModelScenario	Input Stage	MainPCT	MainSite	Specialty
Scenario 1	> Non Elective Demand			All Medical
Scenario 1	> Non Elective Demand			All Medical
Scenario 1	> Non Elective Demand			110 - Trauma & Orthopaedics
Scenario 1	> Non Elective Demand			101 - Urology
Scenario 1	> Non Elective Demand			100 - General Surgery
Scenario 2	> Non Elective Demand			
Scenario 1	> Non Elective Demand			

Elective Demand

ActivityModelScenario	Input Stage	MainPCT	MainSite	Specialty
Scenario 1	> Elective Demand			110 - Trauma & Orthopaedics
Scenario 1	> Elective Demand			101 - Urology
Scenario 1	> Elective Demand			320 - Cardiology
Scenario 1	> Elective Demand			
Scenario 2	> Elective Demand			
Scenario 2	> Elective Demand			
Scenario 2	> Elective Demand			
Scenario 2	> Elective Demand			

Shift to Primary Care Review OP

ActivityModelScenario	Input Stage	Old Category	New Category	MainPCT
	>Shift to Primary Care Review OP	Review Appt - Not GP Referred	Primary Care	
	>Shift to Primary Care Review OP	Review Appt - Not GP Referred	Primary Care	
	>Shift to Primary Care Review OP	Review Appt - Not GP Referred	Primary Care	
	>Shift to Primary Care Review OP	Review Appt - Not GP Referred	Primary Care	
	>Shift to Primary Care Review OP	Review Appt - Not GP Referred	Primary Care	
	>Shift to Primary Care Review OP	Review Appt - Not GP Referred	Primary Care	
	>Shift to Primary Care Review OP	Review Appt - Not GP Referred	Primary Care	
	>Shift to Primary Care Review OP	Review Appt - Not GP Referred	Primary Care	
	>Shift to Primary Care Review OP	Review Appt - Not GP Referred	Primary Care	

Critical Care NEL

ActivityModelScenario	Input Stage	Old Category	New Category	MainPCT
	> Critical Care NEL	Non Electives	Critical Care	
	> Critical Care NEL	Non Electives	Critical Care	

HRG	LOS	AgeBand

MainCategory	HRG	LOS

MainCategory	HRG	LOS

MainCategory	Year	ActivitySummaryScenario

MainCategory	HRG	LOS

MainCategory	HRG	AgeBand

MainCategory	HRG	LOS

MainCategory	HRG	LOS

MainSite	Specialty	HRG
	All Specialties	

MainSite	Specialty	HRG
		G17 - Diagnostic Pancreatic or Biliary Procedures w/o cc

MainSite	Specialty	HRG
		M01 - Lower Genital Tract Minor Procedures
		M02 - Lower Genital Tract Intermediate Procedures
		M05 - Upper Genital Tract Minor Procedures
		L21 - Bladder Minor Endoscopic Procedure w/o cc
		J37 - Minor Skin Procedures - Category 1 w/o cc
		J35 - Minor Skin Procedures - Category 2 w/o cc
		J33 - Minor Skin Procedures - Category 3

MainSite	Specialty	HRG
	420 - Paediatrics	
	320 - Cardiology	
	400 - Neurology	
	303 - Haematology (clinical)	
	330 - Dermatology	
	300 - General Medicine	
	120 - ENT	
	360 - Genito-Urinary Medicine	
	130 - Ophthalmology	

MainSite	Specialty	HRG

Activity

MainSite	Specialty	HRG

MainSite	Specialty	HRG

MainSite	Specialty	HRG
	502 - Obs & Gyn (Gynaecology)	M09 - Threatened or Spontaneous Abortion
	502 - Obs & Gyn (Gynaecology)	N12 - Other Maternity Events
	Maternity	
	110 - Trauma & Orthopaedics	
	100 - General Surgery	Main Theatre Minutes

MainSite	Specialty	HRG
	Maternity	
	110 - Trauma & Orthopaedics	
	100 - General Surgery	Main Theatre Minutes

MainSite	Specialty	HRG

Specialty	MainCategory	HRG
	Day Cases	F35 - Large Intestine - Endoscopic or Intermediate Procedures
	Non Electives	F18 - Stomach or Duodenum Disorders <70 w/o cc
	Non Electives	A33 - Head Injury without Significant Brain Injury w/o cc
430 - Geriatric Medicine	Non Electives	S

MainCategory	HRG	LOS
Non Electives	F47 - General Abdominal Disorders <70 w/o cc	2 days
Non Electives	F47 - General Abdominal Disorders <70 w/o cc	1 day
Non Electives	E36 - Chest Pain <70 w/o cc	1 Day
Non Electives	E36 - Chest Pain <70 w/o cc	2 Days
Non Electives	F46 - General Abdominal Disorders >69 or w cc	2 days
Non Electives	F46 - General Abdominal Disorders >69 or w cc	1 day
Non Electives	E21 - Deep Vein Thrombosis <70 w/o cc	> 2 Days
Elective IP	H	> 10 Days
		> 10 Days
		> 5 Days
Elective IP		>5 days
Elective IP		3 days
Elective IP		4 days
Elective IP		5 days

MainCategory	Specialty	HRG
Day Cases	370 - Medical Oncology	S98 - Chemotherapy with a Haematology, Infectious Disease, Poisoning, or Non-specific Primary Diagnosis
Day Cases	130 - Ophthalmology	B02 - Phakoemulsification Cataract Extraction with Lens Implant
Day Cases	300 - General Medicine	E14 - Cardiac Catheterisation without Complications
Elective IP	110 - Trauma & Orthopaedics	H02 - Primary Hip Replacement
Day Cases	303 - Haematology (clinical)	S98 - Chemotherapy with a Haematology, Infectious Disease, Poisoning, or Non-specific Primary Diagnosis
Electives	101 - Urology	L28 - Prostate Transurethral Resection Procedure <70 w/o cc

MainCategory	HRG	LOS
Non Electives	E	
Non Electives		
Non Electives		
Non Electives		
Non Electives		
Non Electives		
Non Electives		

MainCategory	HRG	LOS
Referrals, OP and Electives		
Referrals, OP and Electives		
Referrals, OP and Electives		
Referrals, OP and Electives		
Referrals		
Outpatients		
Elective IP		
Day Cases		

MainSite	Specialty	HRG
	420 - Paediatrics	
	320 - Cardiology	
	400 - Neurology	
	303 - Haematology (clinical)	
	330 - Dermatology	
	300 - General Medicine	
	120 - ENT	
	360 - Genito-Urinary Medicine	
	130 - Ophthalmology	

MainSite	Specialty	HRG
	420 - Paediatrics	N

Summary of Planning Assumptions
Activity

Year	Baseline Period
Modelling Period	2002/2003

AgeBand	Year	1st Census	2nd Census
	Modelling Period	Mar-01	Mar-02

AgeBand	Year	1st Census	2nd Census
	2002/2003 - 2005/2006	Apr-01	Mar-02

Target PCT	Target Site	Target Specialty	Target Category	Target Year

AgeBand	Year	Over Years

PopulationScenario	Year
ONS	

AgeBand	Year	Cohort	Census
	2002/2003	> 18 Weeks	Mar-02
	2003/2004	15-18 Weeks	Mar-02
	2004/2005	13-14 Weeks	Mar-02
	2005/2006	12 Weeks	Mar-02

AgeBand	Year	Cohort	Census
	2002/2003	> 10 Months	Mar-02
	2003/2004	8-10 Months	Mar-02
	2004/2005	6-7 Months	Mar-02
	2005/2006	5 Months	Mar-02

AgeBand	LOS	Year	Target %	Days in New Location
			75	0.5

AgeBand	LOS	Year	% Moving	Days in New Location
	< 2 Days	Modelling Period	90	0.25
	2 Days	Modelling Period	90	0.5
	3 Days	Modelling Period	90	1
		Modelling Period	50	1

AgeBand	LOS	Year	% Moving	Days in New Location
		Modelling Period	90	
		Modelling Period	90	
		Modelling Period	90	
		Modelling Period	80	
		Modelling Period	90	
		Modelling Period	90	
		Modelling Period	60	

AgeBand	LOS	Year	% Moving	Days in New Location
			25	
			70	
			50	
			35	
			50	
			15	
			30	
			30	
			70	

AgeBand	LOS	Year	% Moving	Days in Old Location	Days in New Location

AgeBand	LOS	Year	% Moving	Days in Old Location	Days in New Location
	> 59 Days	2010/2011	75	28	
	> 21 Days	2010/2011	10	28	

AgeBand	LOS	Year	% Moving	Days in Old Location	Days in New Location
	> 4 Days		50		2

AgeBand	LOS	Year	% Moving	Days in New Location
	< 2 Days	Modelling period	90	0.25
	< 2 Days	Modelling period	90	0.25
		Modelling period	0	0
	< 3 Days	Modelling period	10	1
	< 2 Days	Modelling period	0	0
	2 days	Modelling period	50	1
	< 2 Days	Modelling period	90	0.5

AgeBand	LOS	Year	% Moving	Days in Old Location	Days in New Location
			0		0
			0		0
	> 2 Days		90		0.25
	2 days		40		0.25
	<2 days		90		0.25
	<2 days		10		0.25

AgeBand	LOS	Year	% Moving	Days in New Location

AgeBand	LOS	Year	% Moving	Days in New Location
			50	
	< 3 Days		20	
	< 2 Days		20	
			10	

Activity

AgeBand	Year	Change in LOS
	2010/2011	-1
	2010/2011	-0.5
	2010/2011	-0.5
	2010/2011	-1
	2010/2011	-1
	2010/2011	-0.5
	2010/2011	-1
	2010/2011	-4
	2010/2011	-2
	2010/2011	-1
	2010/2011	-1.5
	2010/2011	-0.5
	2010/2011	-0.5
	2010/2011	-1

Year	Cases	Like HRG	Like Specialty
2010/2011	400	All HRGs	370 - Medical Oncology
2010/2011	1200	All HRGs	100 - General Surgery
2010/2011	1000	All HRGs	300 - General Medicine
2010/2011	300	H02 - Primary Hip Replacement	110 - Trauma & Orthopaedics
2010/2011	100	All HRGs	303 - Haematology (clinical)
2010/2011	200	All HRGs	101-Urology

AgeBand	Year	% Growth
	Modelling Period	2
	Modelling Period	1
	Modelling Period	0.5
	Modelling Period	2
	Modelling Period	2
	Modelling Period	1.7
	Modelling Period	0.5

Activity

AgeBand	Year	% Growth
	Modelling Period	3
	Modelling Period	2
	Modelling Period	3
	Modelling Period	1
	Modelling Period	3
	Modelling Period	3.6
	Modelling Period	-1.4
	Modelling Period	9.2

AgeBand	LOS	Year	% Moving	Days in New Location
			25	
			70	
			50	
			35	
			50	
			15	
			30	
			30	
			70	

AgeBand	LOS	Year	% Moving	Days in Old Location	Days in New Location
	> 4 Days		10		2
			100		35

ANNEXE 2 – AUDIT TRAIL OF IMPACT OF THE PLANNING ASSUMPTIONS

Admitted Care Activity

	2002/03 Baseline							Efficiency - Reduce LOS							Efficie		
	Day Case	Elective IP		Non Electives		Total IP		Day Case	Elective IP		Non-Elective IP		Total IP		Day Case	Elective IP	
National Specialty	FFCE	FFCE	OBD	FFCE	OBD	FFCE	OBD	FFCE	FFCE	OBD	FFCE	OBD	FFCE	OBD	FFCE	FFCE	OBD
100 - General Surge	3588	1527	8793	4760	31008	6287	39801			-746		-227		-972	840	-840	-1412
101 - Urology	1757	600	2450	55	364	655	2814			-295		-2		-296	304	-304	-566
110 - Trauma & Ort	1338	1001	5756	1604	23993	2605	29749			-1124		-2		-1126	441	-441	-604
120 - ENT	661	1165	1544	314	844	1479	2388			-30		0		-30	1022	-1022	-1200
130- Ophthalmolog	0	0	0	0	0	0	0			0		0		0	0	0	0
143 - Orthodontics	38	0	0	0	0	0	0			0		0		0	0	0	0
190 - Anaesthetics	107	4	8	1	14	5	22			0		0		0	4	-4	-7
303 - Haematology	956	62	575	34	348	96	923			-59		0		-59	19	-19	-23
400 - Neurology	6	1	2	1	3	2	5			0		0		0	1	-1	-2
822 - Chemical Patl	0	0	0	0	0	0	0			0		0		0	0	0	0
990 - Joint Consulta	0	0	0	0	0	0	0			0		0		0	0	0	0
420 - Paediatrics	53	38	148	3213	9029	3251	9177			-15		-1		-16	23	-23	-38
180 - Accident and	77	0	0	1	0	1	0			0		0		0	0	0	0
		0												0			
All Medical	4174	321	3869	11352	125854	11673	129723			-357		-8950		-9307	103	-103	-143
370 - Medical Onco	2602	136	183	1	1	137	184			-7		0		-7	117	-117	-120
Maternity	0	0	0	6604	10754	6604	10754			0		-1		-1	0	0	0
502 - Obs & Gyn (C	2071	774	3228	1361	2312	2135	5540			-441		-38		-478	317	-317	-636
170 - Cardiothoraci	0	0	0	0	0	0	0			0		0		0	0	0	0
140 - Oral surgery	213	2	2	0	0	2	2			0		0		0	2	-2	-2
330 - Dermatology	0	7	45	19	164	26	209			-6		0		-6	3	-3	-6
														0			
Total	17641	5638	26603	29320	204688	34958	231291			-3077		-9220		-12297	3195	-3195	-4758
	9750							634									

Bed Profile	1.81							
Acute							717	
Critical Care							30	
Assessment								
Day	39							
Total	39						747	84.8%

Other Beds								
Wolverhampton								
Walsall							inc above	131 at Goscote

Total Health Community						

ncy - Day Surgery				Transfer of Care in/Adjustments							Transfer of care out / Assumed in OBCs							
Non-Elective IP		Total IP		Day Case	Elective IP		Non-Elective IP		Total IP		Day Case	Elective IP		Non-Elective IP		Total IP		Day Case
FFCE	OBD	FFCE	OBD	FFCE	FFCE	OBD	FFCE	OBD	FFCE	OBD	FFCE	FFCE	OBD	FFCE	OBD	FFCE	OBD	FFCE
		-840	-1412	0	0	0	0	0	0	0	-980	0	-513	0	-4115			286
		-304	-566	162	38	205	0	233	38	205	-737	0	-238	0	0			231
		-441	-604	0	300	2149	0	0	300	2149	-57	0	-913	0	-5492			459
		-1022	-1200	0	0	0	0	0	0	0	-16	0	-17	0	-59			138
		0	0	1200	0	0	0	0	0	0	0	0	0	0	0			12
		0	0	0	0	0	0	0	0	0	0	0	0	0	0			3
		-4	-7	0	0	0	0	0	0	0	0	0	0	0	0			9
		-19	-23	100	0	0	0	35	0	0	0	0	-41	0	0			82
		-1	-2	0	0	0	0	0	0	0	0	0	0	0	0			1
		0	0	0	0	0	0	0	0	0	0	0	0	0	0			0
		0	0	0	0	0	0	0	0	0	0	0	0	0	0			0
		-23	-38	0	0	0	0	1840	0	1840	0	0	-10	0	0			6
		0	0	0	0	0	0	0	0	0	-2	0	0	0	0			6
		0	0						0	0								
		-103	-143	1000	0	0	0	0	0	0	-429	0	-211	-19	-22288			329
		-117	-120	400	0	0	0	4	0	0	-3	0	-4	0	0			229
		0	0	0	0	0	0	0	0	0	0	0	0	0	0			0
		-317	-636	0	0	0	0	5	0	0	-422	0	-312	0	0			163
		0	0	0	0	0	0	0	0	0	0	0	0	0	0			0
		-2	-2	0	0	0	0	0	0	0	-8	0	0	0	0			17
		-3	-6	0	0	0	0	4	0	0	0	0	-4	0	0			0
0	0	-3195	-4758	2862	338	2354	0	2120	338	4194	-2653	0	-2264	-19	-31954	0	0	1971

Growth						Bed Occupancy @ 84%							2010/11 Position					
Elective IP		Non-Elective IP		Total IP		Day Case	Elective IP		Non-Elective IP		Total IP		Day Case	Elective IP		Non-Elective IP		Tota
FFCE	OBD	FFCE	OBD	FFCE	OBD	FFCE	FFCE	OBD	FFCE	OBD	FFCE	OBD	FFCE	FFCE	OBD	FFCE	OBD	FFCE
57	604	817	5318	874	5922								3733	744	6726	5577	31984	6321
52	322	9	62	61	384								1718	385	1878	64	658	449
158	1405	65	977	224	2382								2182	1018	6669	1669	19476	2688
12	28	13	34	25	63								1805	155	325	327	820	482
0	0	0	0	0	0								1212	0	0	0	0	0
0	0	0	0	0	0								41	0	0	0	0	0
0	0	0	1	0	1								120	0	1	1	15	1
4	45	1	14	5	59								1157	47	498	35	397	82
0	0	0	0	0	0								7	0	0	1	3	1
0	0	0	0	0	0								0	0	0	0	0	0
0	0	0	0	0	0								0	0	0	0	0	0
1	9	131	368	132	377								83	16	95	3344	11235	3359
0	0	0	0	0	0								81	0	0	1	0	1
18	305	1266	12716	1284	13021								5177	236	3465	12599	107332	12835
2	5	0	0	2	5								3345	21	58	1	5	22
0	0	269	438	269	438								0	0	0	6873	11190	6873
38	210	55	94	93	304								2129	495	2050	1416	2374	1911
0	0	0	0	0	0								0	0	0	0	0	0
0	0	0	0	0	0								224	0	0	0	0	0
0	3	1	7	1	10								3	5	31	20	174	24
341	2937	2628	20028	2969	22966								23016	3122	21796	31929	185663	35051

73					
73					

73					

		Teamwork Stage 2							
al IP		Day Case	Elective IP		Non-Elective IP		Total IP		
OBD		FFCE	FFCE	OBD	FFCE	OBD	FFCE	OBD	
38710				-2435			0	-2435	
2536			-2	-165			-2	-165	
26145				-1162	-31	-3948	-31	-5110	
1145							0	0	
0							0	0	
0							0	0	
15							0	0	
895							0	0	
3							0	0	
0							0	0	
0							0	0	
11330							0	0	
0							0	0	
0							0	0	
110796					-1499	-16702	-1499	-16702	
63							0	0	
11190						-166	0	-166	
4423							0	0	
0							0	0	
0							0	0	
206							0	0	
							0	0	
207458		0	-2	-3762	-1530	-20816	-1532	-24578	

599								-80
33								0
43								0
675								-80

inc above 75 at Goscote								

675								-80

Outpatient Activity

	2002/03 Baseline			Transfer of Care In / Adjustment			Transf
National Specialty	First Attendances	Subsequent Attendances	Total Attendances	First Attendances	Subsequent Attendances	Total Attendances	First Attendances
100 - General Surge	6664	17522	24186	0	708	708	0
101 - Urology	1389	4019	5408	0	736	736	0
110 - Trauma & Or	7701	19584	27285	0	57	57	0
120 - ENT	4899	8630	13529	0	16	16	0
130- Ophthalmolog	0	0	0	0	0	0	0
143 - Orthodontics	543	4347	4890	0	0	0	0
190 - Anaesthetics	565	707	1272	0	0	0	0
303 - Haematology	843	18017	18860	0	0	0	0
400 - Neurology	1005	1049	2054	0	0	0	0
822 - Chemical Pat	424	303	727	0	0	0	0
990 - Joint Consulta	26	433	459	0	0	0	0
420 - Paediatrics	7726	5440	13166	0	0	0	0
180 - Accident and	8	202	210	0	2	2	0
			0				
All Medical	7417	23881	31298	0	0	0	0
370 - Medical Onc	712	2901	3613	0	3	3	0
Maternity	3769	10328	14097	0	0	0	0
502 - Obs & Gyn (C	3926	10608	14534	0	422	422	0
170 - Cardiothoraci	68	181	249	0	0	0	0
140 - Oral surgery	1149	2140	3289	0	8	8	0
330 - Dermatology	2877	3957	6834	0	0	0	0
Total	51711	134249	185960	0	1952	1952	0

er of Care out (assumed in OBCs)		Growth			2010/11 Position		
Subsequent Attendances	Total Attendances	First Attendances	Subsequent Attendances	Total Attendances	First Attendances	Subsequent Attendances	Total Attendances
0	0	552	1511	2063	7216	19741	26957
0	0	238	816	1055	1627	5571	7199
0	0	2054	5240	7294	9755	24880	34636
-2667	-2667	406	580	986	5305	6559	11864
0	0	0	0	0	0	0	0
0	0	45	360	405	588	4707	5295
0	0	47	59	105	612	766	1377
-6759	-6759	70	1423	1493	913	12681	13594
-540	-540	83	59	142	1088	568	1656
0	0	35	25	60	459	328	787
0	0	2	36	38	28	469	497
-1426	-1426	640	404	1044	8366	4418	12784
0	0	1	17	18	9	221	229
	0			0			
-3236	-3236	615	1837	2452	8032	22482	30514
0	0	59	241	300	771	3145	3916
0	0	312	856	1168	4081	11184	15265
0	0	325	914	1239	4251	11944	16195
0	0	6	15	21	74	196	270
0	0	95	178	273	1244	2326	3570
-2007	-2007	238	193	431	3115	2142	5258
-16635	-16635	5824	14762	20586	57535	134328	191864

ANNEXE 3 – IMPACT OF PLANNING ASSUMPTIONS BY SPECIALITY

Annexe 3

All Specialties

	Cases Outpatients	Cases First OP Appts	Cases Review OP	Cases Admitted I	Cases Non Electives	Cases Elective IP	Cases Day Cases	Bed Days Admitted I	Bed Days Non Electives	Bed Days Elective IP	Bed Days Critical Care	Bed Days Assessment Unit
All Stages	191655	57535	134120	49949	23550	3122	23277	192610	170814	21796	7002	7847
Baseline Activity	185961	51711	134250	52599	29320	5638	17641	231291	204688	26603	0	0
Day Case Rate	0	0	0	0	0	-3195	3195	-4758	0	-4758	0	0
Outpatient Procedures	1952	0	1952	-1952	0	0	-1952	0	0	0	0	0
Shift to Primary Care	-6730	0	-6730	0	0	0	0	0	0	0	0	0
Early Discharge to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Intermediate Care	0	0	0	0	0	0	0	-32567	-32567	0	0	0
Shift to Primary Care Review OP	-9904	0	-9904	0	0	0	0	0	0	0	0	0
Service Shifts	0	0	0	-721	-19	0	-701	-208	-208	0	0	0
Change LOS	0	0	0	0	0	0	0	-12297	-9220	-3077	0	0
New Services	0	0	0	3200	0	338	2862	2354	0	2354	0	0
Non Elective Demand	0	0	0	2628	2628	0	0	20028	20028	0	0	0
Elective Demand	20377	5824	14553	2573	0	341	2232	2937	0	2937	0	0
Critical Care NEL	0	0	0		0	0	0	-2302	-2302	0	4738	0
Critical Care	0	0	0		0	0	0	-2264	0	-2264	2264	0
Assessment Unit	0	0	0	-8378	-8378	0	0	-6569	-6569	0	0	4775
Assessment / Admission	0	0	0	0	0	0	0	-3037	-3037	0	0	3072
					Bed days			192610	170814	21796	7002	7847
					Turnover interval			0	0	0		
					occupancy			100%	87%	87%	90%	
								192610	170814	21796		
					days available per day							
					Patients per day							
					Beds needed			749	539.0	68.3	64.9	33.2	43.8
									Non elective	ELIP	DC	Critical	Assessment
								749	539	68	65	33	44

Annexe 3

ENT

	Cases Outpatient	Cases First OP A	Cases Review OF	Cases Admitted I	Cases Non Electives	Cases Elective IP	Cases Day Cases	Bed Days Admitted I	Bed Days Non Electives	Bed Days Elective IP	Bed Days Critical Care	Bed Days Assessment Unit
All Stages	11862	5305	6557	2127	166	155	1806	981	656	325	25	138
Baseline Activity	13529	4899	8630	2140	314	1165	661	2388	844	1544	0	0
Day Case Rate	0	0	0	0	0	-1022	1022	-1200	0	-1200	0	0
Outpatient Procedures	16	0	16	-16	0	0	-16	0	0	0	0	0
Shift to Primary Care	-1643	0	-1643	0	0	0	0	0	0	0	0	0
Early Discharge to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0
Shift to Primary Care Review OP	-1024	0	-1024	0	0	0	0	0	0	0	0	0
Service Shifts	0	0	0	0	0	0	0	0	0	0	0	0
Change LOS	0	0	0	0	0	0	0	-30	0	-30	0	0
New Services	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Demand	0	0	0	13	13	0	0	34	34	0	0	0
Elective Demand	985	406	579	151	0	12	139	28	0	28	0	0
Critical Care NEL	0	0	0		0	0	0	-8	-8	0	8	0
Critical Care	0	0	0		0	0	0	-17	0	-17	17	0
Assessment Unit	0	0	0	-161	-161	0	0	-186	-186	0	0	110
Assessment / Admission	0	0	0	0	0	0	0	-27	-27	0	0	28
					Bed days			981	656	325	25	138
					Turnover interval	1		321	166	155		
					occupancy			75%	80%	68%	90% 75%	50%
								1303	822	480		
					days available per day				365	365	250 365	365
					Patients per day						1	
					Beds needed			12	2	1	8 0	1
									Non elective	ELIP	DC Critical	Assessment

Annexe 3

Anaesthetics

	Cases Outpatient	Cases First OP A	Cases Review OF	Cases Admitted I	Cases Non Electives	Cases Elective IP	Cases Day Cases	Bed Days Admitted I	Bed Days Non Electives	Bed Days Elective IP	Bed Days Critical Care	Bed Days Assessment Unit
All Stages	1377	612	766	121	1	0	120	15	14	1	0	0
Baseline Activity	1272	565	707	112	1	4	107	22	14	8	0	0
Day Case Rate	0	0	0	0	0	-4	4	-7	0	-7	0	0
Outpatient Procedures	0	0	0	0	0	0	0	0	0	0	0	0
Shift to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Early Discharge to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0
Shift to Primary Care Review OP	0	0	0	0	0	0	0	0	0	0	0	0
Service Shifts	0	0	0	0	0	0	0	0	0	0	0	0
Change LOS	0	0	0	0	0	0	0	0	0	0	0	0
New Services	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Demand	0	0	0	0	0	0	0	1	1	0	0	0
Elective Demand	105	47	59	9	0	0	9	0	0	0	0	0
Critical Care NEL	0	0	0		0	0	0	0	0	0	0	0
Critical Care	0	0	0		0	0	0	0	0	0	0	0
Assessment Unit	0	0	0	0	0	0	0	0	0	0	0	0
Assessment / Admission	0	0	0	0	0	0	0	0	0	0	0	0
					Bed days			15	14	1	0.2081414	0.234159085
					Turnover interval	1		1	1	0		
					occupancy			91%	93%	64%	90%	75%	50%
								16	15	1		
					days available per day				365	365	250	365	365
					Patients per day						1.5		
					Beds needed			0	0	0	0.35	0	0
									Non elective	ELIP	DC	Critical	Assessment

Clinical Haematology

	Cases Outpatient	Cases First OP A	Cases Review OF	Cases Admitted I	Cases Non Electives	Cases Elective IP	Cases Day Cases	Bed Days Admitted I	Bed Days Non Electives	Bed Days Elective IP		Bed Days Critical Care	Bed Days Assessment Unit
All Stages	13594	913	12681	1230	26	47	1157	839	341	498		45	11
					10.2				9.955		-3%		
Baseline Activity	18860	843	18017	1052	34	62	956	923	348	575		0	0
Day Case Rate	0	0	0	0	0	-19	19	-23	0	-23		0	0
Outpatient Procedures	0	0	0	0	0	0	0	0	0	0		0	0
Shift to Primary Care	-842	0	-842	0	0	0	0	0	0	0		0	0
Early Discharge to Primary Care	0	0	0	0	0	0	0	0	0	0		0	0
Intermediate Care	0	0	0	0	0	0	0	-4	-4	0		0	0
Shift to Primary Care Review OP	-5917	0	-5917	0	0	0	0	0	0	0		0	0
Service Shifts	0	0	0	0	0	0	0	0	0	0		0	0
Change LOS	0	0	0	0	0	0	0	-59	0	-59		0	0
New Services	0	0	0	100	0	0	100	0	0	0		0	0
Non Elective Demand	0	0	0	1	1	0	0	14	14	0		0	0
Elective Demand	1493	70	1423	85	0	4	82	45	0	45		0	0
Critical Care NEL	0	0	0		0	0	0	-4	-4	0		4	0
Critical Care	0	0	0		0	0	0	-41	0	-41		41	0
Assessment Unit	0	0	0	-9	-9	0	0	-8	-8	0		0	5
Assessment / Admission	0	0	0	0	0	0	0	-6	-6	0		0	6
					Bed days			839	341	498		44.686959	10.87018507
					Turnover interval	1		73	26	47			
					occupancy			92%	93%	91%	90%	75%	50%
								912	368	545			
					days available per day				365	365	250	365	365
					Patients per day						1		
					Beds needed			8	1	1	5.14	0	0
									Non elective	ELIP	DC	Critical	Assessment

Medical Oncology

	Cases Outpatient	Cases First OP A	Cases Review OF	Cases Admitted I	Cases Non Electives	Cases Elective IP	Cases Day Cases	Bed Days Admitted I	Bed Days Non Electives	Bed Days Elective IP	Bed Days Critical Care	Bed Days Assessment Unit
All Stages	3916	771	3145	3366	0	21	3345	58	0	58	4	0
Baseline Activity	3613	712	2901	2739	1	136	2602	184	1	183	0	0
Day Case Rate	0	0	0	0	0	-117	117	-120	0	-120	0	0
Outpatient Procedures	3	0	3	-3	0	0	-3	0	0	0	0	0
Shift to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Early Discharge to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0
Shift to Primary Care Review OP	0	0	0	0	0	0	0	0	0	0	0	0
Service Shifts	0	0	0	0	0	0	0	0	0	0	0	0
Change LOS	0	0	0	0	0	0	0	-7	0	-7	0	0
New Services	0	0	0	400	0	0	400	0	0	0	0	0
Non Elective Demand	0	0	0	0	0	0	0	0	0	0	0	0
Elective Demand	299	59	240	231	0	2	229	5	0	5	0	0
Critical Care NEL	0	0	0		0	0	0	0	0	0	0	0
Critical Care	0	0	0		0	0	0	-4	0	-4	4	0
Assessment Unit	0	0	0	-1	-1	0	0	-1	-1	0	0	0
Assessment / Admission	0	0	0	0	0	0	0	0	0	0	0	0
					Bed days			58	0	58	4.3314268	0.470919937
					Turnover interval	1		21	0	21		
					occupancy			74%	49%	74%	90%	75%	50%
								78	0	78		
					days available per day				365	365	300	365	365
					Patients per day						1		
					Beds needed			13	0	0	12.39	0	0
									Non elective	ELIP	DC	Critical	Assessment

Oral Surgery

	Cases Outpatient	Cases First OP A	Cases Review OF	Cases Admitted I	Cases Non Electives	Cases Elective IP	Cases Day Cases	Bed Days Admitted I	Bed Days Non Electives	Bed Days Elective IP	Bed Days Critical Care	Bed Days Assessment Unit
All Stages	3570	1244	2325	225	0	0	224	0	0	0	0	0
Baseline Activity	3289	1149	2140	215	0	2	213	2	0	2	0	0
Day Case Rate	0	0	0	0	0	-2	2	-2	0	-2	0	0
Outpatient Procedures	8	0	8	-8	0	0	-8	0	0	0	0	0
Shift to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Early Discharge to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0
Shift to Primary Care Review OP	0	0	0	0	0	0	0	0	0	0	0	0
Service Shifts	0	0	0	0	0	0	0	0	0	0	0	0
Change LOS	0	0	0	0	0	0	0	0	0	0	0	0
New Services	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Demand	0	0	0	0	0	0	0	0	0	0	0	0
Elective Demand	273	95	177	18	0	0	18	0	0	0	0	0
Critical Care NEL	0	0	0		0	0	0	0	0	0	0	0
Critical Care	0	0	0		0	0	0	0	0	0	0	0
Assessment Unit	0	0	0	0	0	0	0	0	0	0	0	0
Assessment / Admission	0	0	0	0	0	0	0	0	0	0	0	0
					Bed days			0	0	0	0	0
					Turnover interval	1		0	0	0		
					occupancy			50%	#DIV/0!	50%	90%	75%	50%
								0	0	0		
					days available per day				365	365	250	365	365
					Patients per day						1.5		
					Beds needed			1	0	0	1	0	0
									Non elective	ELIP	DC	Critical	Assessment

	Cases Outpatient	Cases First OP A	Cases Review OP	Cases Admitted F	Cases Non Electives	Cases Elective IP	Cases Day Cases	Bed Days Admitted F	Bed Days Non Electives	Bed Days Elective IP	Bed Days Critical Care	Bed Days Assessment Unit
All Stages	0	0	0	1212	0	0	1212	0	0	0	0	0
Baseline Activity	0	0	0	0	0	0	0	0	0	0	0	0
Day Case Rate	0	0	0	0	0	0	0	0	0	0	0	0
Outpatient Procedures	0	0	0	0	0	0	0	0	0	0	0	0
Shift to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Early Discharge to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0
Shift to Primary Care Review OP	0	0	0	0	0	0	0	0	0	0	0	0
Service Shifts	0	0	0	0	0	0	0	0	0	0	0	0
Change LOS	0	0	0	0	0	0	0	0	0	0	0	0
New Services	0	0	0	1200	0	0	1200	0	0	0	0	0
Non Elective Demand	0	0	0	0	0	0	0	0	0	0	0	0
Elective Demand	0	0	0	12	0	0	12	0	0	0	0	0
Critical Care NEL	0	0	0		0	0	0	0	0	0	0	0
Critical Care	0	0	0		0	0	0	0	0	0	0	0
Assessment Unit	0	0	0	0	0	0	0	0	0	0	0	0
Assessment / Admission	0	0	0	0	0	0	0	0	0	0	0	0
					Bed days			0	0	0	0	0
					Turnover interval	1		0	0	0		
					occupancy			#DIV/0!	#DIV/0!	#DIV/0!	50%	75%	50%
								0	0	0		
					days available per day				365	365	200	365	365
					Patients per day						4		
					Beds needed			3	0	0	3	0	0
									Non elective	ELIP	DC	Critical	Assessment

Annexe 3

Gynaecology

	Cases Outpatient	Cases First OP A	Cases Review OF	Cases Admitted I	Cases Non Electives	Cases Elective IP	Cases Day Cases	Bed Days Admitted I	Bed Days Non Electives	Bed Days Elective IP	Bed Days Critical Care	Bed Days Assessment Unit
All Stages	16164	4251	11913	3135	480	495	2160	3602	1553	2050	330	491
Baseline Activity	14534	3926	10608	4206	1361	774	2071	5540	2312	3228	0	0
Day Case Rate	0	0	0	0	0	-317	317	-636	0	-636	0	0
Outpatient Procedures	422	0	422	-422	0	0	-422	0	0	0	0	0
Shift to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Early Discharge to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Intermediate Care	0	0	0	0	0	0	0	-81	-81	0	0	0
Shift to Primary Care Review OP	0	0	0	0	0	0	0	0	0	0	0	0
Service Shifts	0	0	0	0	0	0	0	0	0	0	0	0
Change LOS	0	0	0	0	0	0	0	-478	-38	-441	0	0
New Services	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Demand	0	0	0	55	55	0	0	94	94	0	0	0
Elective Demand	1208	325	883	232	0	38	194	210	0	210	0	0
Critical Care NEL	0	0	0		0	0	0	-18	-18	0	18	0
Critical Care	0	0	0		0	0	0	-312	0	-312	312	0
Assessment Unit	0	0	0	-936	-936	0	0	-643	-643	0	0	416
Assessment / Admission	0	0	0	0	0	0	0	-73	-73	0	0	74
					Bed days			3602	1553	2050	330	491
					Turnover interval	0.9		878	432	446		
					occupancy			80%	78%	82%	90% 75%	50%
								4480	1985	2495		
					days available per day				365	365	250 365	365
					Patients per day						1.5	
					Beds needed			23	5	7	6 1	3
									Non elective	ELIP	DC Critical	Assessment

Annexe 3

Paediatrics

	Cases Outpatient	Cases First OP A	Cases Review OF	Cases Admitted I	Cases Non Electives	Cases Elective IP	Cases Day Cases	Bed Days Admitted I	Bed Days Non Electives	Bed Days Elective IP	Bed Days Critical Care	Bed Days Assessment Unit
All Stages	12784	8366	4418	1458	1360	16	83	7234	7139	95	2736	1360
Baseline Activity	13166	7726	5440	3304	3213	38	53	9177	9029	148	0	0
Day Case Rate	0	0	0	0	0	-23	23	-38	0	-38	0	0
Outpatient Procedures	0	0	0	0	0	0	0	0	0	0	0	0
Shift to Primary Care	-569	0	-569	0	0	0	0	0	0	0	0	0
Early Discharge to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Intermediate Care	0	0	0	0	0	0	0	-257	-257	0	0	0
Shift to Primary Care Review OP	-857	0	-857	0	0	0	0	0	0	0	0	0
Service Shifts	0	0	0	0	0	0	0	0	0	0	0	0
Change LOS	0	0	0	0	0	0	0	-16	-1	-15	0	0
New Services	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Demand	0	0	0	131	131	0	0	368	368	0	0	0
Elective Demand	1044	640	404	8	0	1	6	9	0	9	0	0
Critical Care NEL	0	0	0		0	0	0	-291	-291	0	2726	0
Critical Care	0	0	0		0	0	0	-10	0	-10	10	0
Assessment Unit	0	0	0	-1984	-1984	0	0	-1476	-1476	0	0	1126
Assessment / Admission	0	0	0	0	0	0	0	-232	-232	0	0	234
					Bed days			7234	7139	95	2736	1360
					Turnover interval	2		2751	2719	32		
					occupancy			72%	72%	75%	90%	60%	50%
								9985	9858	126		
					days available per day				365	365	250	365	365
					Patients per day						1		
					Beds needed			48	27	0	0.37	12	7
									Non elective	ELIP	DC	Critical	Assessment

Annexe 3

All Medical

	Cases Outpatient	Cases First OP A	Cases Review OF	Cases Admitted I	Cases Non Electives	Cases Elective IP	Cases Day Cases	Bed Days Admitted I	Bed Days Non Electives	Bed Days Elective IP	Bed Days Critical Care	Bed Days Assessment Unit
All Stages	14747	3551	11196	14516	9103	236	5177	105361	101865	3496	1534	3933
Baseline Activity	15173	3279	11894	15847	11352	321	4174	129723	125854	3869	0	0
Day Case Rate	0	0	0	0	0	-103	103	-143	0	-143	0	0
Outpatient Procedures	0	0	0	0	0	0	0	0	0	0	0	0
Shift to Primary Care	-837	0	-837	0	0	0	0	0	0	0	0	0
Early Discharge to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Intermediate Care	0	0	0	0	0	0	0	-21543	-21543	0	0	0
Shift to Primary Care Review OP	-777	0	-777	0	0	0	0	0	0	0	0	0
Service Shifts	0	0	0	-448	-19	0	-429	-208	-208	0	0	0
Change LOS	0	0	0	0	0	0	0	-9275	-8950	-325	0	0
New Services	0	0	0	1000	0	0	1000	0	0	0	0	0
Non Elective Demand	0	0	0	1266	1266	0	0	12716	12716	0	0	0
Elective Demand	1188	272	916	347	0	18	329	306	0	306	0	0
Critical Care NEL	0	0	0		0	0	0	-1324	-1324	0	1324	0
Critical Care	0	0	0		0	0	0	-211	0	-211	211	0
Assessment Unit	0	0	0	-3496	-3496	0	0	-2766	-2766	0	0	2015
Assessment / Admission	0	0	0	0	0	0	0	-1915	-1915	0	0	1918

Bed days		105361	101865	3496		1534	3933
Turnover interval	1	13075	12744	330			
occupancy		89%	89%	91%	90%	75%	50%
		118436	114609	3827			
days available per day			365	365	250	365	365
Patients per day					4		
Beds needed		358	308	10	6	12	22
			Non elective	ELIP	DC	Critical	Assessment

Trauma and Orthopaedics

	Cases Outpatient	Cases First OP A	Cases Review OF	Cases Admitted I	Cases Non Electives	Cases Elective IP	Cases Day Cases	Bed Days Admitted I	Bed Days Non Electives	Bed Days Elective IP		Bed Days Critical Care	Bed Days Assessment Unit
All Stages	34622	9755	24867	4817	1604	1018	2195	25012	18343	6669		1067	66
					15	5.8			11	6.5	13%		
Baseline Activity	27285	7701	19584	3943	1604	1001	1338	29749	23993	5756		0	0
Day Case Rate	0	0	0	0	0	-441	441	-604	0	-604		0	0
Outpatient Procedures	57	0	57	-57	0	0	-57	0	0	0		0	0
Shift to Primary Care	0	0	0	0	0	0	0	0	0	0		0	0
Early Discharge to Primary Care	0	0	0	0	0	0	0	0	0	0		0	0
Intermediate Care	0	0	0	0	0	0	0	-6396	-6396	0		0	0
Shift to Primary Care Review OP	0	0	0	0	0	0	0	0	0	0		0	0
Service Shifts	0	0	0	0	0	0	0	0	0	0		0	0
Change LOS	0	0	0	0	0	0	0	-1126	-2	-1124		0	0
New Services	0	0	0	300	0	300	0	2149	0	2149		0	0
Non Elective Demand	0	0	0	65	65	0	0	977	977	0		0	0
Elective Demand	7281	2054	5226	631	0	158	473	1405	0	1405		0	0
Critical Care NEL	0	0	0		0	0	0	-154	-154	0		154	0
Critical Care	0	0	0		0	0	0	-913	0	-913		913	0
Assessment Unit	0	0	0	-66	-66	0	0	-75	-75	0		0	66
Assessment / Admission	0	0	0	0	0	0	0	0	0	0		0	0
					Bed days			25012	18343	6669		1067	66
					Turnover interval	1		2622	1604	1018			
					occupancy			91%	92%	87%	90%	75%	50%
								27635	19947	7688			
					days available per day				365	365	250	365	365
					Patients per day						1.4		
					Beds needed			80	55	21	7.0	4	0
									Non elective	ELIP	DC	Critical	Assessment

Urology

	Cases Outpatient	Cases First OP A	Cases Review OP	Cases Admitted I	Cases Non Electives	Cases Elective IP	Cases Day Cases	Bed Days Admitted I	Bed Days Non Electives	Bed Days Elective IP			Bed Days Critical Care	Bed Days Assessment Unit
All Stages	7087	1627	5460	2269	55	385	1829	2273	394	1878	4.9	7.2	245	18
Baseline Activity	5408	1389	4019	2412	55	600	1757	2814	364	2450	4.1	6.6	0	0
Day Case Rate	0	0	0	0	0	-304	304	-566	0	-566	1.9		0	0
Outpatient Procedures	736	0	736	-736	0	0	-736	0	0	0			0	0
Shift to Primary Care	0	0	0	0	0	0	0	0	0	0			0	0
Early Discharge to Primary Care	0	0	0	0	0	0	0	0	0	0			0	0
Intermediate Care	0	0	0	0	0	0	0	-2	-2	0			0	0
Shift to Primary Care Review OP	0	0	0	0	0	0	0	0	0	0			0	0
Service Shifts	0	0	0	0	0	0	0	0	0	0			0	0
Change LOS	0	0	0	0	0	0	0	-296	-2	-295			0	0
New Services	0	0	0	200	0	38	162	205	0	205	5.5		0	0
Non Elective Demand	0	0	0	9	9	0	0	62	62	0		6.6	0	0
Elective Demand	943	238	705	394	0	52	342	322	0	322	6.2		0	0
Critical Care NEL	0	0	0		0	0	0	-7	-7	0			7	0
Critical Care	0	0	0		0	0	0	-238	0	-238			238	0
Assessment Unit	0	0	0	-9	-9	0	0	-10	-10	0		1.1	0	7
Assessment / Admission	0	0	0	0	0	0	0	-12	-12	0			0	12
					Bed days			2273	394	1878			244.72188	18.49757248
					Turnover interval	1		440	55	385				
					occupancy			84%	88%	83%	90%		75%	50%
								2713	449	2263				
					days available per day				365	365	250		365	365
					Patients per day						2			
					Beds needed			12	1	6	4		1	0
									Non elective	ELIP	DC		Critical	Assessment

Annexe 3

General Surgery

	Cases Outpatient	Cases First OP A	Cases Review OF	Cases Admitted I	Cases Non Electives	Cases Elective IP	Cases Day Cases	Bed Days Admitted I	Bed Days Non Electives	Bed Days Elective IP	Bed Days Critical Care	Bed Days Assessment Unit
All Stages	26905	7216	19689	8410	3862	744	3804	35985	29259	6726	902	1824
Baseline Activity	24186	6664	17522	9875	4760	1527	3588	39801	31008	8793	0	0
Day Case Rate	0	0	0	0	0	-840	840	-1412	0	-1412	0	0
Outpatient Procedures	708	0	708	-708	0	0	-708	0	0	0	0	0
Shift to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Early Discharge to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Intermediate Care	0	0	0	0	0	0	0	-4283	-4283	0	0	0
Shift to Primary Care Review OP	0	0	0	0	0	0	0	0	0	0	0	0
Service Shifts	0	0	0	-272	0	0	-272	0	0	0	0	0
Change LOS	0	0	0	0	0	0	0	-972	-227	-746	0	0
New Services	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Demand	0	0	0	817	817	0	0	5318	5318	0	0	0
Elective Demand	2011	552	1459	414	0	57	357	604	0	604	0	0
Critical Care NEL	0	0	0		0	0	0	-388	-388	0	388	0
Critical Care	0	0	0		0	0	0	-513	0	-513	513	0
Assessment Unit	0	0	0	-1715	-1715	0	0	-1402	-1402	0	0	1029
Assessment / Admission	0	0	0	0	0	0	0	-767	-767	0	0	795
					Bed days			35985	29259	6726	901.562	1824.015891
					Turnover interval	1		4376	3669	707		
					occupancy			89%	89%	90%	90%	75%	50%
						1584		40361	32928	7433		
					days available per day				365	365	250	365	365
					Patients per day						1.5		
					Beds needed			135	90	20	11	3	10
									Non elective	ELIP	DC	Critical	Assessment
									90	20	11	3	10

Annexe 3

Maternity

	Cases Outpatient	Cases First OP A	Cases Review OF	Cases Admitted I	Cases Non Electives	Cases Elective IP	Cases Day Cases	Bed Days Admitted I	Bed Days Non Electives	Bed Days Elective IP	Bed Days Critical Care	Bed Days Assessment Unit
All Stages	15265	4081	11184	6873	6873	0	0	11084	11084	0	106	0
Baseline Activity	14097	3769	10328	6604	6604	0	0	10754	10754	0	0	0
Day Case Rate	0	0	0	0	0	0	0	0	0	0	0	0
Outpatient Procedures	0	0	0	0	0	0	0	0	0	0	0	0
Shift to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Early Discharge to Primary Care	0	0	0	0	0	0	0	0	0	0	0	0
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0
Shift to Primary Care Review OP	0	0	0	0	0	0	0	0	0	0	0	0
Service Shifts	0	0	0	0	0	0	0	0	0	0	0	0
Change LOS	0	0	0	0	0	0	0	-1	-1	0	0	0
New Services	0	0	0	0	0	0	0	0	0	0	0	0
Non Elective Demand	0	0	0	269	269	0	0	438	438	0	0	0
Elective Demand	1168	312	856	0	0	0	0	0	0	0	0	0
Critical Care NEL	0	0	0		0	0	0	-106	-106	0	106	0
Critical Care	0	0	0		0	0	0	0	0	0	0	0
Assessment Unit	0	0	0	0	0	0	0	0	0	0	0	0
Assessment / Admission	0	0	0	0	0	0	0	0	0	0	0	0
					Bed days			11084	11084	0	106.15212	0
					Turnover interval	1		6873	6873	0		
					occupancy			62%	62%	#DIV/0!	90%	75%	50%
								17957	17957	0		
					days available per day				365	365	250	365	365
					Patients per day						1.5		
					Beds needed			50	49	0	0	0	0
									Non elective	ELIP	DC	Critical	Assessment

APPENDIX E

SCHEDULES OF ACCOMMODATION

Facilities for Service Delivery

Having completed an assessment of the levels of activity which must be accommodated and the changes in models of care which will impact on resource utilisation and design the functional content and detailed schedules of accommodation were developed with multiprofessional teams including representatives of the Primary Care Trust.

A summary of the functional content for each key element of the proposed scheme with the detailed Schedules of Accommodation has been developed and agreed.

1 Women's plus Children & Younger People's Services

In order to meet the objectives outlined in the main text of this Outline Business Case, although the functional requirements of each of these services has been separately identified, it is essential that in determining the final solution that the facility is physically adjacent to the inpatient maternity service and that the four core services (Gynaecology, Obstetrics, Breast and Children and Younger People) are co-located

In addition to the above clinical accommodation it has been identified that Office accommodation will need to be provided for approximately 40 clinical and support staff within the Women's Service. The office provision will need to be a mixture of single and multi occupancy rooms, amounting to in the order of 26 rooms. There is an estimated 13 rooms (23 staff) required for Children and Younger People

2 Diagnostic & Treatment Centre

It is recognised that there could be significant benefits in terms of organisational efficiency should the Women's and Children's facilities be co-located with the DTC development, however the functional content as outlined below is anticipated to provide a self contained facility.

The establishment of the DTC will require the provision of administrative support accommodation to ensure that organisational as well as clinical needs are addressed. It is estimated that 80 staff will require offices of single or multi occupancy size, which would equate to 60 plus offices

3 Pathology

Although included within the project, the solution for the reprovision of the Pathology Services does not require any physical adjacency to existing or new facilities, although in order to ensure that specimen transportation needs are met it is presumed that wherever the new

laboratories are located there will be a pneumatic tube system (or equivalent) linking them to key areas including the new Women's and Children's, DTC and existing Theatres, A&E etc.

As with the other clinical areas Office Accommodation within the Laboratory area will be required for in the region of 20 staff, which due to work distribution is likely to equate to 16 offices of single/ multi occupancy size.

4 *South Wing*

The beds within the South Wing are currently utilised for mainly medical patients, but the replacement facility will be designed to ensure that the space could be used by all acute specialties.

The location of the new unit close to the Accident and Emergency Unit and Clinical Decision Unit will be vital in terms of the delivery of the new models of care, as will be the provision of a dedicated Therapies Unit.

With a considerable proportion of the inpatient facilities being located in this new provision, there is also recognition of the need to provide office and administrative support. An allowance for 16 offices in a combination of single and multiple occupancy rooms, together with Staff Resource basis have been included in the detailed schedule of Accommodation.

5 *Administrative Support Accommodation*

(As highlighted earlier in the document, it is anticipated that the scope of this project will include the replacement of the St. John's Block). This facility is largely occupied by Administrative, Training and Medical records storage functions. Alternative provision, outside the scope of this project has been identified for a number of the functions, but it is anticipated that as part of this development an additional 1,750 m2 of office style accommodation will need to be reprovided, over and above that which has been outlined within the Output Specifications listed for the Clinical Services.

6 *Multi Professional Education Centre*

Education and training is undertaken in a wide range of building on the Manor and Goscote Hospital sites, supplemented by the occasional use of off site facilities. The educational strategy for the health community seeks to establish cross organisational and professional programmes, delivered in a single, central location which is easily accessed by acute and primary care staff and facilities improved co-ordination of training.

The current facilities are inadequate for the delivery of modern training for the expanding workforces of both the Walsall Hospitals Trust and Walsall tPCT. Furthermore, in recognition, of the educational and training benefits offered at Walsall the acute Trust has been granted a significant increase in the number of undergraduate students allocated to the hospitals, all of whom will be trained using the new curriculum for which clinical skills laboratory

facilities are essential and cannot be adequately provided within the existing educational buildings.

The Public Sector Comparator and Schedules of Accommodation have been developed on the basis that the new facilities will be located on the periphery of the Manor Site adjacent to the Dorothy Patterson Site

APPENDIX F

DESCRIPTION OF OPTIONS

Summary of Options

As set out under section 5.6 of the Outline Business Case six options have been short-listed for further development as follows:

- Option 1: Do Minimum
- Option 2: Interim OBC updated
- Option 3: CABE/ Design Exemplar Updated
- Option 4: Two Centre Option
- Option 5: Tower Option
- Option 5a; Tower Option (with South Wing replacement)
- Option 6: Radical Option (with South Wing replacement)

A separate review of the Clinical Models of Care determined by the Project Team for Pathology determined that the issues affecting the re-provision of Pathology were common to all the options under consideration (other than Option 1) This was essentially due to the introduction of the pneumatic tube system for the transfer of samples around the Hospital complex together with the provision of dedicated phlebotomy areas within each of the main clinical areas. The key parameters for the location of Pathology were defined as:

- Co-terminus with the Manor Site Hospital Street
- Ability for couriers to deliver samples from Community based facilities
- Ability for large vehicles to offload supplies

Relative proximity to the retained Histology and Mortuary Departments. This review undertook an option appraisal of three short listed option for the re-provision of Pathology, A new Build solution on the existing Sister Dora Out Patient / Surgical Day Unit site was the preferred Option and this has been taken forward within Options 2 to 6 above. Details of this Option Appraisal process are available on request.

As part of the technical review of each option a detailed analysis was undertaken by the Trust. This analysis underpins the on-cost assessment within the Capital Costs. The review comprises of two sections:

- An Architectural Appraisal for each Option which forms part of this appendix;
- An Engineering Appraisal (Technical appraisal & servicing philosophy) which is available as a separate document.

No.	Topic	Proposals	Ref Docs/ Drawings	Pro's	Con's
2.00	**Option 2 - "Interim" OBC**	**To build in the first phase family services centre in the vacant site between the existing West Wing and Maternity followed by a second phase DTC on the site vacated by the demolished St Johns and East Wing. Refurbish buildings 55 and 68 to provide admin accommodation**			
2.10	**Phasing, Enabling & Demolitions**			The first phase can be carried out without significant enabling works being required.	The second phase required the demolition of East Wing and St Johns to clear the site for the DTC build.
2.20	**Architectural Aspects**			The proposals reinforces the existing building line given by West Wing giving space for the setting of the listed building on Pleck Road.	
2.21				Allow for modern architectural statement onto Pleck Road with the opportunity to address the juntion with Moat Road with the clearing of the above ground infrastructure (HV Sub Sta and Tug)	Requires 3 - 4 storeys for the DTC in close proximity to existing adjacent houses.
2.30	**Circulation / Wayfinding**			Gives clear location of entrances into family services and the DTC visible from Pleck Road on entrance to the site.	Does not give as good an opportunity to create on entrance to the hospital.
2.31					DTC is remote from the existing diagnostic facilities and theatres.

No.	Topic	Proposals	Ref Docs/ Drawings	Pro's	Con's
2.40	**Planning Comments**			The principle of the scheme has arleady been granted outline planning consent. The planners rated this option 4th in order of preference. The planners would prefer a building design that addressed the junction of Pleck Road and Moat Road more visibly than the outline consent provided.	No adverse comments
2.50	**Highways Comments**	The creation of a new access point off Pleck Road in line with existing section 106 agreement. Providing clear access in to the site and an internal road giving access to the campus. A number of other access points would be provided around the site with Bus access from IDA road into the site at one of two locations.			No adverse comments
2.60	**Site Access and Circulation**	Main Traffic would access the site from Pleck Road. The access point into the site from Moat Road would be for Staff and Blue Light Traffic only. Main traffic could be able to exit the site onto Moat Road.		This was generally acceptable and appeared not to raise any major concerns with Highways.	
2.70	**Carparking**	To create car parking along Pleck Road starting in front of the South Wing and continuing to Moat road / Pleck Road junction.		Out-patient and visitor car parking close to site entrance onto Pleck Road allowing for ease of parking. Out-patient parking close to the DTC.	Visitor parking remote from the current Inpatient and visitor entrance as per the existing situation. Wayfinding from vehicle access point and parking to decentralised hospital entrances needs careful consideration.
2.71				Main car parking is remote from existing houses on Moat Road reducing potential nuisance.	The location of the parking along Pleck Road was considered as a minus point by the planners as the building is set back from the street scape.

Option 3 - CABE / Design Exemplar

No.	Topic	Proposals	Ref Docs/ Drawings	Pro's	Con's
3.00	**Option 3 - CABE / Design Exemplar**	**To build a single phase a combined unit to accommodate family services and the DTC/ACAD upon the existing vacant site between West Wing and Maternity.**			
3.10	**Phasing, Enabling & Demolitions**			The new build development can be carried out in a single phase. Does not require short term demolition of East Wing.	The carparking will require some phasing during the demolitions of East Wing and St Johns. Requires considerable M&E infrastructure enabling works to be carried out in a single phase.
3.20	**Architectural Aspects**			Allows for a strong architectural statement and a prominent landmark building for the hospital onto Pleck Road and the proposed new main entrance to the site.	Deep plan footprint difficult to plan clinically to provide adequate daylighting.
3.21				4 storey new build allows the creation of a good presence for the hospital facing Walsall city centre. Main massing is away from housing on Moat Road.	The 4 storey building is in close proximity to the listed building on Pleck Road.
3.30	**Circulation / Wayfinding**			Gives clear location of a new main entrance to the hospital visible from Pleck Road and the proposed entrance to the site, gathering together current different entrances to clinical and admin accommodation.	

Option 3 - CABE / Design Exemplar

No.	Topic	Proposals	Ref Docs/ Drawings	Pro's	Con's
3.40	**Planning Comments**			The planners viewed this as a positive move forward over the previous option as it was nearer to the road. It therefore gives greater presence to the building and therefore the site. The improvements were noted also to the potential quality of the spaces	Concern was raised however about the proximity to the listed building on Pleck Road (this scheme ranked 3rd in order of preference).
3.50	**Highways Comments**	The creation of a new access point off Pleck Road in line with existing section 106 agreement. Providing clear access in to the site and an internal road giving access to the campus. A number of other access points would be provided around the site with Bus access from IDA road into the site at one of two locations.		Parking strategy in this option was an improvement as all car parking can be accessed from internal site roads and there is clear wayfinding from the carparking to the proposed main entrance to the hospital.	No adverse comments
3.60	**Site Access and Circulation**	Main Traffic would access the site from Pleck Road. The access point into the site from Moat Road would be for Staff and Blue Light Traffic only. Main traffic could be able to exit the site onto Moat Road.			Proximity to Pleck Road makes access arrangements of internal road network more difficult.
3.70	**Carparking**	To create car parking along Moat Road on the demolished East Wing and St Johns site and continuing to Moat road / Pleck Road junction.		Out-patient and visitor parking close to main entrance and easily accessible from the propsed main site entrance.	Parking is close to housing on Moat Road with potential noise and nuisance issues.

Option 4 - Radical Laundry Option

No.	Topic	Proposals	Ref Docs/ Drawings	Pro's	Con's
4.00	**Option 4 - Radical Laundry Option**	**To remove the existing laundry from the site prior to commencement of the works and locate the DTC / ACAD on the newly vacated site. Construct the family services building in the existing vacant site between West Wing and the Maternity building**			
4.10	**Phasing, Enabling & Demolitions**			The new build development can be carried out in a single phase, utilising the proposed vacated site of the laundry and the area between West Wing and Maternity. Does not require short term demolition of East Wing.	
4.11					Requires relocation of the laundry buiding off site pior to commencement of the works.
4.20	**Architectural Aspects**			The proposals for the family services reinforces the existing building line given by West Wing, giving space for the setting of the listed building on Pleck Road.	DTC up to 5 / 6 storeys which may be difficult to plan clinically. Gives a tall building behind existing houses on Ida Road which is a planning issue. Less potential for an architectural statement for the hospital to either Pleck Road or Walsall city centre.
4.30	**Circulation / Wayfinding**				As Option 2, does not lend itself to creation of a single entrance to the hospital, and continues current philosophy of different entrances to various clinical functions. Route to DTC required new out-patients entrance remodelling on the west of the site adjacent t the existing canteen area from the west upper carpark.
4.31					Potentially tricky link into the existing hospital street from the new build DTC on the vacated laundry site.

Option 4 - Radical Laundry Option

No.	Topic	Proposals	Ref Docs/ Drawings	Pro's	Con's
4.40	**Planning Comments**				This schme caused to planners most concern as it would overshadow the houses on Ida Road. The was also concern regarding way finding as the DTC would be located remotely from the site access and the entrance would be proposed for the back of the site (this scheme was ranked 5th in order of preference by the planners).
4.50	**Highways Comments**	The creation of a new access point off Pleck Road in line with existing section 106 agreement. Providing clear access in to the site and an internal road giving access to the campus. A number of other access points would be provided around the site with Bus access from IDA road into the site at one of two locations.			Concerns regarding way finding and location of the busy DTC in terms of parking remote from the proposed site entrance and the distance of the DTC from the entrance to the hospital from the parking for out-patients.
4.60	**Site Access and Circulation**	Main Traffic would access the site from Pleck Road. The access point into the site from Moat Road would be for Staff and Blue Light Traffic only. Main traffic could be able to exit the site onto Moat Road.		Other than wayfinding concerns, this was generally acceptable and appeared not to raise any major concerns with Highways.	
4.70	**Carparking**	To create car parking along Pleck Road starting in front of the South Wing and continuing to Moat road / Pleck Road junction.		Main car parking is remote from existing houses on Moat Road reducing potential nuisance.	Out-patient parking for the DTC is remote from the proposed main entrance.
4.71					The location of the parking along Pleck Road was considered as a minus point by the planners as the buildings are set back from the street scape.

Option 5 - Tower Option

No.	Topic	Proposals	Ref Docs/ Drawings	Pro's	Con's
5.00	**Option 5 - Radical Tower Option**	**As per Option 3, however, this option compresses the CABE solution to give a smaller floorplate the increased distances between the new development and the listed building. The new build would be 5 storeys and deliver family services and the DTC in a sin**			
5.10	**Phasing, Enabling & Demolitions**			The new build development can be carried out in a single phase, utilising the proposed vacated site of the laundry and the area between West Wing and Maternity. Does not require short term demolition of East Wing.	
5.11				Required less enabling works prior to commencement of the works than the CABE Option 3.	
5.20	**Architectural Aspects**			Building gives excellent potential to create a landmark building for the hospital to address Pleck Road and Walsall city centre to the east.	New building would be 5 storeys, which may be difficult to plan clinically.
5.21				Improved relationship between the new building and the existing listed building on Pleck Road.	
5.30	**Circulation / Wayfinding**			DTC relatioinship to West Wing and existing diagnostics improved.	
5.31				As Option 3, solution lends itself to a single point of entrance for the hospital clearly visible and accessible from the proposed main site entrance on Pleck Road.	

Option 5 - Tower Option

No.	Topic	Proposals	Ref Docs/ Drawings	Pro's	Con's
5.40	**Planning Comments**			The planners were very positve about this solution as it addresses the desire for a statement building whilst addressing the Pleck Road frontage and respecting the listd building. Car Parking strategy was as per the CABE solution and therefore no further	
5.50	**Highways Comments**	The creation of a new access point off Pleck Road in line with existing section 106 agreement. Providing clear access in to the site and an internal road giving access to the campus. A number of other access points would be provided around the site with B		No adverse comments.	
5.60	**Site Access and Circulation**	Main Traffic would access the site from Pleck Road. The access point into the site from Moat Road would be for Staff and Blue Light Traffic only. Main traffic could be able to exit the site onto Moat Road.		Increased distance between the new building and the new entrance onto Pleck Road imporved internal site circulation upon site ingress.	
5.70	**Carparking**	To create car parking along Pleck Road starting in front of the South Wing and continuing to Moat road / Pleck Road junction.		Out-patient and visitor parking close to main entrance and easily accessible from the propsed main site entrance.	Parking is close to housing on Moat Road with potential noise and nuisance issues.

Option 5a Tower Option

No.	Topic	Proposals	Ref Docs/ Drawings	Pro's	Con's
5.00	**Option 5 - Radical Tower Option**	**As per Option 5a, however, this option compresses the CABE solution to give a smaller floorplate the increased distances between the new development and the listed building. The new build would be 5 storeys and deliver family services and the DTC in a single phase. The laundry would be moved off site, and South Wing would be replaced on the vacated laundry site.**			
5.10	**Phasing, Enabling & Demolitions**			The new build development can be carried out in a single phase, utilising the proposed vacated site of the laundry and the area between West Wing and Maternity. Does not require short term demolition of East Wing.	
5.11				Required less enabling works prior to commencement of the works than the CABE Option 3.	The laundry is required to be moved off site.
5.20	**Architectural Aspects**			Building gives excellent potential to create a landmark building for the hospital to address Pleck Road and Walsall city centre to the east.	New building would be 5 storeys, which may be difficult to plan clinically.
5.21				Improved relationship between the new building and the existing listed building on Pleck Road.	
5.30	**Circulation / Wayfinding**			DTC relatioinship to West Wing and existing diagnostics improved.	
5.31				As Option 3, solution lends itself to a single point of entrance for the hospital clearly visible and accessible from the proposed main site entrance on Pleck Road.	

Option 5a Tower Option

No.	Topic	Proposals	Ref Docs/ Drawings	Pro's	Con's
5.40	**Planning Comments**				This schme caused to planners concern as it would overshadow the houses on Ida Road.
5.50	**Highways Comments**	The creation of a new access point off Pleck Road in line with existing section 106 agreement. Providing clear access in to the site and an internal road giving access to the campus. A number of other access points would be provided around the site with Bus access from IDA road into the site at one of two locations.		No adverse comments.	
5.60	**Site Access and Circulation**	Main Traffic would access the site from Pleck Road. The access point into the site from Moat Road would be for Staff and Blue Light Traffic only. Main traffic could be able to exit the site onto Moat Road.		Increased distance between the new building and the new entrance onto Pleck Road imporved internal site circulation upon site ingress.	
5.70	**Carparking**	To create car parking along Pleck Road starting in front of the South Wing and continuing to Moat road / Pleck Road junction.		Out-patient and visitor parking close to main entrance and easily accessible from the propsed main site entrance.	Parking is close to housing on Moat Road with potential noise and nuisance issues.

Option 6 - Radical South Option

No.	Topic	Proposals	Ref Docs/ Drawings	Pro's	Con's
6.00	**Option 6 - Radical South Option**	**Construccction of family services on the vacant site between existing Maternity and West Wing. Construction of replacement for South Wing on the vacated laundry site. Second phase construction of the DTC on the newly vacated South Wing site.**			
6.10	**Phasing, Enabling & Demolitions**				The new build is carried out in 2 phases, with the laundry required to be moved off site prior to commencement of the works.
6.20	**Architectural Aspects**			Has a excellent opportunity to create an architectural statement for the hospital onto Pleck Road while maintaing a respectful relationship to the existing listed building.	
6.21				Solution proposes replacement for existing south wing accommodation. Provides opportunity for new frontage onto Pleck Road.	
6.30	**Circulation / Wayfinding**			DTC relationship to West Wing and existing theatres excellent. DTC also close to and clearly visible from the proposed main site entrance from Pleck Road and main car parking areas.	Potentially tricky link into the existing hospital street from the new build South Wing on the vacated laundry site.
6.31				Has potential to create a single point of entrance for the hospital clearly visible off the proposed site entrnace from Pleck Road and the main new parking areas.	

Option 6 - Radical South Option

No.	Topic	Proposals	Ref Docs/ Drawings	Pro's	Con's
6.40	**Planning Comments**			The planners were in favour of this scheme as it provided a building that directly addressed the Pleck Road frontage. The other buildings mask the existing hospital and were considered to be workable (ranked 2nd in order of preference).	Planners had initial concerns regarding the close proximity of the South Wing replacement to the eixsting houses on Ida Road, but this was considered manageable in the final solution.
6.50	**Highways Comments**	The creation of a new access point off Pleck Road in line with existing section 106 agreement. Providing clear access in to the site and an internal road giving access to the campus. A number of other access points would be provided around the site with Bus access from IDA road into the site at one of two locations.			Some concerns regarding way finding and location of the busy DTC from the parking.
6.60	**Site Access and Circulation**	Main Traffic would access the site from Pleck Road. The access point into the site from Moat Road would be for Staff and Blue Light Traffic only. Main traffic could be able to exit the site onto Moat Road.		Other than wayfinding concerns, this was generally acceptable and appeared not to raise any major concerns with Highways.	
6.70	**Carparking**	To create car parking along Pleck Road starting in front of the South Wing and continuing to Moat road / Pleck Road junction.		Main car parking is close to proposed entrance to site and potential single hospital entrances.	Propsed car parking is close to existing houses on Moat Road with potential for nuisance.

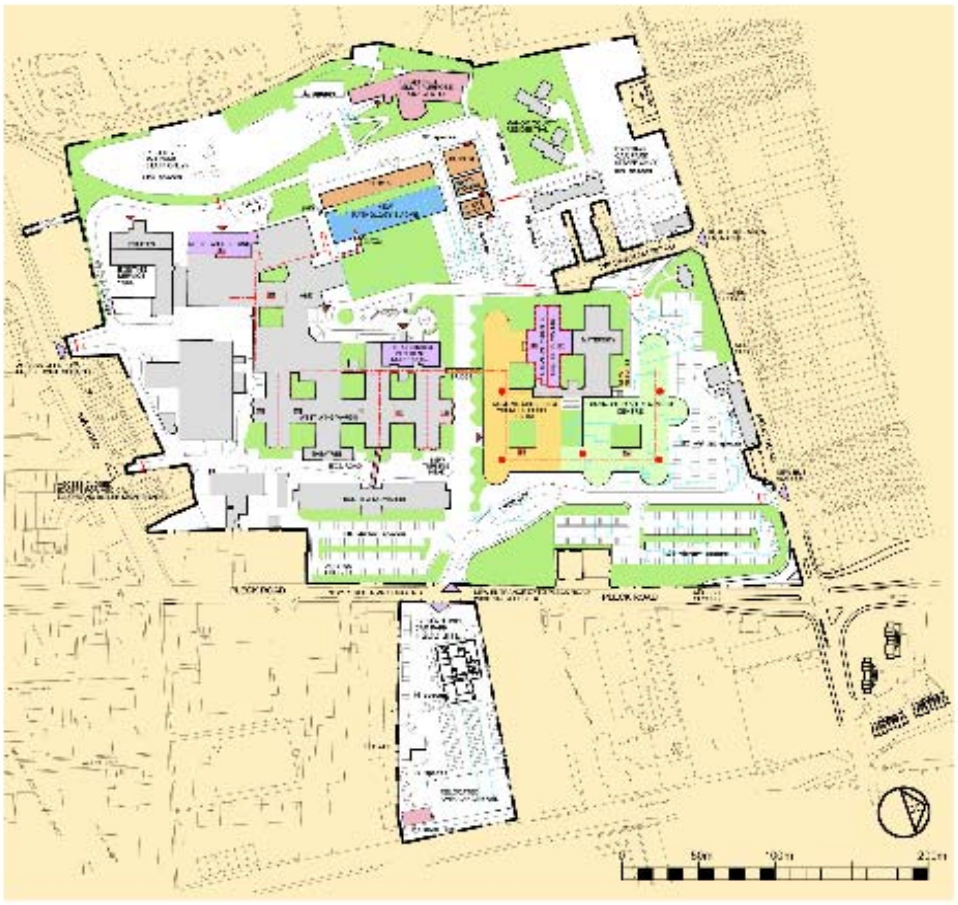
APPENDIX G

SITE PLANS FOR OPTIONS

Option Drawings

As set out under section 5.6 of the Outline Business Case six options have been short-listed for further development as follows and site plans for each option are included within this appendix:

- Option 1: Do Minimum
- Option 2: Interim OBC updated
- Option 3: CABE/ Design Exemplar Updated
- Option 4: Two Centre Option
- Option 5: Tower Option
- Option 5a; Tower Option (with South Wing replacement)
- Option 6: Radical Option (with South Wing replacement)



OPTION 2

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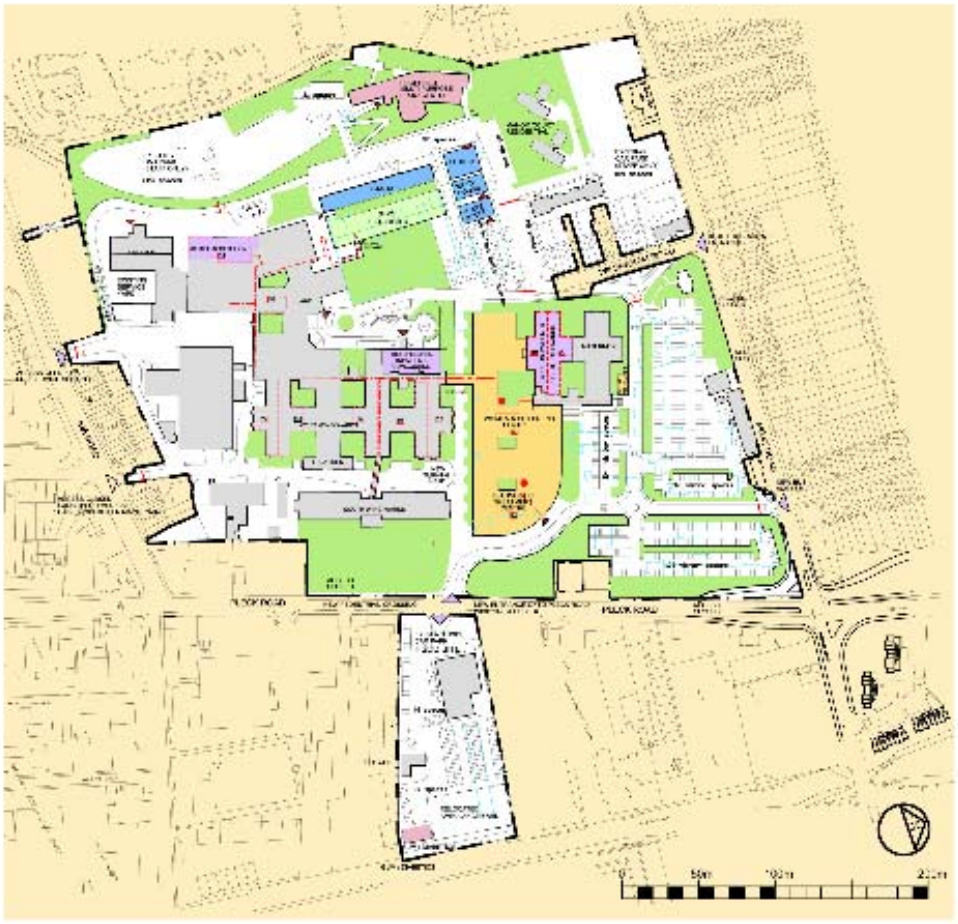

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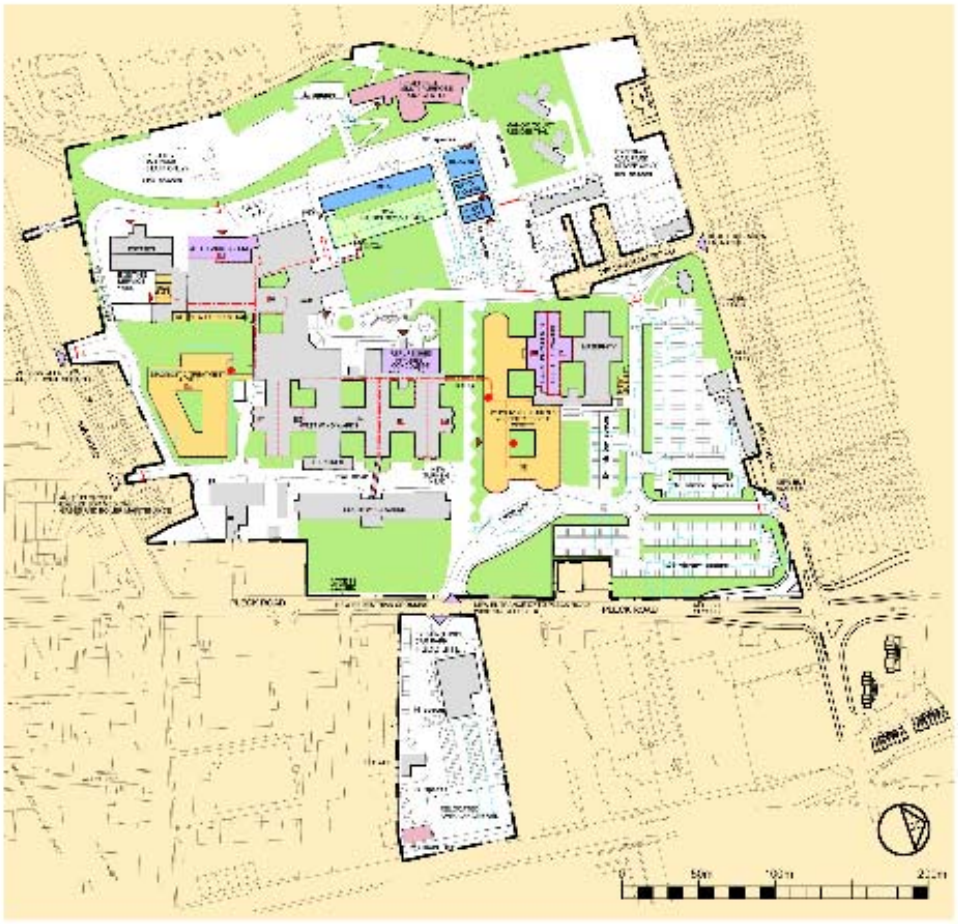

OPTION 4

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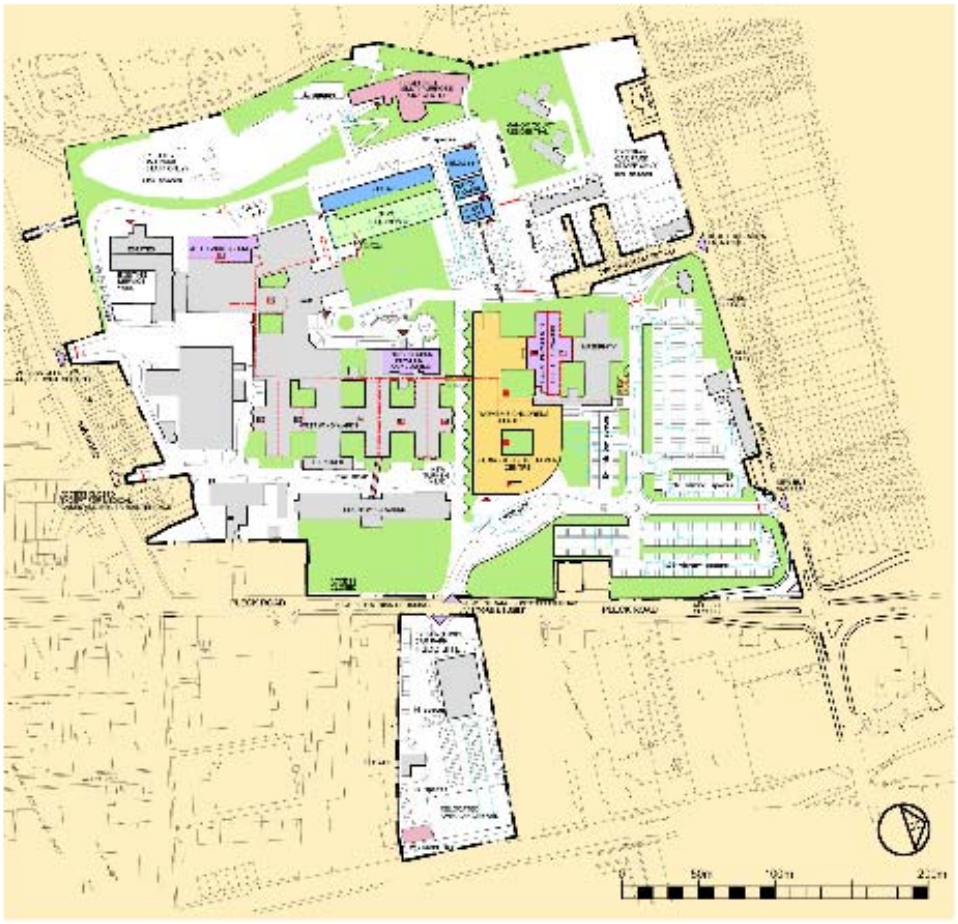

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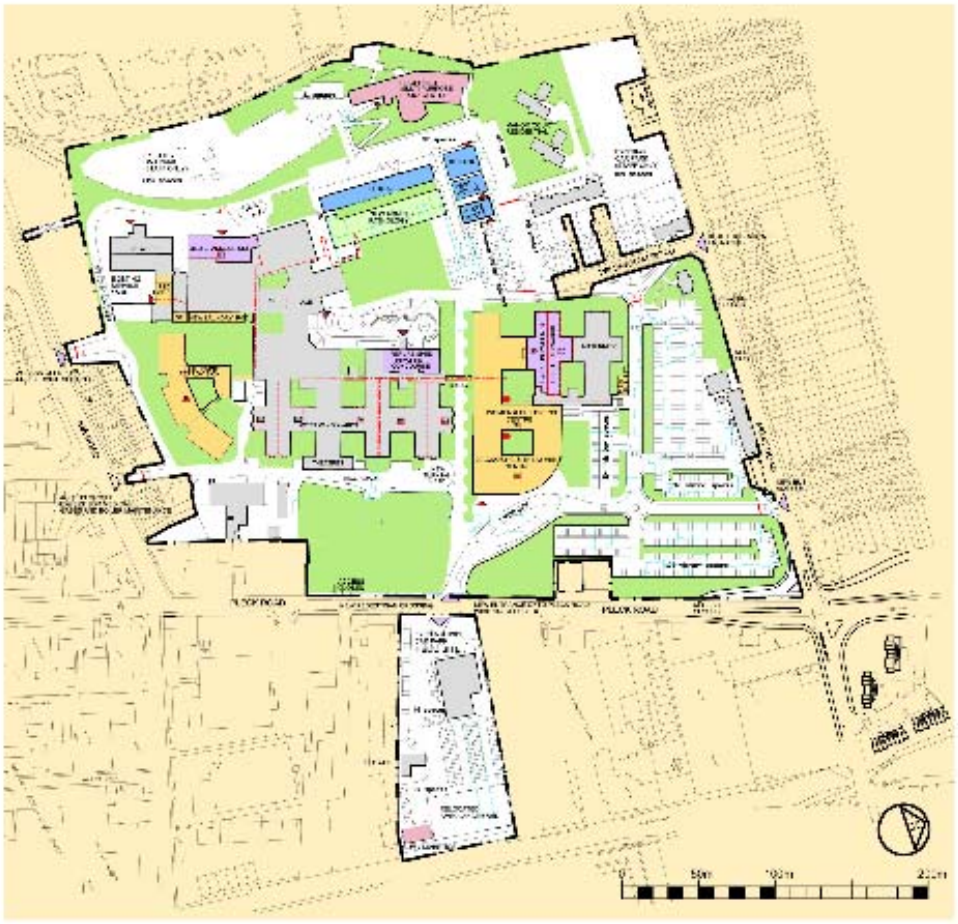

OPTION 5a

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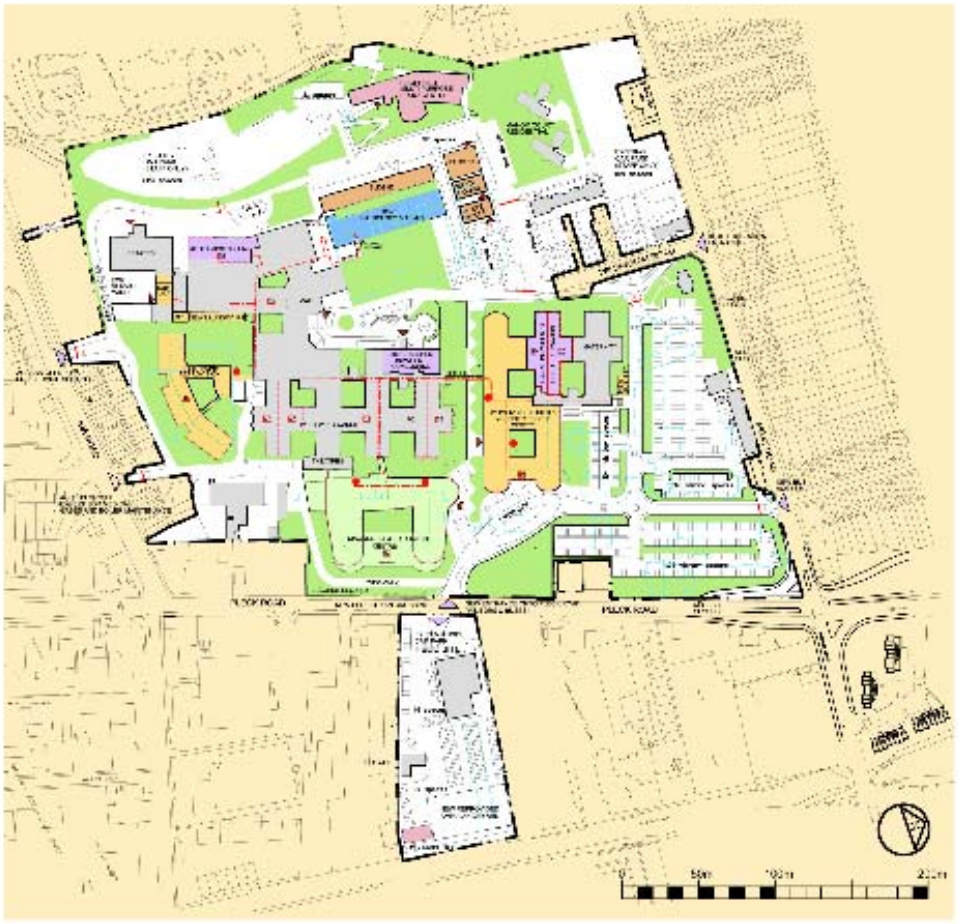


OPTION 6

KEY

APPENDIX H

NON-FINANCIAL APPRAISAL

Attached to this Appendix are the detailed results of the non-financial appraisal covering the Main Option Appraisal.

Based on Average Scores				
	Option	Weighted Scores	Rank	Difference
1	Do Minimum	167	7	-75.85%
2	SOC Option	487	5	-29.43%
3	CABE Option	540	4	-21.77%
4	Two Centre Option	484	6	-29.91%
5	Tower Option	581	3	-15.85%
5a	Tower Option with South Block	583	2	-15.53%
6	Radical Option with South Block	690	1	0.00%

Based on Mode Scores				
	Option	Weighted Scores	Rank	Difference
1	Do Minimum	36	7	-94.41%
2	SOC Option	486	5	-24.53%
3	CABE Option	506	4	-21.43%
4	Two Centre Option	478	6	-25.78%
5	Tower Option	586	3	-9.01%
5a	Tower Option with South Block	604	2	-6.21%
6	Radical Option with South Block	644	1	0.00%

Based on Median Scores				
	Option	Weighted Scores	Rank	Difference
1	Do Minimum	127	7	-81.70%
2	SOC Option	494	5	-28.82%
3	CABE Option	512	4	-26.22%
4	Two Centre Option	494	5	-28.82%
5	Tower Option	578	2	-16.71%
5a	Tower Option with South Block	578	2	-16.71%
6	Radical Option with South Block	694	1	0.00%

Ref.	Benefit Criteria	Weight		Option 1		Option 2		Option 3		Option 4		Option 5		Option 5a		Option 6	
		Points	%	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score
1	Better access to services	18	18%	1.47	26	4.67	84	5.47	98	3.70	67	5.90	106	6.00	108	6.83	123
2	Improved clinical quality of services	20	20%	1.60	32	4.83	97	5.30	106	4.53	91	5.97	119	6.00	120	7.33	147
3	Improved environmental quality of services	6	6%	1.90	11	5.23	31	5.17	31	4.97	30	5.57	33	5.57	33	6.70	40
4	Developing existing services and / or providing new services	10	10%	1.50	15	4.93	49	5.73	57	5.20	52	5.67	57	5.67	57	7.30	73
5	Improved strategic fit of services	6	6%	1.30	8	4.37	26	5.47	33	5.07	30	5.50	33	5.50	33	7.07	42
6	Meeting national, regional and local policy imperatives	14	14%	1.60	22	5.07	71	5.40	76	5.37	75	5.70	80	5.70	80	6.63	93
7	Meeting training, teaching and research needs	6	6%	1.43	9	4.60	28	5.50	33	5.47	33	5.53	33	5.53	33	6.70	40
8	Making more effective use of resources	14	14%	1.37	19	5.03	70	5.47	77	5.37	75	6.00	84	6.00	84	7.13	100
9	Ease of Delivery	6	6%	4.00	24	5.10	31	4.90	29	5.23	31	5.90	35	5.86	35	5.37	32
	Total	100	100%		167		487		540		484		581		583		690
	Rank				7		5		4		6		3		2		1
	Difference				-75.85%		-29.43%		-21.77%		-29.91%		-15.85%		-15.53%		0.00%

Ref.	Benefit Criteria	Weight		Option 1		Option 2		Option 3		Option 4		Option 5		Option 5a		Option 6	
		Points	%	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score
1	Better access to services	18	18%	0	0	4	72	5	90	4	72	6	108	7	126	7	126
2	Improved clinical quality of services	20	20%	0	0	5	100	5	100	5	100	7	140	7	140	6	120
3	Improved environmental quality of services	6	6%	1	6	5	30	5	30	5	30	4	24	4	24	7	42
4	Developing existing services and / or providing new services	10	10%	0	0	6	60	5	50	6	60	5	50	5	50	8	80
5	Improved strategic fit of services	6	6%	0	0	4	24	5	30	5	30	5	30	5	30	8	48
6	Meeting national, regional and local policy imperatives	14	14%	0	0	5	70	5	70	5	70	5	70	5	70	6	84
7	Meeting training, teaching and research needs	6	6%	0	0	5	30	5	30	5	30	5	30	5	30	5	30
8	Making more effective use of resources	14	14%	0	0	5	70	5	70	4	56	7	98	7	98	6	84
9	Ease of Delivery	6	6%	5	30	5	30	6	36	5	30	6	36	6	36	5	30
	Total	100	100%		36		486		506		478		586		604		644
	Rank				7		5		4		6		3		2		1
	Difference				-94.41%		-24.53%		-21.43%		-25.78%		-9.01%		-6.21%		0.00%

Ref.	Benefit Criteria	Weight		Option 1		Option 2		Option 3		Option 4		Option 5		Option 5a		Option 6	
		Points	%	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score
1	Better access to services	18	18%	1	18	5	90	5	90	4	72	6	108	6	108	7	126
2	Improved clinical quality of services	20	20%	1	20	5	100	5	100	5	100	6	120	6	120	8	150
3	Improved environmental quality of services	6	6%	2	12	5	30	5	30	5	30	6	36	6	36	7	42
4	Developing existing services and / or providing new services	10	10%	1	10	5	50	6	55	6	55	5	50	5	50	8	80
5	Improved strategic fit of services	6	6%	1	6	4	24	5	30	5	30	5	30	5	30	7	42
6	Meeting national, regional and local policy imperatives	14	14%	1	14	5	70	5	70	5	70	6	84	6	84	6	84
7	Meeting training, teaching and research needs	6	6%	1	6	5	30	5	30	5	30	5	30	5	30	7	42
8	Making more effective use of resources	14	14%	1	14	5	70	6	77	6	77	6	84	6	84	7	98
9	Ease of Delivery	6	6%	4.5	27	5	30	5	30	5	30	6	36	6	36	5	30
	Total	100	100%		127		494		512		494		578		578		694
	Rank				7		5		4		5		2		2		1
	Difference				-81.70%		-28.82%		-26.22%		-28.82%		-16.71%		-16.71%		0.00%

Ref.	Benefit Criteria	Weight		Option 1		Option 2		Option 3		Option 4		Option 5		Option 5a		Option 6	
		Points	%	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score	Score	Weighted Score
1	Better access to services	6	6%	1.47	9	4.67	28	5.47	33	3.70	22	5.90	35	6.00	36	6.83	41
2	Improved clinical quality of services	15	15%	1.60	24	4.83	73	5.30	80	4.53	68	5.97	90	6.00	90	7.33	110
3	Improved environmental quality of services	17	17%	1.90	32	5.23	89	5.17	88	4.97	84	5.57	95	5.57	95	6.70	114
4	Developing existing services and / or providing new services	15	15%	1.50	23	4.93	74	5.73	86	5.20	78	5.67	85	5.67	85	7.30	110
5	Improved strategic fit of services	10	10%	1.30	13	4.37	44	5.47	55	5.07	51	5.50	55	5.50	55	7.07	71
6	Meeting national, regional and local policy imperatives	10	10%	1.60	16	5.07	51	5.40	54	5.37	54	5.70	57	5.70	57	6.63	66
7	Meeting training, teaching and research needs	15	15%	1.43	22	4.60	69	5.50	83	5.47	82	5.53	83	5.53	83	6.70	101
8	Making more effective use of resources	6	6%	1.37	8	5.03	30	5.47	33	5.37	32	6.00	36	6.00	36	7.13	43
9	Ease of Delivery	6	6%	4.00	24	5.10	31	4.90	29	5.23	31	5.90	35	5.86	35	5.37	32
	Total	100	100%		170		488		540		503		571		572		687
	Rank				7		6		4		5		3		2		1
	Difference				-75.21%		-29.01%		-21.46%		-26.84%		-16.88%		-16.76%		0.00%

Ref	Benefit Criteria		Option 1																															
		Weight	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Average	Mode	Median
		%																																
1	Better access to services	18	2	2	1	2	3	4	3	4	3	2	2	3	0	0	0	0	0	1	0	2	1	3	0	1	0	0	4	1	0	0	44	1.47	0	1
2	Improved clinical quality of services	20	4	4	1	3	3	4	3	5	4	1	1	3	0	4	0	0	0	0	0	2	1	2	0	0	0	0	2	1	0	0	48	1.60	0	1
3	Improved environmental quality of services	6	3	3	1	2	3	3	4	5	4	1	1	4	0	4	2	2	2	1	0	2	1	2	0	3	1	0	2	1	0	0	57	1.90	1	2
4	Developing existing services and / or providing new services	10	3	3	1	2	2	4	4	4	2	1	1	4	0	0	0	2	2	1	0	1	1	2	0	2	0	0	2	1	0	0	45	1.50	0	1
5	Improved strategic fit of services	6	3	3	1	1	3	3	3	4	4	2	2	3	0	0	0	0	0	0	0	1	1	1	0	1	0	0	2	1	0	0	39	1.30	0	1
6	Meeting national, regional and local policy imperatives	14	4	4	1	3	1	3	3	6	3	2	2	5	0	0	0	0	2	1	0	1	1	2	0	1	0	0	2	1	0	0	48	1.60	0	1
7	Meeting training, teaching and research needs	6	2	2	1	2	4	4	3	3	2	1	2	5	0	0	0	0	2	0	0	1	1	2	0	2	0	0	3	1	0	0	43	1.43	0	1
8	Making more effective use of resources	14	2	3	1	0	2	4	3	4	4	1	1	4	0	0	2	0	2	0	0	1	1	2	0	1	0	0	2	1	0	0	41	1.37	0	1
9	Ease of Delivery	6	3	4	5	10	2	7	5	5	5	2	4	8	0	0	0	5	2	2	0	4	6	0	5	5	5	7	4	9	6	0	120	4.00	5	4.5
	Total		26	28	13	25	23	36	31	40	31	13	16	39	0	8	4	9	12	6	0	15	14	16	5	16	6	7	23	17	6	0	485	16.17	6	14
			3	3.2	1.2	2.5	2.5	3.9	3.3	4.5	3.4	1.4	1.6	4	0	1	0.4	0.6	1.1	0.6	0	1.6	1.3	2	0.3	1.3	0.4	0.4	2.5	1.5	0.4	0				

Ref	Benefit Criteria		Option 2																															
		Weight	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Average	Mode	Median
		%																																
1	Better access to services	18	4	4	3	5	7	4	6	6	9	4	4	4	6	7	2	5	8	5	3	6	5	7	5	6	2	2	6	3	0	2	140	4.67	4	5
2	Improved clinical quality of services	20	5	5	4	7	7	5	5	6	8	3	7	5	6	7	3	6	5	3	0	5	5	7	3	3	1	3	6	4	4	7	145	4.83	5	5
3	Improved environmental quality of services	6	5	5	3	6	8	5	6	6	8	3	5	6	6	5	2	6	8	5	4	6	5	7	5	5	4	3	6	5	3	6	157	5.23	5	5
4	Developing existing services and / or providing new services	10	6	6	4	6	7	6	7	7	6	4	5	4	4	5	0	6	4	2	4	8	5	7	3	6	4	3	6	3	3	7	148	4.93	6	5
5	Improved strategic fit of services	6	5	6	4	6	7	4	5	6	6	4	3	3	4	5	1	5	4	5	2	6	3	7	3	4	4	3	6	2	3	5	131	4.37	4	4
6	Meeting national, regional and local policy imperatives	14	5	5	5	7	7	5	6	6	7	5	6	6	3	5	0	5	6	4	2	8	5	7	4	4	4	3	6	3	3	10	152	5.07	5	5
7	Meeting training, teaching and research needs	6	5	5	4	5	7	5	5	8	8	5	5	4	4	4	0	5	5	2	2	8	5	6	3	5	2	3	7	3	3	5	138	4.60	5	5
8	Making more effective use of resources	14	6	5	4	7	7	5	6	6	9	6	6	3	4	5	2	5	5	2	2	7	5	7	5	5	5	3	6	3	3	7	151	5.03	5	5
9	Ease of Delivery	6	6	6	5	7	6	5	7	6	8	5	5	4	3	5	2	5	5	5	2	5	6	6	3	7	3	2	5	7	6	6	153	5.10	5	5
	Total		47	47	36	56	63	44	53	57	69	39	46	39	40	48	12	48	50	33	21	59	44	61	34	45	29	25	54	33	28	55	1315	43.83	44	44
			5.1	5	4	6.3	7	4.9	5.8	6.2	7.9	4.3	5.4	4.4	4.7	5.7	1.5	5.4	5.7	3.6	2.1	6.5	4.9	6.9	3.9	4.8	3	2.8	6	3.5	2.8	6.2				

Ref	Benefit Criteria		Option 3																															
		Weight	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Average	Mode	Median
		%																																
1	Better access to services	18	5	5	6	6	8	5	5	8	9	3	3	4	5	7	4	8	8	5	3	6	5	7	4	5	3	2	7	6	3	9	164	5.47	5	5
2	Improved clinical quality of services	20	5	5	6	6	7	5	5	6	7	4	7	5	5	7	3	7	4	3	2	6	5	7	5	2	2	5	6	7	3	12	159	5.30	5	5
3	Improved environmental quality of services	6	5	5	5	6	8	4	6	7	7	3	5	4	5	5	2	7	8	5	4	6	5	8	5	4	2	5	6	5	3	5	155	5.17	5	5
4	Developing existing services and / or providing new services	10	5	5	6	5	7	6	7	7	6	5	5	6	5	5	4	7	6	5	4	8	5	7	5	7	5	5	7	6	3	8	172	5.73	5	5.5
5	Improved strategic fit of services	6	5	4	7	7	6	4	7	7	8	5	7	3	6	6	2	8	7	5	4	7	5	8	4	5	4	4	6	5	3	5	164	5.47	5	5
6	Meeting national, regional and local policy imperatives	14	5	5	5	7	6	5	6	5	7	5	6	6	4	5	0	8	6	5	2	8	5	7	4	5	5	5	6	6	3	10	162	5.40	5	5
7	Meeting training, teaching and research needs	6	5	5	6	5	7	5	5	8	7	5	5	4	5	5	2	7	7	5	5	8	5	8	5	5	7	4	7	5	3	5	165	5.50	5	5
8	Making more effective use of resources	14	6	6	6	7	6	5	5	7	7	4	6	3	5	5	2	6	5	5	2	8	5	7	5	6	5	4	7	6	3	10	164	5.47	5	5.5
9	Ease of Delivery	6	6	6	5	6	8	4	4	8	8	4	3	4	2	6	2	7	5	3	2	5	5	7	3	3	4	3	6	6	6	6	147	4.90	6	5
	Total		47	46	52	55	63	43	50	63	66	38	47	39	42	51	21	65	56	41	28	62	45	66	40	42	37	37	58	52	30	70	1452	48.40	46	46
			5.2	5.1	5.8	6.2	7	4.9	5.5	6.8	7.4	4.1	5.3	4.5	4.7	5.9	2.5	7.2	6	4.5	2.8	6.9	5	7.2	4.5	4.6	3.9	4.1	6.5	6	3.2	8.9				

Ref	Benefit Criteria		Option 4																															
		Weight	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Average	Mode	Median
		%																																
1	Better access to services	18	4	4	5	6	5	5	6	6	7	5	4	4	1	3	5	2	0	4	0	4	2	4	3	3	1	1	3	4	3	7	111	3.70	4	4
2	Improved clinical quality of services	20	4	4	5	7	7	6	5	6	5	4	7	5	1	3	3	4	4	2	0	5	5	6	5	5	1	5	5	4	3	10	136	4.53	5	5
3	Improved environmental quality of services	6	4	4	5	5	7	5	5	7	5	5	5	4	3	5	4	5	8	5	4	6	5	7	4	5	5	5	6	4	3	4	149	4.97	5	5
4	Developing existing services and / or providing new services	10	5	5	6	6	7	6	6	6	2	5	6	6	3	5	4	6	6	5	4	8	5	6	3	6	5	3	7	3	3	8	156	5.20	6	5.5
5	Improved strategic fit of services	6	4	4	7	6	7	5	5	7	5	4	4	3	3	6	4	6	6	5	4	7	5	8	5	7	5	4	5	2	5	4	152	5.07	5	5
6	Meeting national, regional and local policy imperatives	14	5	5	5	7	7	6	6	7	5	5	6	6	3	5	4	5	6	4	2	8	5	7	4	5	5	5	6	4	3	8	161	5.37	5	5
7	Meeting training, teaching and research needs	6	5	5	6	5	7	6	5	8	5	6	5	7	3	5	2	5	7	5	5	8	5	8	5	6	7	5	6	3	4	5	164	5.47	5	5
8	Making more effective use of resources	14	4	4	6	6	6	6	6	7	4	5	6	4	4	4	4	8	6	5	2	7	5	7	5	7	4	7	6	4	4	8	161	5.37	4	5.5
9	Ease of Delivery	6	5	5	5	5	7	4	6	6	7	6	5	4	3	6	3	6	5	5	2	7	5	7	4	6	6	5	5	5	6	6	157	5.23	5	5
	Total		40	40	50	53	60	49	50	60	45	45	48	43	24	42	33	47	48	40	23	60	42	60	38	50	42	37	50	32	36	60	1347	44.90	44	45
			4.4	4.4	5.4	6.2	6.5	5.6	5.6	6.5	5	4.9	5.5	4.8	2.4	4.2	3.8	4.9	4.6	4.1	1.9	6.3	4.5	6.3	4.2	5.3	3.9	3.9	5.4	3.6	3.8	7.4				

Ref	Benefit Criteria		Option 5																															
		Weight	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Average	Mode	Median
		%																																
1	Better access to services	18	6	6	7	7	8	6	6	8	8	4	6	6	4	8	8	8	8	5	2	7	3	5	3	6	2	3	7	6	6	8	177	5.90	6	6
2	Improved clinical quality of services	20	7	7	6	8	7	5	7	7	8	3	7	8	3	7	6	7	4	5	2	6	4	7	4	5	2	4	6	6	6	15	179	5.97	7	6
3	Improved environmental quality of services	6	8	8	6	7	7	6	6	7	8	4	5	6	3	5	4	7	8	5	4	6	4	7	4	6	3	4	5	7	3	4	167	5.57	4	6
4	Developing existing services and / or providing new services	10	5	5	6	7	7	6	7	7	8	5	5	9	3	5	5	7	6	5	4	8	5	7	3	5	5	3	6	5	3	8	170	5.67	5	5
5	Improved strategic fit of services	6	5	5	7	7	7	6	7	6	5	5	8	4	3	6	4	8	7	5	4	7	4	8	3	5	5	3	6	4	6	5	165	5.50	5	5
6	Meeting national, regional and local policy imperatives	14	5	5	5	7	7	7	6	7	8	5	6	7	3	5	4	8	6	6	2	8	5	7	3	4	4	3	6	5	6	11	171	5.70	5	6
7	Meeting training, teaching and research needs	6	6	6	7	5	7	6	5	8	8	5	5	8	3	6	4	7	7	5	5	8	5	7	5	5	2	3	5	5	3	5	166	5.53	5	5
8	Making more effective use of resources	14	6	7	7	6	8	7	6	6	7	4	6	7	4	5	4	7	7	5	4	8	5	8	4	6	5	4	7	6	3	11	180	6.00	7	6
9	Ease of Delivery	6	6	6	5	7	8	7	5	8	7	5	5	8	4	6	6	7	6	4	4	6	5	8	4	8	6	5	7	6	3	5	177	5.90	6	6

	Total		54	55	56	61	66	56	55	64	67	40	53	63	30	53	45	66	59	45	31	64	40	64	33	50	34	32	55	50	39	72	1552	51.73	50	51
			6	6.2	6.2	6.9	7.4	6.1	6.2	7.1	7.6	4.2	6	7.1	3.4	6.1	5.3	7.4	6.3	5.1	3	7.1	4.3	6.9	3.6	5.4	3.5	3.5	6.3	5.6	4.7	9.5				

Ref	**Benefit Criteria**		**Option 6**																																
		Weight	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Average	Mode	Median
		%																																		
1	Better access to services	18	4	4	6	7	6	7	6	6	8	7	7	8	5	7	8	5	9	6	7	6	5	6	7	10	7	7	8	7	10	9	205	6.83	7	7
2	Improved clinical quality of services	20	6	6	6	6	7	6	8	6	9	8	7	9	4	8	4	4	8	6	6	8	5	8	9	10	10	9	8	7	10	12	220	7.33	6	7.5
3	Improved environmental quality of services	6	5	5	6	7	7	6	7	7	8	6	8	7	4	5	3	4	9	7	6	6	5	8	8	9	9	9	7	8	10	5	201	6.70	7	7
4	Developing existing services and / or providing new services	10	6	6	7	8	7	6	8	7	9	8	7	8	5	8	4	5	8	5	7	8	5	8	7	9	10	9	8	8	10	8	219	7.30	8	8
5	Improved strategic fit of services	6	5	5	7	8	6	7	8	6	9	8	7	8	4	8	3	6	8	7	6	8	5	9	7	9	10	9	8	6	10	5	212	7.07	8	7
6	Meeting national, regional and local policy imperatives	14	5	5	5	8	6	7	6	6	9	6	6	9	4	8	3	4	6	6	6	8	5	7	8	6	7	9	7	7	10	10	199	6.63	6	6
7	Meeting training, teaching and research needs	6	5	6	7	6	7	6	5	8	8	7	5	6	4	7	3	5	8	5	6	8	5	8	8	9	10	9	8	7	10	5	201	6.70	5	7
8	Making more effective use of resources	14	4	5	7	6	6	8	6	6	7	7	8	9	4	6	6	5	9	6	6	8	5	7	8	9	10	10	8	8	10	10	214	7.13	6	7
9	Ease of Delivery	6	4	5	5	6	6	5	6	8	7	7	5	2	3	7	6	5	5	3	2	6	5	5	5	6	6	8	5	4	10	4	161	5.37	5	5
	Total		44	47	56	62	58	58	60	60	74	64	60	66	37	64	40	43	70	51	52	66	45	66	67	77	79	79	67	62	90	68	1832	61.07	58	62
			4.9	5.2	6.2	6.8	6.4	6.6	6.7	6.4	8.3	7.2	6.8	7.9	4.2	7.2	4.8	4.7	7.9	5.8	6	7.4	5	7.2	7.7	8.8	8.7	8.7	7.6	7.1	10	8.8				

Total Scores																															Total	Average	Mean	Mode	Rank
Option 1		26	28	13	25	23	36	31	40	31	13	16	39	0	8	4	9	12	6	0	15	14	16	5	16	6	7	23	17	6	0	485	16.17	16	14.5	6
Option 2		47	47	36	56	63	44	53	57	69	39	46	39	40	48	12	48	50	33	21	59	44	61	34	45	29	25	54	33	28	55	1,315	43.83	47	45.5	5
Option 3		47	46	52	55	63	43	50	63	66	38	47	39	42	51	21	65	56	41	28	62	45	66	40	42	37	37	58	52	30	70	1,452	48.40	47	47	3
Option 4		40	40	50	53	60	49	50	60	45	45	48	43	24	42	33	47	48	40	23	60	42	60	38	50	42	37	50	32	36	60	1,347	44.90	60	45	4
Option 5		54	55	56	61	66	56	55	64	67	40	53	63	30	53	45	66	59	45	31	64	40	64	33	50	34	32	55	50	39	72	1,552	51.73	55	54.5	2
Option 6		44	47	56	62	58	58	60	60	74	64	60	66	37	64	40	43	70	51	52	66	45	66	67	77	79	79	67	62	90	68	1,832	61.07	60	62	1

Score Rank																																			
Option 1		6	6	6	6	6	6	6	6	6	6	6	4	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6				
Option 2		2	2	5	3	2	4	3	5	2	4	5	4	2	4	5	3	4	5	5	5	3	4	4	4	5	5	4	4	5	5				
Option 3		2	4	3	4	2	5	4	2	4	5	4	4	1	3	4	2	3	3	3	3	1	1	2	5	3	2	2	2	4	2				
Option 4		5	5	4	5	4	3	4	3	5	2	3	3	5	5	3	4	5	4	4	4	4	5	3	2	2	2	5	5	3	4				
Option 5		1	1	1	2	1	2	2	1	3	3	2	2	4	2	1	1	2	2	2	2	5	3	5	2	4	4	3	3	2	1				
Option 6		4	2	1	1	5	1	1	3	1	1	1	1	3	1	2	5	1	1	1	1	1	1	1	1	1	1	1	1	1	3				

Weighted Scores																															Total	Average		Mode	Rank
Option 1		296	316	124	248	248	392	328	454	342	144	162	400	0	104	40	62	112	60	0	162	130	200	30	132	36	42	254	148	36	0	5,002	166.73		138	6
Option 2		512	504	396	630	700	486	584	622	786	428	538	440	468	570	154	536	570	356	210	648	494	688	390	480	300	276	600	350	284	616	14,616	487.20		499	4
Option 3		520	514	580	618	696	492	546	682	738	412	532	448	474	588	248	724	600	448	280	688	500	718	450	456	396	408	648	602	318	888	16,202	540.07		526	3
Option 4		436	436	542	616	650	558	562	652	504	486	554	480	238	422	380	490	464	408	186	630	446	628	418	526	394	388	538	364	378	744	14,518	483.93		483	5
Option 5		602	616	624	694	738	614	624	710	762	422	604	710	338	612	534	738	634	508	302	712	432	690	358	542	348	352	626	564	474	946	17,430	581.00		613	2
Option 6		492	518	616	684	642	660	672	640	830	716	682	794	422	724	480	466	792	578	604	740	500	724	768	878	874	872	762	706	###	876	20,712	690.40		695	1

Weighted Rank																															Mode	Median	1st Rank	2nd Rank	3rd Rank	4th Rank	5th Rank	6th Rank
Option 1		6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	0	0	0	0	0	30
Option 2		3	4	5	3	2	5	3	5	2	3	4	5	2	4	5	3	4	5	4	4	3	4	4	4	5	5	4	5	5	5	5	4	0	3	6	10	11	0
Option 3		2	3	3	4	3	4	5	2	4	5	5	4	1	3	4	2	3	3	3	3	1	2	2	5	3	2	2	2	4	2	2	3	2	9	9	6	4	0
Option 4		5	5	4	5	4	3	4	3	5	2	3	3	5	5	3	4	5	4	5	5	4	5	3	3	2	3	5	4	3	4	5	4	0	2	9	8	11	0
Option 5		1	1	1	1	1	2	2	1	3	4	2	2	4	2	1	1	2	2	2	2	5	3	5	2	4	4	3	3	2	1	2	2	9	11	4	4	2	0
Option 6		4	2	2	2	5	1	1	4	1	1	1	1	3	1	2	5	1	1	1	1	1	1	1	1	1	1	1	1	1	3	1	1	20	4	2	2	2	0

Ref	Benefit Criteria		Option 1																															
		Weight	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Average	Mode	Median
		%																																
1	Better access to services	6	2	2	1	2	3	4	3	4	3	2	2	3	0	0	0	0	0	1	0	2	1	3	0	1	0	0	4	1	0	0	44	1.47	0	1
2	Improved clinical quality of services	15	4	4	1	3	3	4	3	5	4	1	1	3	0	4	0	0	0	0	0	2	1	2	0	0	0	0	2	1	0	0	48	1.60	0	1
3	Improved environmental quality of services	17	3	3	1	2	3	3	4	5	4	1	1	4	0	4	2	2	2	1	0	2	1	2	0	3	1	0	2	1	0	0	57	1.90	1	2
4	Developing existing services and / or providing new services	15	3	3	1	2	2	4	4	4	2	1	1	4	0	0	0	2	2	1	0	1	1	2	0	2	0	0	2	1	0	0	45	1.50	0	1
5	Improved strategic fit of services	10	3	3	1	1	3	3	3	4	4	2	2	3	0	0	0	0	0	0	0	1	1	1	0	1	0	0	2	1	0	0	39	1.30	0	1
6	Meeting national, regional and local policy imperatives	10	4	4	1	3	1	3	3	6	3	2	2	5	0	0	0	0	2	1	0	1	1	2	0	1	0	0	2	1	0	0	48	1.60	0	1
7	Meeting training, teaching and research needs	15	2	2	1	2	4	4	3	3	2	1	2	5	0	0	0	0	2	0	0	1	1	2	0	2	0	0	3	1	0	0	43	1.43	0	1
8	Making more effective use of resources	6	2	3	1	0	2	4	3	4	4	1	1	4	0	0	2	0	2	0	0	1	1	2	0	1	0	0	2	1	0	0	41	1.37	0	1
9	Ease of Delivery	6	3	4	5	10	2	7	5	5	5	2	4	8	0	0	0	5	2	2	0	4	6	0	5	5	5	7	4	9	6	0	120	4.00	5	4.5
	Total		26	28	13	25	23	36	31	40	31	13	16	39	0	8	4	9	12	6	0	15	14	16	5	16	6	7	23	17	6	0	485	16.17	6	14
			3	3.1	1.2	2.5	2.7	3.8	3.4	4.4	3.3	1.3	1.6	4.2	0	1.3	0.5	0.9	1.4	0.6	0	1.6	1.3	1.8	0.3	1.7	0.5	0.4	2.4	1.5	0.4	0				

Ref	Benefit Criteria		Option 2																															
		Weight	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Average	Mode	Median
		%																																
1	Better access to services	6	4	4	3	5	7	4	6	6	9	4	4	4	6	7	2	5	8	5	3	6	5	7	5	6	2	2	6	3	0	2	140	4.67	4	5
2	Improved clinical quality of services	15	5	5	4	7	7	5	5	6	8	3	7	5	6	7	3	6	5	3	0	5	5	7	3	3	1	3	6	4	4	7	145	4.83	5	5
3	Improved environmental quality of services	17	5	5	3	6	8	5	6	6	8	3	5	6	6	5	2	6	8	5	4	6	5	7	5	5	4	3	6	5	3	6	157	5.23	5	5
4	Developing existing services and / or providing new services	15	6	6	4	6	7	6	7	7	6	4	5	4	4	5	0	6	4	2	4	8	5	7	3	6	4	3	6	3	3	7	148	4.93	6	5
5	Improved strategic fit of services	10	5	6	4	6	7	4	5	6	6	4	3	3	4	5	1	5	4	5	2	6	3	7	3	4	4	3	6	2	3	5	131	4.37	4	4
6	Meeting national, regional and local policy imperatives	10	5	5	5	7	7	5	6	6	7	5	6	6	3	5	0	5	6	4	2	8	5	7	4	4	4	3	6	3	3	10	152	5.07	5	5
7	Meeting training, teaching and research needs	15	5	5	4	5	7	5	5	8	8	5	5	4	4	4	0	5	5	2	2	8	5	6	3	5	2	3	7	3	3	5	138	4.60	5	5
8	Making more effective use of resources	6	6	5	4	7	7	5	6	6	9	6	6	3	4	5	2	5	5	2	2	7	5	7	5	5	5	3	6	3	3	7	151	5.03	5	5
9	Ease of Delivery	6	6	6	5	7	6	5	7	6	8	5	5	4	3	5	2	5	5	5	2	5	6	6	3	7	3	2	5	7	6	6	153	5.10	5	5
	Total		47	47	36	56	63	44	53	57	69	39	46	39	40	48	12	48	50	33	21	59	44	61	34	45	29	25	54	33	28	55	1,315	43.83	44	44
			5.2	5.3	3.9	6.2	7.1	5	5.8	6.5	7.5	4.1	5.2	4.5	4.6	5.3	1.3	5.5	5.5	3.5	2.4	6.7	4.9	6.8	3.7	4.8	3.1	2.9	6.1	3.6	3.2	6.3				

Ref	Benefit Criteria		Option 3																															
		Weight	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Average	Mode	Median
		%																																
1	Better access to services	6	5	5	6	6	8	5	5	8	9	3	3	4	5	7	4	8	8	5	3	6	5	7	4	5	3	2	7	6	3	9	164	5.47	5	5
2	Improved clinical quality of services	15	5	5	6	6	7	5	5	6	7	4	7	5	5	7	3	7	4	3	2	6	5	7	5	2	2	5	6	7	3	12	159	5.30	5	5
3	Improved environmental quality of services	17	5	5	5	6	8	4	6	7	7	3	5	4	5	5	2	7	8	5	4	6	5	8	5	4	2	5	6	5	3	5	155	5.17	5	5
4	Developing existing services and / or providing new services	15	5	5	6	5	7	6	7	7	6	5	5	6	5	5	4	7	6	5	4	8	5	7	5	5	7	6	5	6	3	8	172	5.73	5	5.5
5	Improved strategic fit of services	10	5	4	7	7	6	4	7	7	8	5	7	3	6	6	2	8	7	5	4	7	5	8	4	5	4	4	6	5	3	5	164	5.47	5	5
6	Meeting national, regional and local policy imperatives	10	5	5	5	7	6	5	6	5	7	5	6	6	4	5	0	8	6	5	2	8	5	7	4	5	5	5	6	6	3	10	162	5.40	5	5
7	Meeting training, teaching and research needs	15	5	5	6	5	7	5	5	8	7	5	5	4	5	5	2	7	7	5	5	8	5	8	5	5	7	4	7	5	3	5	165	5.50	5	5
8	Making more effective use of resources	6	6	6	6	7	6	5	5	7	7	4	6	3	5	5	2	6	5	5	2	8	5	7	5	6	5	4	7	6	3	10	164	5.47	5	5.5
9	Ease of Delivery	6	6	6	5	6	8	4	4	8	8	4	3	4	2	6	2	7	5	3	2	5	5	7	3	3	4	3	6	6	6	6	147	4.90	6	5
	Total		47	46	52	55	63	43	50	63	66	38	47	39	42	51	21	65	56	41	28	62	45	66	40	42	37	37	58	52	30	70	1,452	48.40	46	46
			5.1	5	5.8	6	7	4.8	5.7	6.9	7.1	4.3	5.4	4.5	4.8	5.6	2.4	7.2	6.3	4.6	3.4	7	5	7.4	4.6	4.6	4.1	4.4	6.4	5.7	3.2	7.6				

Ref	Benefit Criteria		Option 4																															
		Weight	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Average	Mode	Median
		%																																
1	Better access to services	6	4	4	5	6	5	5	6	6	7	5	4	4	1	3	5	2	0	4	0	4	2	4	3	3	1	1	3	4	3	7	111	3.70	4	4
2	Improved clinical quality of services	15	4	4	5	7	7	6	5	6	5	4	7	5	1	3	3	4	4	2	0	5	5	6	5	5	1	5	5	4	3	10	136	4.53	5	5
3	Improved environmental quality of services	17	4	4	5	5	7	5	5	7	5	5	5	4	3	5	4	5	8	5	4	6	5	7	4	5	5	5	6	4	3	4	149	4.97	5	5
4	Developing existing services and / or providing new services	15	5	5	6	6	7	6	6	6	2	5	6	6	3	5	4	6	6	5	4	8	5	6	3	6	5	3	7	3	3	8	156	5.20	6	5.5
5	Improved strategic fit of services	10	4	4	7	6	7	5	5	7	5	4	4	3	3	6	4	6	6	5	4	7	5	8	5	7	5	4	5	2	5	4	152	5.07	5	5
6	Meeting national, regional and local policy imperatives	10	5	5	5	7	7	6	6	7	5	5	6	6	3	5	4	5	6	4	2	8	5	7	4	5	5	5	6	4	4	8	161	5.37	5	5
7	Meeting training, teaching and research needs	15	5	5	6	5	7	6	5	8	5	6	5	7	3	5	2	5	7	5	5	8	5	8	5	6	7	5	6	3	4	5	164	5.47	5	5
8	Making more effective use of resources	6	4	4	6	6	6	6	6	7	4	5	6	4	4	4	4	8	6	5	2	7	5	7	5	7	7	4	7	3	4	8	161	5.37	4	5.5
9	Ease of Delivery	6	5	5	5	5	7	4	6	6	7	6	5	4	3	6	3	6	5	5	2	7	5	7	4	6	6	5	5	5	6	6	157	5.23	5	5
	Total		40	40	50	53	60	49	50	60	45	45	48	43	24	42	33	47	48	40	23	60	42	60	38	50	42	37	50	32	36	60	1,347	44.90	44	45
			4.5	4.5	5.6	5.9	6.8	5.6	5.4	6.7	4.7	5	5.5	5	2.6	4.7	3.6	5.2	5.8	4.4	2.9	6.8	4.8	6.8	4.3	5.6	4.6	4.3	5.7	3.5	3.8	6.6				

Ref	Benefit Criteria		Option 5																															
		Weight	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Average	Mode	Median
		%																																
1	Better access to services	6	6	6	7	7	8	6	6	8	8	4	6	6	4	8	8	8	8	5	2	7	3	5	3	6	2	3	7	6	6	8	177	5.90	6	6
2	Improved clinical quality of services	15	7	7	6	8	7	5	7	7	8	3	7	8	3	7	6	7	4	5	2	6	4	7	4	5	2	4	6	6	6	15	179	5.97	7	6
3	Improved environmental quality of services	17	8	8	6	7	7	6	6	7	8	4	5	6	3	5	4	7	8	5	4	6	4	7	4	6	3	4	5	7	3	4	167	5.57	4	6
4	Developing existing services and / or providing new services	15	5	5	6	7	7	6	7	7	8	5	5	9	3	5	5	7	6	5	4	8	5	7	3	5	5	3	6	5	3	8	170	5.67	5	5
5	Improved strategic fit of services	10	5	5	7	7	7	6	7	6	5	5	8	4	3	6	4	8	7	5	4	7	4	8	3	5	5	3	6	4	6	5	165	5.50	5	5
6	Meeting national, regional and local policy imperatives	10	5	5	5	7	7	7	6	7	8	5	6	7	3	5	4	8	6	6	2	8	5	7	3	4	4	3	6	5	6	11	171	5.70	5	6
7	Meeting training, teaching and research needs	15	6	6	7	5	7	6	5	8	8	5	5	8	3	6	4	7	7	5	5	8	5	7	5	5	2	3	5	5	3	5	166	5.53	5	5
8	Making more effective use of resources	6	6	7	7	6	8	7	6	6	7	4	6	7	4	5	4	7	7	5	4	8	5	8	4	6	5	4	7	6	3	11	180	6.00	7	6
9	Ease of Delivery	6	6	6	5	7	8	7	5	8	7	5	5	8	4	6	6	7	6	4	4	6	5	8	4	8	6	5	7	6	3	5	177	5.90	6	6

	Total		54	55	56	61	66	56	55	64	67	40	53	63	30	53	45	66	59	45	31	64	40	64	33	50	34	32	55	50	39	72	1,552	51.73	50	51
			6.1	6.2	6.2	6.8	7.2	6.1	6.2	7.1	7.6	4.4	5.8	7.1	3.2	5.8	4.8	7.3	6.5	5	3.5	7.1	4.5	7.1	3.7	5.4	3.5	3.5	5.9	5.6	4.2	7.9				

Ref	**Benefit Criteria**		**Option 6**																																
		Weight	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Average	Mode	Median
		%																																		
1	Better access to services	6	4	4	6	7	6	7	6	6	8	7	7	8	5	7	8	5	9	6	7	6	5	6	7	10	7	7	8	7	10	9	205	6.83	7	7
2	Improved clinical quality of services	15	6	6	6	7	6	8	6	9	8	7	9	4	8	4	4	8	6	6	8	5	8	9	10	10	9	8	7	10	12	220	7.33	6	7.5
3	Improved environmental quality of services	17	5	5	6	7	7	6	7	7	8	6	8	7	4	5	3	4	9	7	6	6	5	8	8	9	9	9	7	8	10	5	201	6.70	7	7
4	Developing existing services and / or providing new services	15	6	6	7	8	7	6	8	7	9	8	7	8	5	8	4	5	8	5	7	8	5	8	7	9	10	9	8	8	10	8	219	7.30	8	8
5	Improved strategic fit of services	10	5	5	7	8	6	7	8	6	9	8	7	8	4	8	3	6	8	7	6	8	5	9	7	9	10	9	8	6	10	5	212	7.07	8	7
6	Meeting national, regional and local policy imperatives	10	5	5	5	8	6	7	6	6	9	6	6	9	4	8	3	4	6	6	6	8	5	7	8	6	7	9	7	7	10	10	199	6.63	6	6
7	Meeting training, teaching and research needs	15	5	6	7	6	7	6	5	8	8	7	5	6	4	7	3	5	8	5	6	8	5	8	8	9	10	9	8	7	10	5	201	6.70	5	7
8	Making more effective use of resources	6	4	5	7	6	6	8	6	6	7	7	8	9	4	6	6	5	9	6	6	8	5	7	8	9	10	10	8	8	10	10	214	7.13	6	7
9	Ease of Delivery	6	4	5	5	6	6	5	6	8	7	7	5	2	3	7	6	5	5	3	2	6	5	5	5	6	6	8	5	4	10	4	161	5.37	5	5
	Total		44	47	56	62	58	58	60	60	74	64	60	66	37	64	40	43	70	51	52	66	45	66	67	77	79	79	67	62	90	68	1,832	61.07	58	62
			5.1	5.4	6.3	6.9	6.6	6.3	6.8	6.7	8.4	7.1	6.7	7.5	4.2	7.1	4	4.7	7.9	5.8	6	7.4	5	7.6	7.7	8.7	9.1	8.9	7.6	7.1	10	7.5				

Total Scores																															Total	Average	Mean	Mode	Rank
Option 1		26	28	13	25	23	36	31	40	31	13	16	39	0	8	4	9	12	6	0	15	14	16	5	16	6	7	23	17	6	0	485	16.17	16	14.5	6
Option 2		47	47	36	56	63	44	53	57	69	39	46	39	40	48	12	48	50	33	21	59	44	61	34	45	29	25	54	33	28	55	1,315	43.83	47	45.5	5
Option 3		47	46	52	55	63	43	50	63	66	38	47	39	42	51	21	65	56	41	28	62	45	66	40	42	37	37	58	52	30	70	1,452	48.40	47	47	3
Option 4		40	40	50	53	60	49	50	60	45	45	48	43	24	42	33	47	48	40	23	60	42	60	38	50	42	37	50	32	36	60	1,347	44.90	60	45	4
Option 5		54	55	56	61	66	56	55	64	67	40	53	63	30	53	45	66	59	45	31	64	40	64	33	50	34	32	55	50	39	72	1,552	51.73	55	54.5	2
Option 6		44	47	56	62	58	58	60	60	74	64	60	66	37	64	40	43	70	51	52	66	45	66	67	77	79	79	67	62	90	68	1,832	61.07	60	62	1

Score Rank																																			
Option 1		6	6	6	6	6	6	6	6	6	6	6	4	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6				
Option 2		2	2	5	3	2	4	3	5	2	4	5	4	2	4	5	3	4	5	5	5	3	4	4	4	5	5	4	4	5	5				
Option 3		2	4	3	4	2	5	4	2	4	5	4	4	1	3	4	2	3	3	3	3	1	1	2	5	3	2	2	2	4	2				
Option 4		5	5	4	5	4	3	4	3	5	2	3	3	5	5	3	4	5	4	4	4	4	5	3	2	2	2	5	5	3	4				
Option 5		1	1	1	2	1	2	2	1	3	3	2	2	4	2	1	1	2	2	2	2	5	3	5	2	4	4	3	3	2	1				
Option 6		4	2	1	1	5	1	1	3	1	1	1	1	3	1	2	5	1	1	1	1	1	1	1	1	1	1	1	1	1	3				

Weighted Scores																															Total	Average		Mode	Rank
Option 1		298	310	124	251	268	381	344	443	330	132	159	418	0	128	46	94	138	60	0	156	130	184	30	173	47	42	239	148	36	0	5,109	170.30		143	6
Option 2		521	525	393	616	711	499	581	645	752	411	520	453	460	527	125	547	554	352	240	665	486	679	368	483	313	288	609	363	315	627	14,628	487.60		509.5	5
Option 3		512	502	577	596	703	492	571	692	713	427	542	449	482	558	237	720	629	458	335	696	500	742	462	462	406	439	642	573	318	760	16,185	539.50		527	3
Option 4		446	446	556	587	682	555	543	673	473	496	545	500	264	468	355	516	577	439	287	675	482	677	425	556	464	430	572	350	379	659	15,077	502.57		498	4
Option 5		614	620	621	679	718	607	619	711	758	441	582	713	318	579	481	726	647	504	353	708	446	710	374	537	354	350	586	557	423	792	17,128	570.93		596.5	2
Option 6		512	539	630	693	662	632	682	674	838	713	671	748	415	710	396	468	791	579	597	742	500	764	766	873	911	888	755	710	###	748	20,607	686.90		701.5	1

Weighted Rank																															Mode	Median	1st Rank	2nd Rank	3rd Rank	4th Rank	5th Rank	6th Rank
Option 1		6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	0	0	0	0	0	30
Option 2		2	3	5	3	2	4	3	5	3	5	5	4	2	4	5	3	5	5	5	5	3	4	5	4	5	5	3	4	5	5	5	4	0	3	7	6	14	0
Option 3		3	4	3	4	3	5	4	2	4	4	4	5	1	3	4	2	3	3	3	3	1	2	2	5	3	2	2	2	4	2	3	3	2	8	9	8	3	0
Option 4		5	5	4	5	4	3	5	4	5	2	3	3	5	5	3	4	4	4	4	4	4	5	3	2	2	3	5	5	3	4	5	4	0	3	7	10	10	0
Option 5		1	1	2	2	1	2	2	1	2	3	2	2	4	2	1	1	2	2	2	2	5	3	4	3	4	4	4	3	2	1	2	2	7	13	4	5	1	0
Option 6		3	2	1	1	5	1	1	3	1	1	1	1	3	1	2	5	1	1	1	1	1	1	1	1	1	1	1	1	1	3	1	1	22	2	4	0	2	0

APPENDIX I

FINANCIAL APPRAISAL

- Attached to this Appendix is the summary output of the financial and economic option appraisal. In the interests of Commercial Confidentiality, detailed workings of the financial models are not included.

FINANCIAL AND ECONOMIC ANALYSIS	USING MIPS UPDATE
SUMMARY OF OUTPUTS	VOLUME 13 No.2

TRUST:	WALSALL HOSPITALS NHS TRUST
PROJECT:	MANOR HOSPITAL REDEVELOPMENT
PRICE BASE:	2003/04

1. CAPITAL	COST SUMMARY:	MIPS VOP	OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5	OPTION 5A	OPTION 6
			£000	£000	£000	£000	£000	£000	£000
	Works Cost		14,958	62,470	64,503	64,163	63,165	81,353	80,283
	Fees		1,962	7,901	8,155	8,113	7,988	10,262	10,128
	Equipment (Groups 2 and 3)		1,105	8,660	8,660	8,720	8,660	9,086	9,086
	Non works costs		155	305	305	805	305	1,305	1,305
	Planning contingency		2,727	11,900	12,243	12,270	12,018	15,301	15,120
	VAT @17.5% - fees excepted		3,264	14,376	14,785	14,830	14,516	18,464	18,248
	AT APPROVAL LEVEL MIPS	**385**	**24,171**	**105,613**	**108,652**	**108,901**	**106,653**	**135,770**	**134,171**
	AT OUTTURN LEVEL MIPS	**448**	**29,682**	**129,608**	**133,351**	**133,540**	**130,888**	**166,507**	**164,536**
	AT CURRENT LEVEL		**26,889**	**117,216**	**120,614**	**120,782**	**118,379**	**150,684**	**148,896**
	LAND ACQUISITION not included above		**0**	**0**	**0**	**0**	**0**	**0**	**0**

2. REVENUE	COST SUMMARY:		OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5	OPTION 5A	OPTION 6
			£000	£000	£000	£000	£000	£000	£000
	Base Year	**2003/04**							
	Clinical		76,773	76,773	76,773	76,773	76,773	76,773	76,773
	PFI Services		12,550	12,550	12,550	12,550	12,550	12,550	12,550
	Trust Retained Services		10,222	10,222	10,222	10,222	10,222	10,222	10,222
	Other Revenue Costs		0	0	0	0	0	0	0
	Gross Expenditure excluding Capital Charges		99,545	99,545	99,545	99,545	99,545	99,545	99,545
	Capital Charges		9,222	9,222	9,222	9,222	9,222	9,222	9,222
	Gross Expenditure		**108,767**	**108,767**	**108,767**	**108,767**	**108,767**	**108,767**	**108,767**
	Category C Income		(8,101)	(8,101)	(8,101)	(8,101)	(8,101)	(8,101)	(8,101)
	Net Expenditure		**100,665**	**100,665**	**100,665**	**100,665**	**100,665**	**100,665**	**100,665**
	Forecast Year	**2010/11**							
	Clinical		76,891	76,891	76,891	76,891	76,891	76,803	76,803
	PFI Services		12,417	12,988	12,893	12,965	12,950	13,082	13,105
	Trust Retained Services		9,896	9,896	9,896	9,896	9,896	9,896	9,896
	Other Revenue Costs		0	0	0	0	0	0	0
	Gross Expenditure excluding Capital Charges		99,204	99,775	99,680	99,752	99,737	99,780	99,803
	Capital Charges		8,808	14,764	14,966	14,982	14,833	16,603	16,496
	Gross Expenditure		**108,012**	**114,539**	**114,646**	**114,734**	**114,570**	**116,383**	**116,299**
	Category C Income		(8,349)	(8,349)	(8,349)	(8,349)	(8,349)	(8,349)	(8,349)
	Net Expenditure		**99,663**	**106,189**	**106,296**	**106,385**	**106,220**	**108,033**	**107,950**
	Revenue Impact - Change over base at	**2010/11**							
	Clinical		118	118	118	118	118	29	29
	PFI Services		(133)	438	343	415	400	532	555
	Trust Retained Services		(326)	(326)	(326)	(326)	(326)	(326)	(326)
	Other Revenue Costs		0	0	0	0	0	0	0
	Gross Expenditure excluding Capital Charges		(341)	230	135	207	192	235	258
	Capital Charges		(414)	5,542	5,744	5,760	5,611	7,381	7,274
	Gross Expenditure - Increase / (Savings)		**(755)**	**5,772**	**5,879**	**5,967**	**5,803**	**7,616**	**7,532**
	Category C Income		(248)	(248)	(248)	(248)	(248)	(248)	(248)
	Net Expenditure - Increase / (Savings)		**(1,003)**	**5,524**	**5,631**	**5,719**	**5,555**	**7,368**	**7,284**
	VARIANCE OVER OPTION 2			**0**	**107**	**196**	**31**	**1,844**	**1,761**

3. ECONOMIC	SUMMARY ANALYSIS:	YEARS	OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5	OPTION 5A	OPTION 6
	NOT TAX ADJUSTED	**66**							
	DISCOUNT RATE	**3.50%**							
			£000	£000	£000	£000	£000	£000	£000
	Net Present Value (NPV)		2,553,297	2,651,759	2,653,117	2,655,066	2,652,110	2,671,515	2,670,240
	Equivalent Annual Cost EAC)		93,973	97,597	97,647	97,719	97,610	98,324	98,278
	RANK		**1**	**2**	**4**	**5**	**3**	**7**	**6**
	EAC SWITCH VALUE OVER OPTION 2			**13**	**(50)**	**(122)**	**(13)**	**(727)**	**(680)**

APPENDIX J

THE PREFERRED OPTION

Option 6: The Radical Solution (with replacement of South Block)

As detailed under section 8 of the Outline Business Case, Option 6 has been selected as the preferred option.

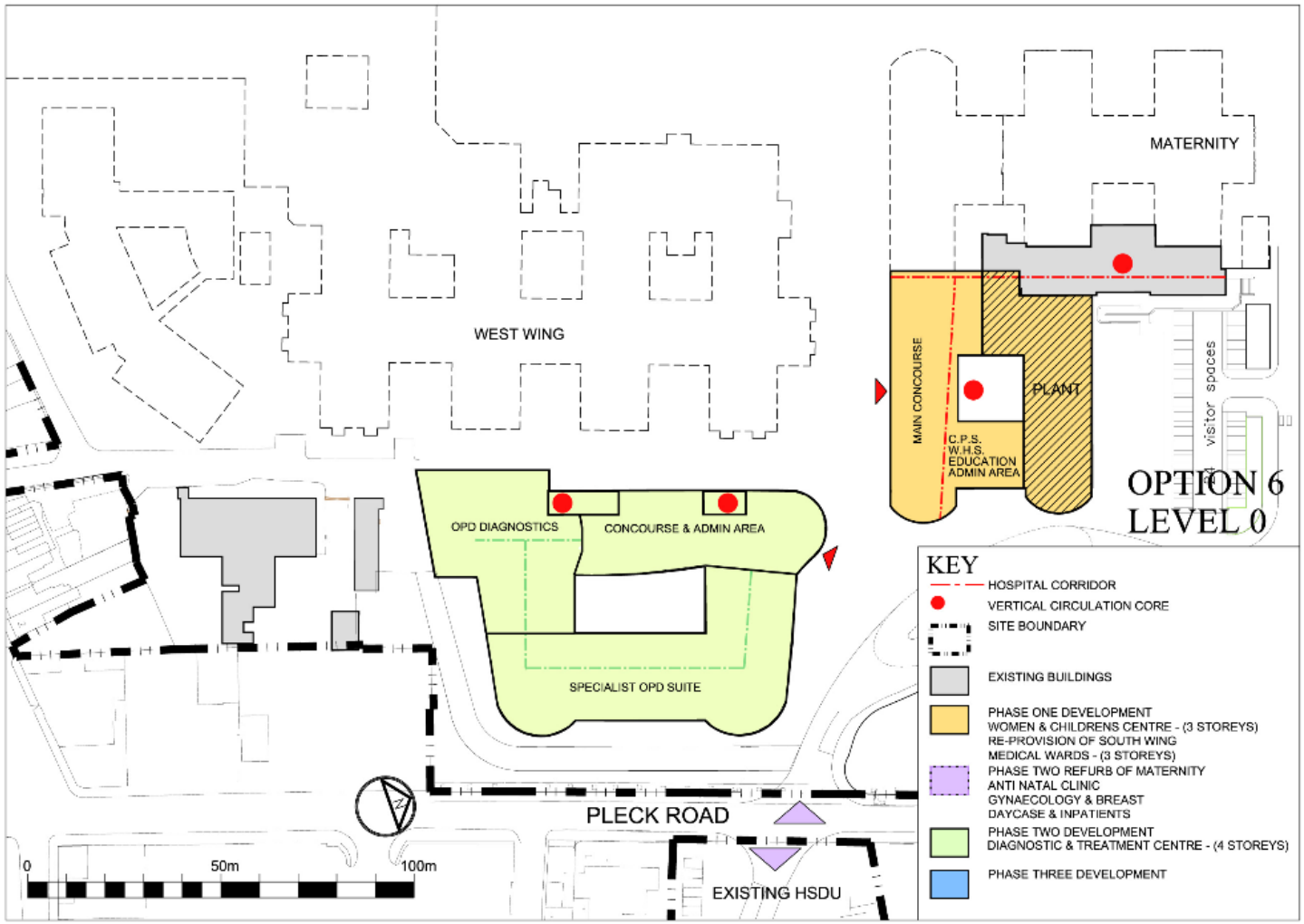
Attached to this Appendix are block plans for this option which show departmental relationships on a floor by floor basis together with a site cross section:

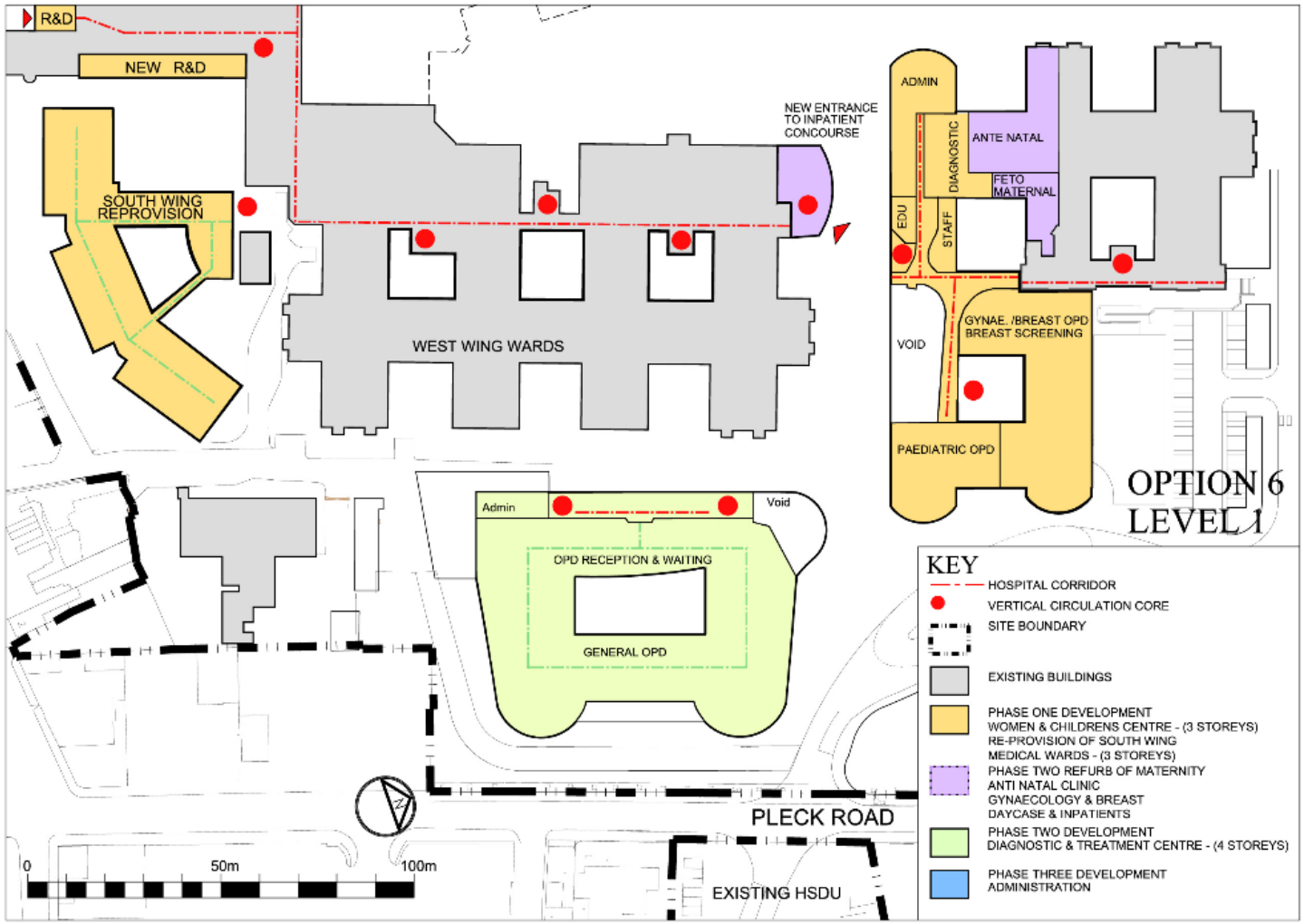
- Lower ground floor
- Ground Floor
- First Floor
- Second Floor
- Cross Sections

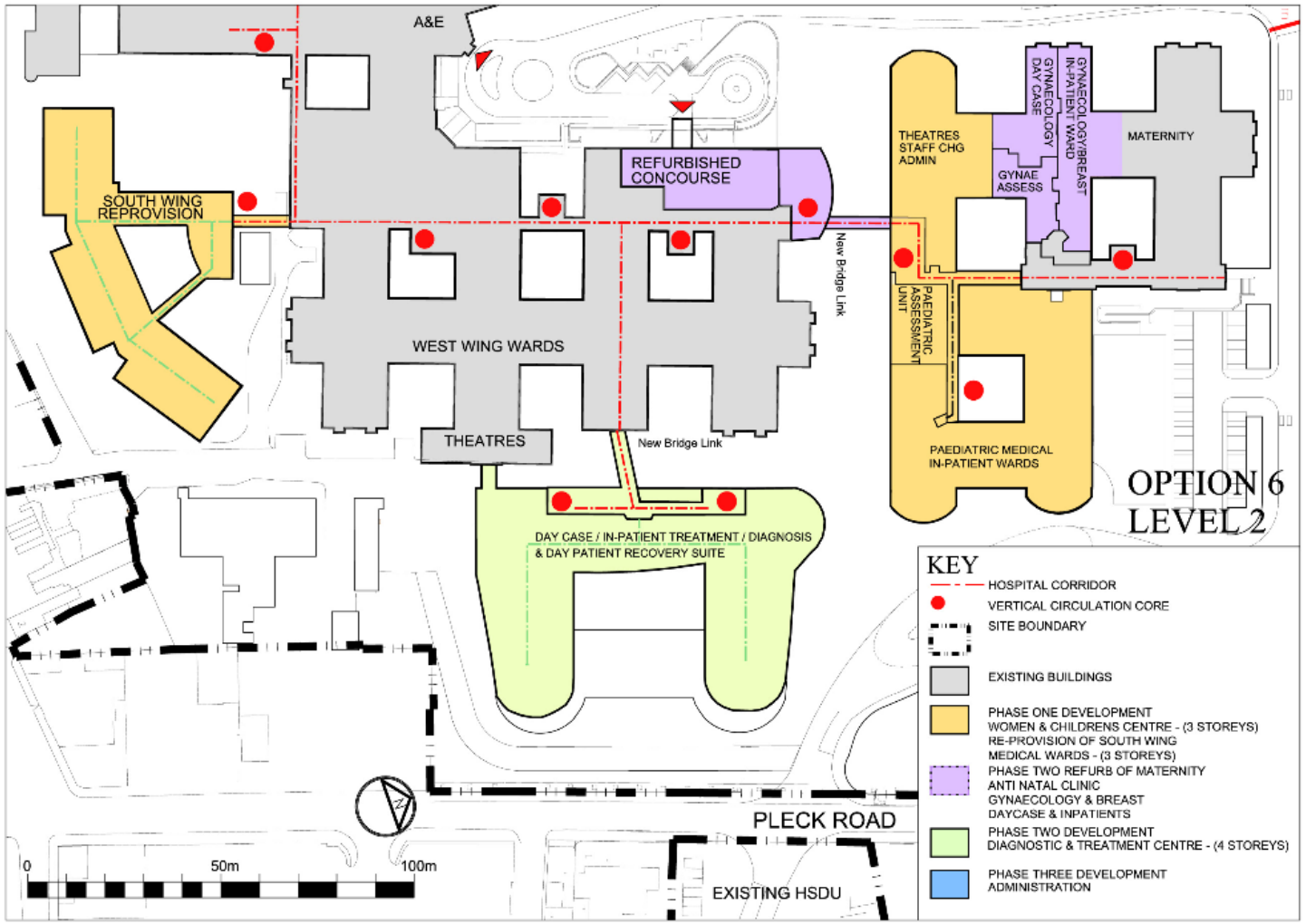
In addition the Trust has developed this option further and produced a series of 1:200 scale plans showing room relationships and room sizes. The purpose of these drawings are twofold:

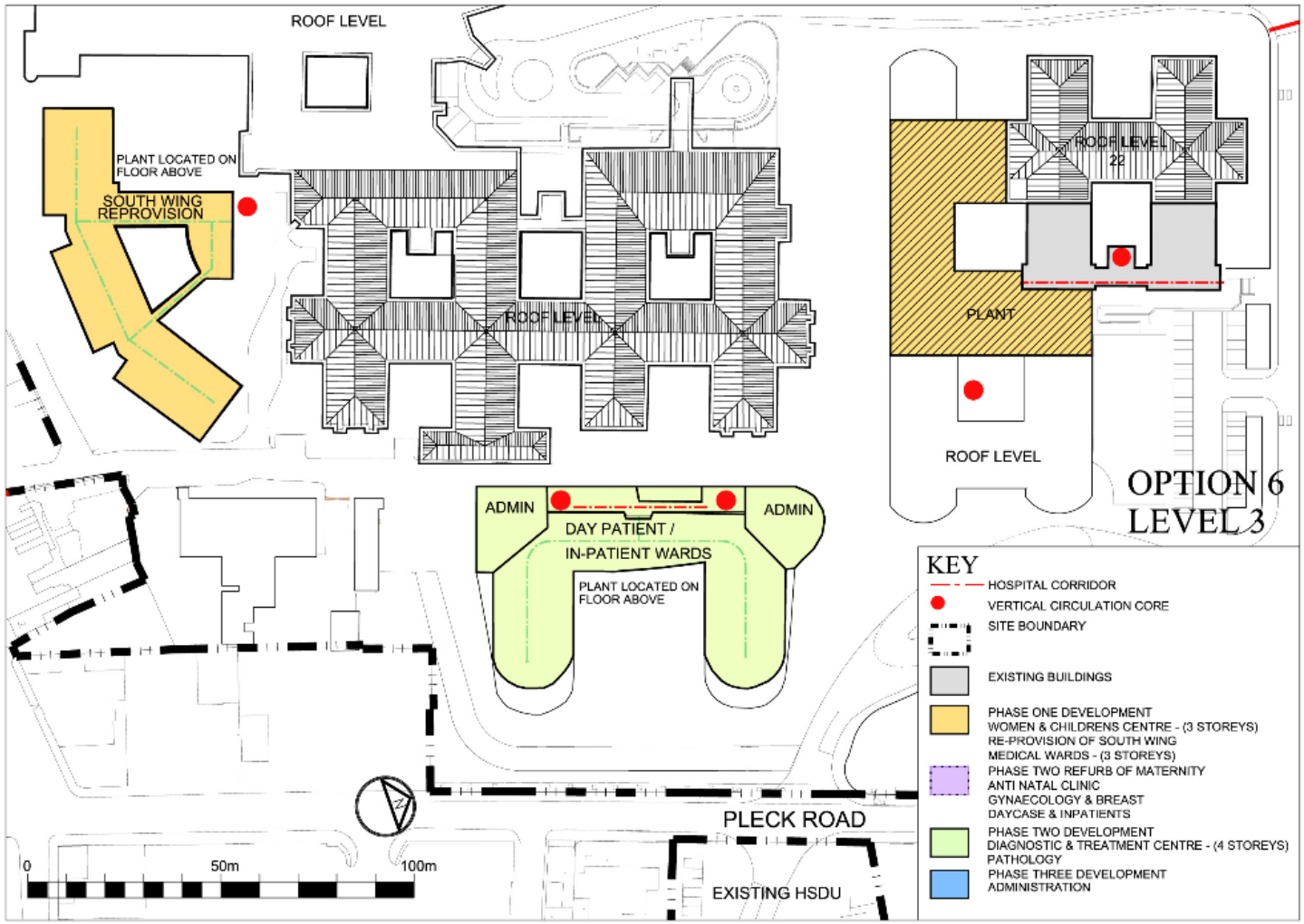
- To underpin the Capital Costs by validating the schedules of accommodation including circulation allowances, DCA's and On-costs.
- To test the Clinical Output Specifications to ensure consistency between the Models of Care, Schedules of Accommodation and potential physical solutions.

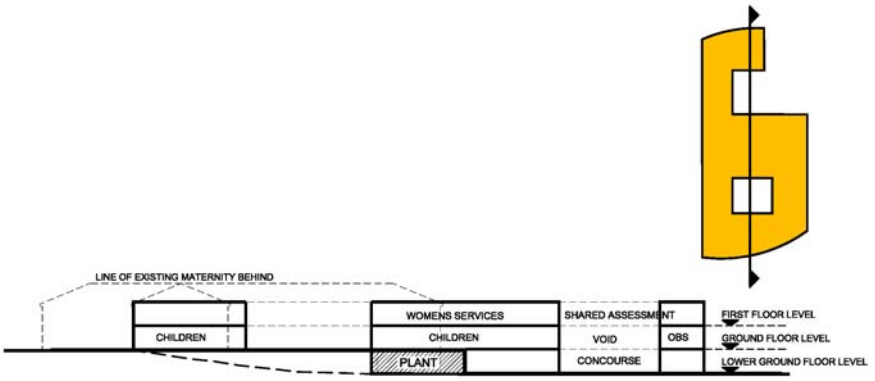
These 1:200 will form an integral part of the Public Sector Comparator in the Full Business Case.


MATERNITY
WEST WING
MAIN CONCOURSE
PLANT
C.P.S.
W.H.S.
EDUCATION
ADMIN AREA
visitor spaces
OPD DIAGNOSTICS
CONCOURSE & ADMIN AREA
SPECIALIST OPD SUITE
OPTION 6
LEVEL 0
KEY
HOSPITAL CORRIDOR
VERTICAL CIRCULATION CORE
SITE BOUNDARY
EXISTING BUILDINGS
PHASE ONE DEVELOPMENT
WOMEN & CHILDRENS CENTRE - (3 STOREYS)
RE-PROVISION OF SOUTH WING
MEDICAL WARDS - (3 STOREYS)
PHASE TWO REFURB OF MATERNITY
ANTI NATAL CLINIC
GYNAECOLOGY & BREAST
DAYCASE & INPATIENTS
PHASE TWO DEVELOPMENT
DIAGNOSTIC & TREATMENT CENTRE - (4 STOREYS)
PHASE THREE DEVELOPMENT
PLECK ROAD
EXISTING HSDU
0
50m
100m

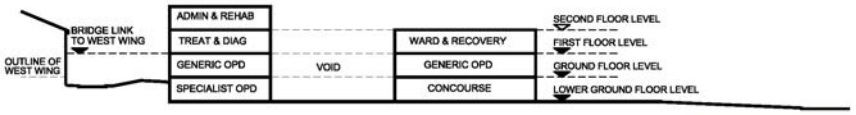

R&D
NEW R&D
SOUTH WING REPROVISION
NEW ENTRANCE TO INPATIENT CONCOURSE
WEST WING WARDS
ADMIN
ANTE NATAL
DIAGNOSTIC
FETO MATERNAL
EDU
STAFF
VOID
GYNAE. /BREAST OPD BREAST SCREENING
PAEDIATRIC OPD
OPTION 6
LEVEL 1
Admin
Void
OPD RECEPTION & WAITING
GENERAL OPD
PLECK ROAD
EXISTING HSDU
0
50m
100m
KEY
HOSPITAL CORRIDOR
VERTICAL CIRCULATION CORE
SITE BOUNDARY
EXISTING BUILDINGS
PHASE ONE DEVELOPMENT
WOMEN & CHILDRENS CENTRE - (3 STOREYS)
RE-PROVISION OF SOUTH WING
MEDICAL WARDS - (3 STOREYS)
PHASE TWO REFURB OF MATERNITY
ANTI NATAL CLINIC
GYNAECOLOGY & BREAST
DAYCASE & INPATIENTS
PHASE TWO DEVELOPMENT
DIAGNOSTIC & TREATMENT CENTRE - (4 STOREYS)
PHASE THREE DEVELOPMENT
ADMINISTRATION


A&E
SOUTH WING REPROVISION
REFURBISHED CONCOURSE
WEST WING WARDS
THEATRES
New Bridge Link
THEATRES STAFF CHG ADMIN
GYNAECOLOGY DAY CASE
GYNAECOLOGY IN-PATIENT WARD
GYNAECOLOGY/BREAST
MATERNITY
GYNAE ASSESS
PAEDIATRIC ASSESSMENT UNIT
PAEDIATRIC MEDICAL IN-PATIENT WARDS
DAY CASE / IN-PATIENT TREATMENT / DIAGNOSIS & DAY PATIENT RECOVERY SUITE
OPTION 6
LEVEL 2
PLECK ROAD
EXISTING HSDU
0
50m
100m
KEY
HOSPITAL CORRIDOR
VERTICAL CIRCULATION CORE
SITE BOUNDARY
EXISTING BUILDINGS
PHASE ONE DEVELOPMENT
WOMEN & CHILDRENS CENTRE - (3 STOREYS)
RE-PROVISION OF SOUTH WING
MEDICAL WARDS - (3 STOREYS)
PHASE TWO REFURB OF MATERNITY
ANTI NATAL CLINIC
GYNAECOLOGY & BREAST
DAYCASE & INPATIENTS
PHASE TWO DEVELOPMENT
DIAGNOSTIC & TREATMENT CENTRE - (4 STOREYS)
PHASE THREE DEVELOPMENT
ADMINISTRATION

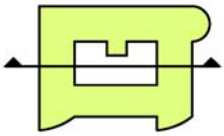

ROOF LEVEL
PLANT LOCATED ON FLOOR ABOVE
SOUTH WING REPROVISION
ROOF LEVEL
ROOF LEVEL 22
PLANT
ROOF LEVEL
OPTION 6
LEVEL 3
ADMIN
DAY PATIENT / IN-PATIENT WARDS
ADMIN
PLANT LOCATED ON FLOOR ABOVE
KEY
HOSPITAL CORRIDOR
VERTICAL CIRCULATION CORE
SITE BOUNDARY
EXISTING BUILDINGS
PHASE ONE DEVELOPMENT
WOMEN & CHILDRENS CENTRE - (3 STOREYS)
RE-PROVISION OF SOUTH WING
MEDICAL WARDS - (3 STOREYS)
PHASE TWO REFURB OF MATERNITY
ANTI NATAL CLINIC
GYNAECOLOGY & BREAST
DAYCASE & INPATIENTS
PHASE TWO DEVELOPMENT
DIAGNOSTIC & TREATMENT CENTRE - (4 STOREYS)
PATHOLOGY
PHASE THREE DEVELOPMENT
ADMINISTRATION
PLECK ROAD
0
50m
100m
EXISTING HSDU



SECTION THROUGH WOMEN & CHILDREN



SECTION THROUGH DTC BLOCK



OPTION 6 - SECTIONS

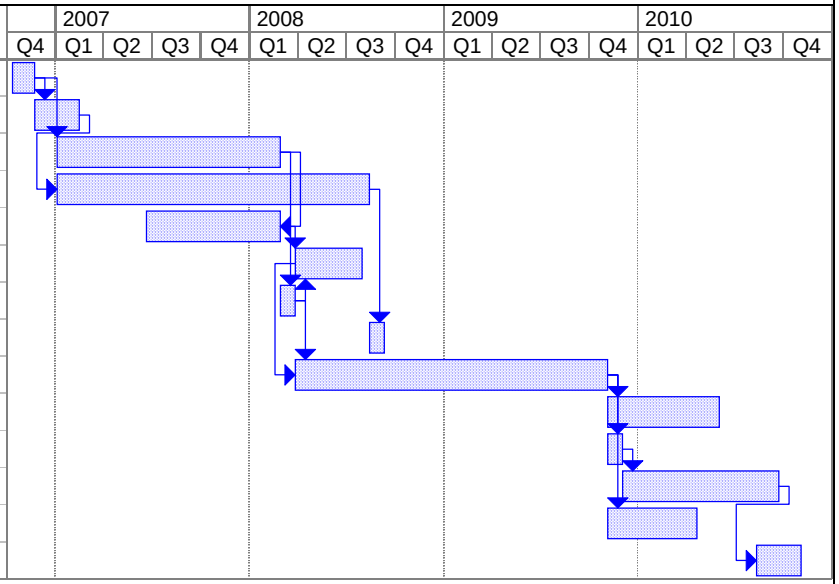
APPENDIX K

Construction Programme

Included in this Appendix is the Construction Programme for the Preferred Option.

Walsall Hospitals NHS Trust Timescale for Construction of Public Sector Comparator Appendix

ID	Task Name	Duration	Start	Finish	Predecessors
1	Mobilisation	6 wks	Fri 13/10/06	Thu 23/11/06	
2	Stage 1: Initial Preparatory Works	12 wks	Fri 24/11/06	Thu 15/02/07	1
3	Stage 2a: South Wing Replacement	60 wks	Fri 05/01/07	Thu 28/02/08	1FS+6 wks
4	Stage 2b: Women's, Children & Younger Persons Uni	84 wks	Fri 05/01/07	Thu 14/08/08	2FS-6 wks
5	Stage 2c: Temporary Works	36 wks	Fri 22/06/07	Thu 28/02/08	3FF
6	Stage 2d: Initial West Wing Works	18 wks	Fri 28/03/08	Thu 31/07/08	7,5
7	Stage 3a: Demolition of South Wing	4 wks	Fri 29/02/08	Thu 27/03/08	3
8	Stage 3b: Demolition of East Wing & St John's	4 wks	Fri 15/08/08	Thu 11/09/08	4
9	Stage 4a: Diagnostic & Treatment Centre	84 wks	Fri 28/03/08	Thu 05/11/09	6SS,7
10	Stage 4b: Assessment Unit	30 wks	Fri 06/11/09	Thu 03/06/10	9
11	Stage 5: Demolition SDU / Outpatients	4 wks	Fri 06/11/09	Thu 03/12/09	9
12	Stage 6a: Pathology	42 wks	Fri 04/12/09	Thu 23/09/10	11
13	Stage 6b: Final West Wing Works	24 wks	Fri 06/11/09	Thu 22/04/10	9
14	Stage 7: Final Site Works	12 wks	Fri 13/08/10	Thu 04/11/10	12FS-6 wks



Project: Construction Plan 09-06-04
Date: Fri 11/06/04

Task
Split
Progress
Milestone
Summary
Project Summary
External Tasks
External Milestone
Deadline

APPENDIX L

Risk Register

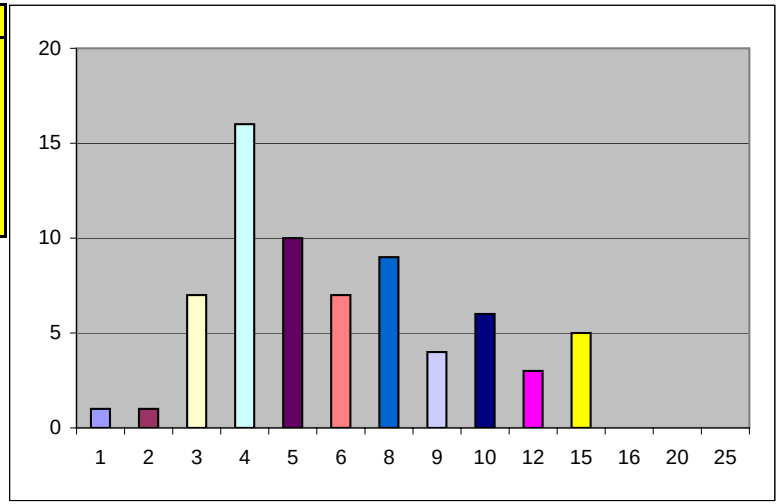
Included in this Appendix is the Risk Register developed by the Trust as outlined in section 10.9 of the OBC.

Walsall Hospitals NHS Trust: Manor Hospital Redevelopment PFI Project

Summary of Scores from Risk Register for Trust as at 9th February 2004

Score	Frequency
1	1
2	1
3	7
4	16
5	10
6	7
8	9
9	4
10	6
12	3
15	5
16	0
20	0
25	0
	69

Summary	
69	Number of Risk Items
459	Aggregate Risk Scores
6.65	Average Score
5	Middle Score
4	Most Common Score



Walsall Hospitals NHS Trust:
Manor Hospital Redevelopment PFI Project
Risk Register for Trust as at 9th February 2004

Risk Area			Risk Assessment				Risk Owner			Risk Commentary		
Ref.	Category	Description	Impact	Likelihood	Overall	Risk Level	Organisation	Officer	Advisor	Action to Mitigate	Date for Review	Notes
1	APP	Lack of agreed Whole Health Economy Strategy leads to delay in OBC approval and project launch	5	3	15	RED	TRUST	Chief Executive		(1) All whole health economy strategies to be signed off as part of the Black Country Review on 9 March. (2) Programme Board to be established to deliver Black Country Review. (3) Interim Steering Group to endure compliance with timetables for planning assumptions needed to deliver the OBC (4) Steering Group comprises all Chief Execs so has right people to resolve issues and push forward solutions	Weekly Advisory Team Review	Standing item for Project Team and Project Board Agenda
2	APP	Development of detailed PFI documentation delays launch	3	2	6	AMBER	TRUST	Project Director	SHP	1. Detailed project plan in place. 2. Weekly monitoring of progress. 3. Advisory Team resources identified. 4. Project Team resources identified.		
3	APP	Outline Planning Approval obtained, but discussions with Planning Authority may raise issues of cost or delay to the project	1	1	1	GREEN	TRUST	Project Director	SHP			
4	APP	No confirmation of OBC approval due to link of scheme to Wolverhampton	5	3	15	RED	TRUST	Project Director		1. Regular dialogue with Strategic Health Authority.	Weekly Advisory Team Review	Standing item for Project Team and Project Board Agenda
5	APP	Preparation of OBC documentation delayed	3	1	3	GREEN	TRUST	Project Director	SHP	1. Detailed project plan in place. 2. Weekly monitoring of progress. 3. Advisory Team resources identified. 4. Project Team resources identified.		
6	APP	Approval delay due to Enabling Works not being robust enough	3	1	3	GREEN	TRUST	Project Director	SHP			
7	APP	Affordability issues causes delay to OBC or requires a re-definition of the scheme	5	3	15	RED	TRUST	Project Director		1. Outline affordability impact discussed with PCTs. 2. Detailed programme of work in place for finalising affordability.	Weekly Advisory Team Review	Standing item for Project Team and Project Board Agenda
8	APP	PCT Sign off delayed or not obtained (including LIFT)	5	1	5	AMBER	TRUST	Project Director		1. Project Director meeting Chief Executive 4/3/04; Project Board Review 24/3/04; Regular review in conjunction PCT and LIFT		
9	APP	Recasting of OBC required due to Strategic Review	5	2	10	AMBER	TRUST	Project Director				
10	APP	Gateway approval not obtained (other than as a result of above risks)	4	2	8	AMBER	TRUST	Project Director		1. Gateway process established, and documentation being prerpared.		
11	PROC	Lack of range and quality of bidders to secure effective competition	4	2	8	AMBER	TRUST	Project Director				
12	PROC	Procurement batched with Wolverhampton	5	3	15	RED	TRUST	Project Director		1. Dialogue established with Strategic Health Authority. 2. PFU review arranged.	Weekly Advisory Team Review	Standing item for Project Team and Project Board Agenda
13	PROC	Alternative siting for Laundry agreed and developed by 2006	5	2	10	AMBER	TRUST	Support Services				
14	PROC	Development of new MPEC completed on time	3	3	9	AMBER	TRUST	Support Services				
15	PROC	Current Trust developments not completed on time, leading to change in Trust requirements	2	2	4	GREEN	TRUST	Support Services				
16	PROC	Transfer to Trust ownership from Council of part of Car Park not secured by 2006	5	2	10	AMBER	TRUST	Project Director	Pinsents	1. Trust commenced dialogue with Walsall MBC to acquire land. 2. Pinsents to be advised if/when agreement for sale is reached.	Weekly Advisory Team Review	
17	PROC	Confirmation of Trust ownership of whole of Manor Hospital not secured by 2006	5	1	5	AMBER	TRUST	Project Director	Pinsents	1. Pinsents to make necessary applications to the Land Registry. 2.Pinsents to contact PCT to acquire missing block of land	Weekly Advisory Team Review	
18	PROC	3rd Party property rights on Manor Site not clarified and secured by 2006	4	1	4	GREEN	TRUST	Project Director	Pinsents	1. Trust to continue its estate management to terminate/relocate occupiers. 2. Pinsents to supply appropriate forms of document to assist the Trust in documenting undocumented occupancies.	7th April 2004	
19	PROC	Patient Services contractor (Wandsworth) not integrated within project	3	2	6	AMBER	TRUST	Project Director	Pinsents	1. Wandsworth to be invited to agree to act as Project Co's/building contractor's sub-contractor in installation of patient power infrastructure. 2. Output specification in ITN/Project Agreement to identify such infrastructure as part of the "works". 3. Pinsents to draft letter to Wandsworth	7th April 2004	
20	PROC	Changes in NHS requirements leading to delay or additional cost during procurement	5	1	5	AMBER	TRUST	Project Director				

Walsall Hospitals NHS Trust:
Manor Hospital Redevelopment PFI Project
Risk Register for Trust as at 9th February 2004

Risk Area			Risk Assessment				Risk Owner			Risk Commentary		
Ref.	Category	Description	Impact	Likelihood	Overall	Risk Level	Organisation	Officer	Advisor	Action to Mitigate	Date for Review	Notes
21	PROC	Integration of current ICT contracts into PFI Procurement	5	2	10	AMBER	TRUST	Project Director	Pinsents	1. Draft contract will provide for assumption of ICT infrastructure responsibilities and bidders will be notified of existing contractual arrangements. 2. BT to be advised of position at appropriate point.	7th April 2004	
22	PROC	Impact of Existing Building Stock on Procurement process	2	2	4	GREEN	TRUST	Support Services				
23	PROC	Impact of being able to transfer suitable Equipment	3	4	12	RED	TRUST	Project Director		1. Financial forecasts based on existing stock of equipment; 2. Trust reviewing Asset Register and impact on Project on quarterly basis; 3. Annual capital programme for equipment refreshment in advance of contract signature.		
24	PROC	Inadequacy of Trust Project Resource	5	2	10	AMBER	TRUST	Project Director				
25	PROC	Impact on Project of other Trust parallel activities	4	2	8	AMBER	TRUST	Support Services				
26	PROC	Progress of ICT Projects	2	2	4	GREEN	TRUST	Inf Director				
27	PROC	Staff Consultation Process	3	2	6	AMBER	TRUST	HR Director		1. Good employee relations already exist within the Trust; 2. New management of change policy(s) drafted; 3. Clear framework for consultation and involvement for PFI project completed; 4. Timetable for consultation process devised and imminent commencement; 5. Regular updates on OBC and BCReview with Staff Side through JNC.		
28	PROC	Change in TUPE legislation	1	5	5	AMBER	TRUST	Project Director	Pinsents			
29	PROC	Maintenance of Statutory Approvals for Existing Buildings	1	4	4	GREEN	TRUST	Support Services				
30	PROC	Agenda for Change impact on the Project	3	4	12	RED	TRUST	HR Director		1. Agenda for change project plan for the trust identified; 2. Implementation Project Structure identified; 3. Initial meetings for planning, implementation and training commenced; 4. Explanatory Information regarding AFC available to bidders ; 5. Clarification around final job evaluations will become clearer by October 2004; 6. AFC implementation and T&C's harmonised to one pay structure by End 2005 prior to contract completion; 7. More attractive for the purposes of staff management and T&C's for bidders streamlined and less complex		
31	PROC	Ability to deliver a viable and affordable Full Business Case	4	2	8	AMBER	TRUST	Project Director				
32	PROC	Change in HR National Policy	3	3	9	AMBER	TRUST	HR Director		Additional HR Resources identified and in place for future NHS project work		
33	PROC	Ability to achieve a viable and signed off design solution	4	2	8	AMBER	TRUST	Project Director	SHP			
34	PROC	Hidden Defects / Antiquities	4	2	8	AMBER	TRUST	Project Director	SHP			
35	PROC	Achieving effective risk allocation on Project Specific Contractual issues	4	2	8	AMBER	TRUST	Project Director	Pinsents	1. Standard form Project Agreement (SF3) has been adapted to address project specific issues. 2. Draft Contract to be reviewed by project team in early April 2004.	7th April 2004	
36	PROC	Adequacy of Bidder resources to achieve Commercial and Financial Close	4	2	8	AMBER	PROJECTCO					
37	PROC	Section 106 Agreement and other Planning Conditions completion leads to delay	2	2	4	GREEN	PROJECTCO					
38	PROC	Off-Balance Sheet treatment not agreed	5	1	5	AMBER	TRUST	Project Director	KPMG	KPMG will constantly monitor the issues relating to the accounting treatment of the PFI deal. Throughout the procurement process we will advise the Trust concerning issues that could impact upon the accounting treatment of the scheme.		
39	PROC	Planning Permission delayed or approval increases cost	5	1	5	AMBER	PROJECTCO					
40	PROC	Judicial review of Planning Permission	4	1	4	GREEN	TRUST	Project Director	Pinsents	1. Outline planning permission to be reviewed by Pinsents. 2. Project Co application for full planning permission to be reviewed by Pinsents in due course.	7th April 2004	
41	PROC	Judicial review of OJEU Process	4	1	4	GREEN	TRUST	Project Director	Pinsents	Adherence to current Department of Health guidelines and regular review of procurement process.	Each Project milestone.	

Walsall Hospitals NHS Trust:
Manor Hospital Redevelopment PFI Project
Risk Register for Trust as at 9th February 2004

Risk Area			Risk Assessment				Risk Owner			Risk Commentary		
Ref.	Category	Description	Impact	Likelihood	Overall	Risk Level	Organisation	Officer	Advisor	Action to Mitigate	Date for Review	Notes
42	PROC	VAT recovery not approved	3	1	3	GREEN	TRUST	Project Director	KPMG	KPMG's VAT team will provide the Trust with advice concerning the issues that determine if the unitary charge is VAT recoverable. KPMG will liaise with HMC&E regularly throughout the procurement and will seek provisional approval for the scheme at an early stage in the procurement process.		
43	DES	Delay arising from Design Development after Financial Close	2	2	4	GREEN	PROJECTCO					
44	DES	Delay arising from Change in Requirements after Financial Close	4	1	4	GREEN	TRUST					
45	DES	Cost implications arising from Change in Requirements after Financial Close	4	1	4	GREEN	TRUST					
46	CONST	Difficulties in maintaining operations on site during construction	4	3	12	RED	PROJECTCO					
47	CONST	Delay in Construction (Contractor)	2	2	4	GREEN	CONTRACTOR					
48	CONST	Delay in Construction (Force Majeure and Delay Events)	5	1	5	AMBER	PROJECTCO					
49	CONST	Default of Contractor during Construction	4	1	4	GREEN	PROJECTCO					
50	COMM	Building Commissioning Delays	3	2	6	AMBER	TRUST					
51	COMM	Delay in procuring Equipment to be fitted by ProjectCo	3	1	3	GREEN	PROJECTCO					
52	COMM	Operational Commissioning Delay	4	2	8	AMBER	TRUST					
53	COMM	User Training Delay / Availability	3	1	3	GREEN	TRUST					
54	COMM	Operational Commissioning Cost Impact	3	1	3	GREEN	TRUST					
55	COMM	ICT Commissioning Delay	3	3	9	AMBER	TRUST					
56	COMM	ICT Funding availability	3	2	6	AMBER	TRUST					
57	PROJECTCO	ProjectCo Operating Costs are higher than forecast at Financial Close	1	2	2	GREEN	PROJECTCO					
58	PROJECTCO	Recruitment and Retention of staff to ProjectCo	2	2	4	GREEN	PROJECTCO					
59	OPS	Trust Managerial Resources to continue to develop and manage the project	3	2	6	AMBER	TRUST					
60	OPS	Insolvency of ProjectCo	5	1	5	AMBER	PROJECTCO					
61	OPS	Availability of funding to Trust in meeting RPI escalation of Unitary Payment	5	1	5	AMBER	TRUST					
62	OPS	Change in Trust Requirements during Operations leading to additional costs	3	5	15	RED	TRUST					
63	OPS	Change on NHS Specific Law during Operations leading to additional costs	3	2	6	AMBER	TRUST					
64	OPS	Impact on Trust of General Change in Law during Operations	2	5	10	AMBER	PROJECTCO					
65	OPS	Unavailability of facilities during Operations	1	5	5	AMBER	PROJECTCO					
66	OPS	Default of Hard FM Contractor during Operation	4	1	4	GREEN	PROJECTCO					
67	OPS	Default of Soft FM Contractor during Operation	4	1	4	GREEN	PROJECTCO					
68	OPS	NHS Demand reduces during Operations	3	1	3	GREEN	TRUST					
69	OPS	NHS Demand exceeds facilities capacity during Operations	3	3	9	AMBER	TRUST					
70	OPS				0	GREEN						

Walsall Hospitals NHS Trust:

Risk Register for Trust as at 9th February 2004

Category	Narrative
APP	*Approvals*
PROC	*Procurement*
DES	*Design*
CONST	*Construction*
COMM	*Commissioning*
OPS	*Facilities Operations*
PROJECTCO	*ProjectCo Operations*
NHS	*NHS specific Legislation*
LEG	*Legislation / Regulation*

Likelihood	Narrative	Possible Quantification
1	Very unlikely to occur	*Insert here more detailed definition*
2	Unlikely to occur	*Insert here more detailed definition*
3	As likely to occur as not	*Insert here more detailed definition*
4	Likely to occur	*Insert here more detailed definition*
5	Very likely to occur	*Insert here more detailed definition*

Impact	Narrative	Possible Quantification
1	Minimal Impact	*Insert here more detailed definition*
2	Low Impact	*Insert here more detailed definition*
3	Medium Impact	*Insert here more detailed definition*
4	High Impact	*Insert here more detailed definition*
5	Very High Impact	*Insert here more detailed definition*

Risk Level	Definition	Action Plan
1 - 4	**GREEN**	No need for specific action plan
5 - 10	**AMBER**	Prepare outline action plan
12 - 25	**RED**	Detailed action plan required

Organisation	Narrative
TRUST	*Walsall Hospitals NHS Trust*
PROJECTCO	*LIFTCo*
CONTRACTOR	*Contractor*
PCT	*Walsall teaching PCT*
3RD PARTY	*3rd Party Tenants*
ADVISORS	*Trust PFI Advisory Team*

Officer	Narrative
Project Director	*Project Director*
FD	*Finance Director*
Support Services	*Director of Estates & Support Services*
Clinical Leads	*Clinical Lead Officers*
HR Director	*Director of Human Resources*
Inf Director	*Director of Infomatics*
Chief Executive	*Trust Chief Executive*
Pinsents	*Trust Legal Advisors*
KPMG	*Trust Financial Advisors*
SHP	*Trust Technical Advisors*

APPENDIX M

PROJECT PLAN

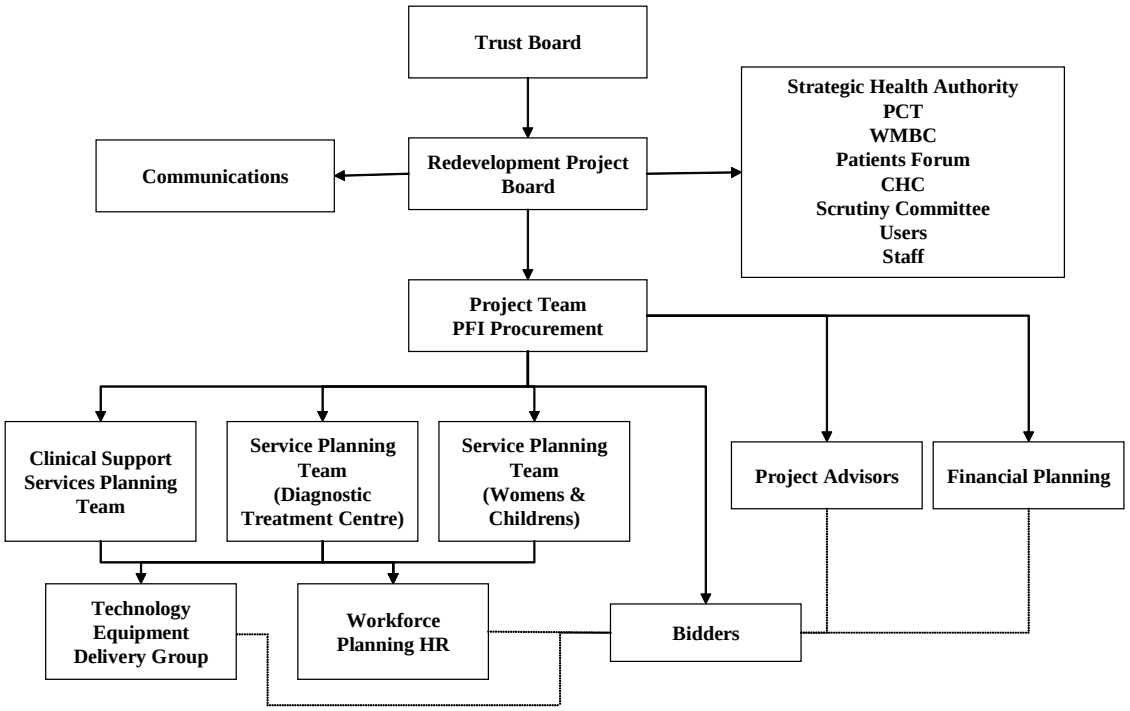
Project Structure

Attached is a graphic illustrating the project structure put in place to ensure a robust process for the active management of the project is in place. Within this structure, the following key personnel have the responsibility indicated below:

1	**PROJECT DIRECTOR**	Mr David Lawson – Director of Estates and Support Services
2	**PROJECT CLINICIANS**	
	Women's and Children's	Mr Mike Browne – Medical Director Mr David Drew – Consultant Paediatrician Ms Liz McMillan – Consultant Obstetricain Mr Karl Fortes-Mayer – Breast Surgeon
	DTC	Dr Chris Newson – Consultant Anaesthetist Dr Mark Cox – Consultant Gastroenterologist Mr Tim Muscroft – Consultant Surgeon Dr R Brooks – Consultant Physician
	Pathology	Dr Yin Hock – Consultant Histopathologist Dr Paul Giles – Consultant Chemical Pathologist Mr Jim Bourne – Pathology Services Manager
	Clinical Managers	Mrs Eileen Fallon – Manager, Women's & Children's Services Mrs Linda Pascall – General Manager, Surgical Specialties Mrs Sue Bailey – Outpatients Services Manager Mr Richard Miller – General Manager, Medicine Miss Bala Kainth – General Manager, Elderly Care
	Project Administration	Mrs Diane Hogg – Project Administrator Mrs Paula Plant – Assistant Administrator
	Human Resouces	Mrs Sandra Berns – PFI HR
	Finance	Mr Bernard Chalk – Director of Finance
	Nursing	Mrs Angie Matthews – Project Nurse

WALSALL HOSPITALS NHS TRUST

HOSPITAL REDEVELOPMENT SCHEME – PROJECT NUMBER WHT02007
PROJECT STRUCTURE



DL/PFI/GENERAL/ProjectStructure/SF/1604 – 16 APRIL 2003
PROJECT STRUCTURE – HOSPITAL REDEVELOPMENT SCHEME (WHT2007)

Striving for Excellence in Healthcare

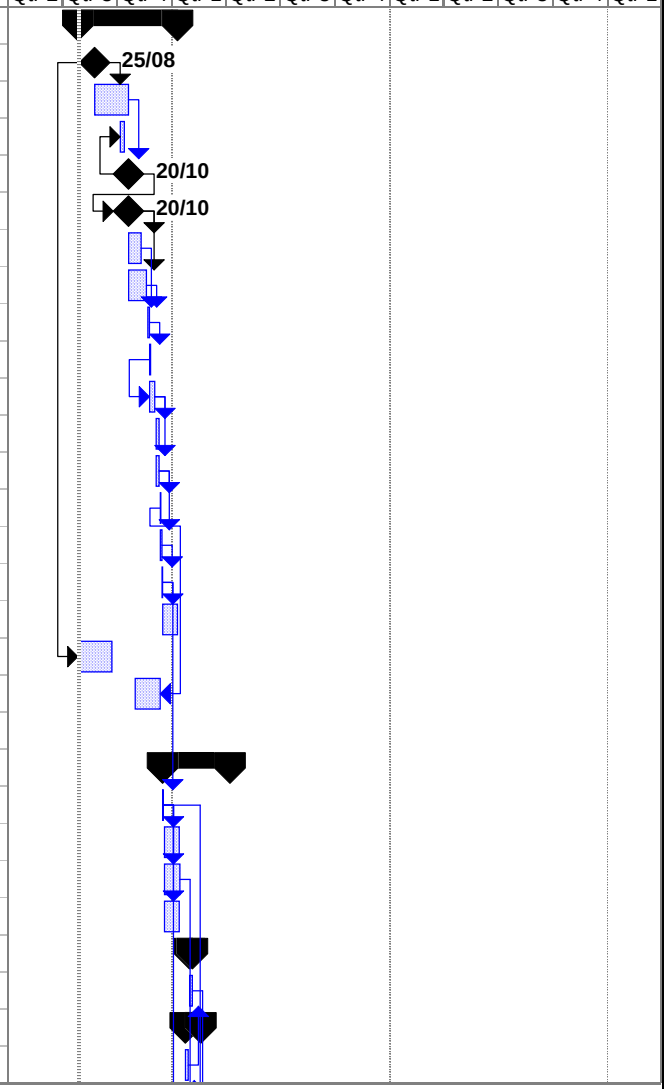
PAGE 1 OF 1

Project Plan

Attached is a detailed project plan prepared to show all the activities required in delivering this project from OBC submission to Full Business Case approval and signature of the PFI Project Agreement.

WALSALL HOSPITAL REDEVELOPMENT PROJECT PLAN

ID	Task Name	Duration	Start	Finish
1	**PREQUALIFICATION**	**22.2 wks**	**Wed 28/07/04**	**Mon 10/01/05**
2	Place OJEU	0 days	Wed 25/08/04	Wed 25/08/04
3	Bidders Respond	40 days	Wed 25/08/04	Wed 20/10/04
4	Review Risk Register	1 wk	Thu 07/10/04	Wed 13/10/04
5	Bidder Open Day	0 days	Wed 20/10/04	Wed 20/10/04
6	Send out MOI & PQQ	0 days	Wed 20/10/04	Wed 20/10/04
7	Establish Declaration of Interest	3 wks	Thu 21/10/04	Wed 10/11/04
8	MOI Response Period	22 days	Thu 21/10/04	Fri 19/11/04
9	Deselect Non Qualifiers / Compile long list	3 days	Mon 22/11/04	Wed 24/11/04
10	Review Qualifiers / Select short list (4)	2 days	Thu 25/11/04	Fri 26/11/04
11	Shortlist report	7 days	Thu 25/11/04	Fri 03/12/04
12	Staff Council Consultation	1 wk	Mon 06/12/04	Fri 10/12/04
13	QA with NHSE and HMT	5 days	Mon 06/12/04	Fri 10/12/04
14	Agree shortlist (4) with board	1 day	Mon 13/12/04	Mon 13/12/04
15	Trust Board approve Shortlist	3 days	Mon 13/12/04	Wed 15/12/04
16	Notify	1 day	Thu 16/12/04	Thu 16/12/04
17	Debrief	2 wks	Fri 17/12/04	Mon 10/01/05
18	Appointment of Insurance Advisors	8 wks	Wed 28/07/04	Wed 22/09/04
19	Prepare Stage Plan for next Stage	6 wks	Mon 01/11/04	Mon 13/12/04
20				
21	**PRELMINARY ITN (SELECT 2)**	**14.4 wks**	**Fri 17/12/04**	**Fri 08/04/05**
22	Issue PITN	1 day	Fri 17/12/04	Fri 17/12/04
23	Review Risk Register	12 days	Mon 20/12/04	Thu 13/01/05
24	Bidder Review	13 days	Mon 20/12/04	Fri 14/01/05
25	Initial Optional Site Visit Opportunity	12 days	Mon 20/12/04	Thu 13/01/05
26	**Finance/Legals**	**1 wk**	**Mon 31/01/05**	**Fri 04/02/05**
27	Clarification Meeting	5 days	Mon 31/01/05	Fri 04/02/05
28	**Services/Equipment**	**4 wks**	**Mon 24/01/05**	**Fri 18/02/05**
29	Clarification Meeting #1	5 days	Mon 24/01/05	Fri 28/01/05

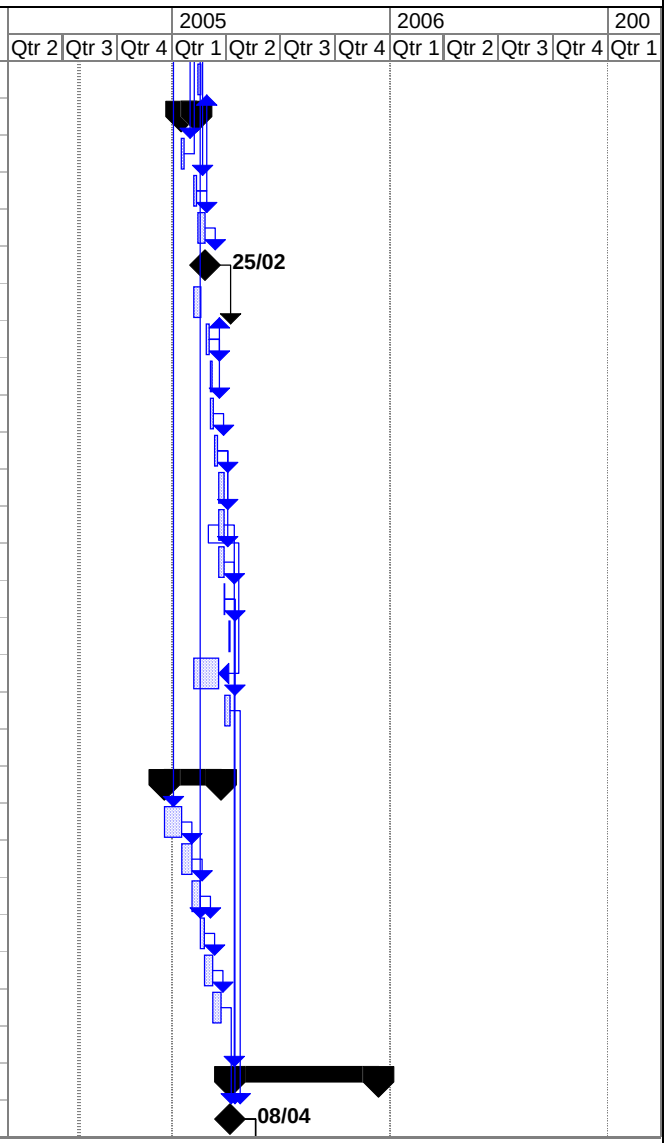


Project: Walsall Overall Plan July-04 u
Date: Wed 28/07/04
Prepared by Sue Dye (SHP)

Task
Split
Progress
Milestone
Summary
Project Summary
External Tasks
External Milestone
Deadline

WALSALL HOSPITAL REDEVELOPMENT PROJECT PLAN

ID	Task Name	Duration	Start	Finish
30	Clarification Meeting #2	5 days	Mon 14/02/05	Fri 18/02/05
31	**Clinical & Design Requirements**	**4 wks**	**Mon 17/01/05**	**Fri 11/02/05**
32	Clarification Meeting #1	5 days	Mon 17/01/05	Fri 21/01/05
33	Clarification Meeting #2	5 days	Mon 07/02/05	Fri 11/02/05
34	Bidder prepare Response	10 days	Mon 14/02/05	Fri 25/02/05
35	Bidder submit Response	0 days	Fri 25/02/05	Fri 25/02/05
36	Update Declarations of Interest	2 wks	Mon 07/02/05	Fri 18/02/05
37	Initial Evaluation	5 days	Mon 28/02/05	Fri 04/03/05
38	Presentations: Team/Board, Staff Council Reps & Trust Board	3 days	Mon 07/03/05	Wed 09/03/05
39	Evaluation	5 days	Mon 07/03/05	Fri 11/03/05
40	Prepare Evaluation Report	5 days	Mon 14/03/05	Fri 18/03/05
41	Staff Council Consultation	1 wk	Mon 21/03/05	Tue 29/03/05
42	Project Board approve Selection of 2 Bidders	1 wk	Mon 21/03/05	Tue 29/03/05
43	Trust Board approve Selection of 2 Bidders	1 wk	Mon 21/03/05	Tue 29/03/05
44	Notify Bidders	1 day	Wed 30/03/05	Wed 30/03/05
45	Debrief	2 days	Thu 07/04/05	Fri 08/04/05
46	Prepare Stage Plan for next Stage	6 wks	Mon 07/02/05	Mon 21/03/05
47	Review Stage Plan with Bidders	7 days	Thu 31/03/05	Fri 08/04/05
48				
49	**FITN**	**12.4 wks**	**Mon 20/12/04**	**Thu 24/03/05**
50	Draft FITN	14 days	Mon 20/12/04	Mon 17/01/05
51	Review FITN	13 days	Tue 18/01/05	Thu 03/02/05
52	Compile FITN	2 wks	Fri 04/02/05	Thu 17/02/05
53	Identify updates required to PITN	5 days	Fri 18/02/05	Thu 24/02/05
54	Draft changes	10 days	Fri 25/02/05	Thu 10/03/05
55	Complile Document	10 days	Fri 11/03/05	Thu 24/03/05
56				
57	**SELECT PREFERRED BIDDER**	**34.8 wks**	**Fri 08/04/05**	**Tue 13/12/05**
58	Issue FITN	0 days	Fri 08/04/05	Fri 08/04/05



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Progress
Milestone
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Project Summary
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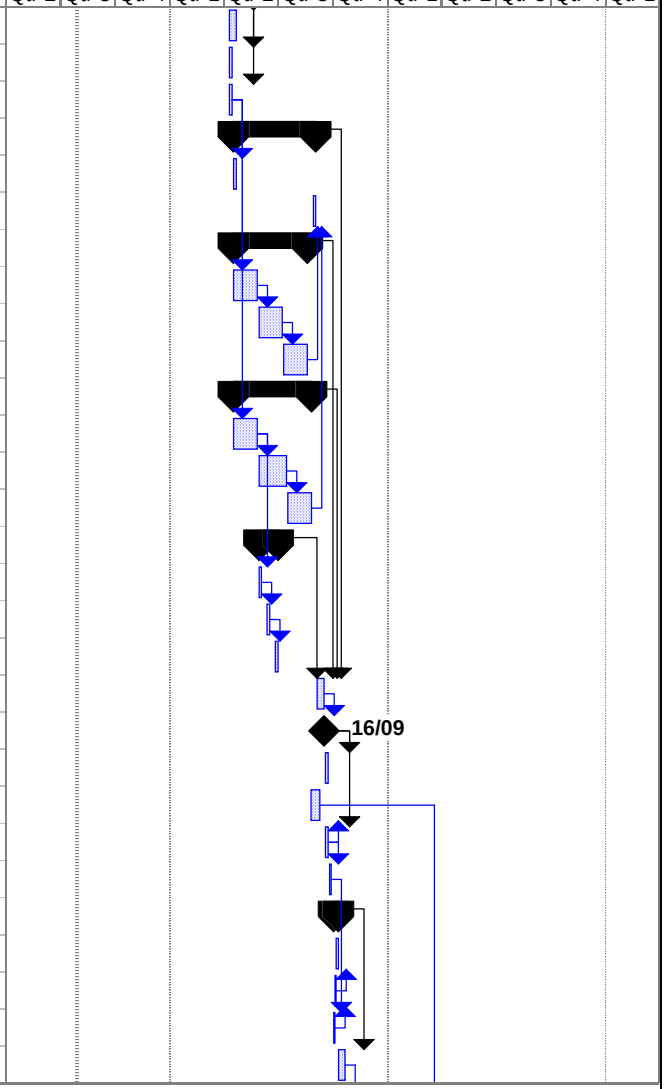
WALSALL HOSPITAL REDEVELOPMENT PROJECT PLAN

ID	Task Name	Duration	Start	Finish
59	Review Risk Register	2 wks	Mon 11/04/05	Fri 22/04/05
60	Inform GAD of progress	1 wk	Mon 11/04/05	Fri 15/04/05
61	Bidder Review	5 days	Mon 11/04/05	Fri 15/04/05
62	**Finance / Legals**	**19.4 wks**	**Mon 18/04/05**	**Fri 02/09/05**
63	Meeting #1	5 days	Mon 18/04/05	Fri 22/04/05
64	Meeting #2	4 days	Tue 30/08/05	Fri 02/09/05
65	**Services & Equipment**	**17.6 wks**	**Mon 18/04/05**	**Fri 19/08/05**
66	Meeting #1	29 days	Mon 18/04/05	Fri 27/05/05
67	Meeting #2	29 days	Tue 31/05/05	Fri 08/07/05
68	Meeting #3	30 days	Mon 11/07/05	Fri 19/08/05
69	**Clinical Requirements**	**18.6 wks**	**Mon 18/04/05**	**Fri 26/08/05**
70	1:200 Review #1	29 days	Mon 18/04/05	Fri 27/05/05
71	1:200 Review #2	34 days	Tue 31/05/05	Fri 15/07/05
72	Selected 1:50 Review	30 days	Mon 18/07/05	Fri 26/08/05
73	**Design & Construction**	**4.8 wks**	**Tue 31/05/05**	**Fri 01/07/05**
74	Meeting #1	4 days	Tue 31/05/05	Fri 03/06/05
75	Meeting #2	5 days	Mon 13/06/05	Fri 17/06/05
76	Meeting #3	5 days	Mon 27/06/05	Fri 01/07/05
77	Bidder prepare response	10 days	Mon 05/09/05	Fri 16/09/05
78	Bidder Submit response	0 days	Fri 16/09/05	Fri 16/09/05
79	Design Review Panel	1 wk	Mon 19/09/05	Fri 23/09/05
80	Update Declarations of Interest	2 wks	Fri 26/08/05	Fri 09/09/05
81	Initial Evaluation	5 days	Mon 19/09/05	Fri 23/09/05
82	Project/Trust Board Presentation	3 days	Mon 26/09/05	Wed 28/09/05
83	**Clarification**	**1.2 wks**	**Mon 03/10/05**	**Mon 10/10/05**
84	Finance / Legals	2 days	Fri 07/10/05	Mon 10/10/05
85	Services / Equipment	2 days	Wed 05/10/05	Thu 06/10/05
86	Clinical & Design Requirements	2 days	Mon 03/10/05	Tue 04/10/05
87	Evaluation	9 days	Tue 11/10/05	Fri 21/10/05



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Milestone
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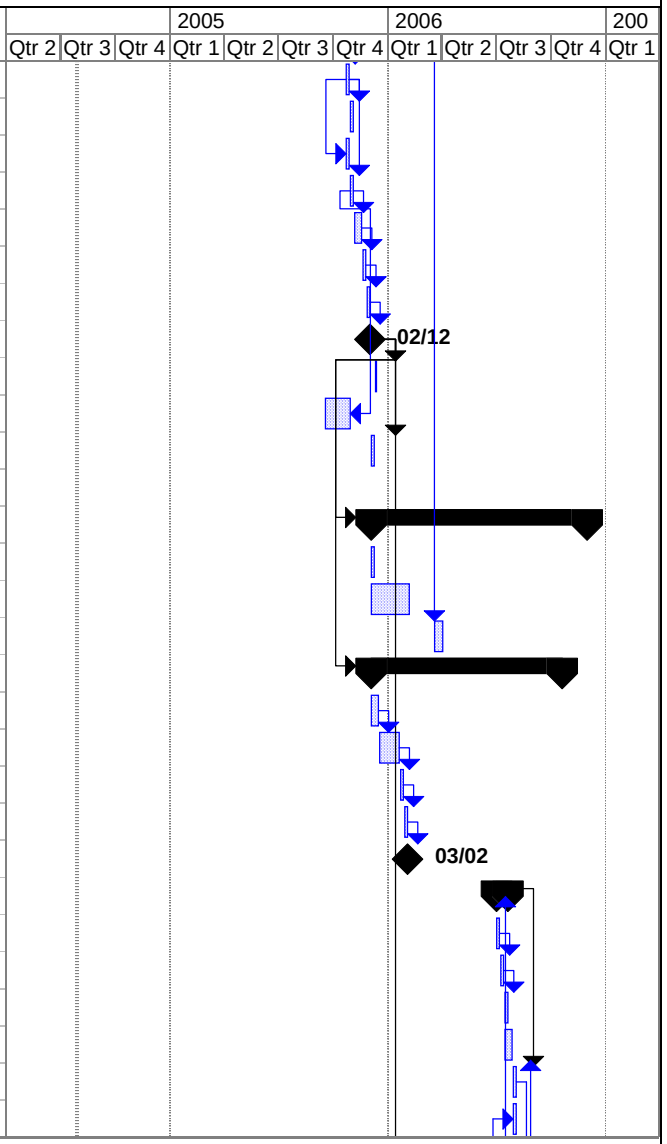
WALSALL HOSPITAL REDEVELOPMENT PROJECT PLAN

ID	Task Name	Duration	Start	Finish
88	Prepare Evaluation Report	5 days	Mon 24/10/05	Fri 28/10/05
89	Staff Council Consultation	1 wk	Mon 31/10/05	Fri 04/11/05
90	Prepare draft Preferred Bidder Letter	1 wk	Mon 24/10/05	Fri 28/10/05
91	Project Board approve Preferred Bidder Letter & Evaluation Report	1 wk	Mon 31/10/05	Fri 04/11/05
92	Discuss Preferred Bidder Letter with Preferred Bidder	2 wks	Mon 07/11/05	Fri 18/11/05
93	PFU Approve Preferred Bidder Letter	1 wk	Mon 21/11/05	Fri 25/11/05
94	Trust Board approve Preferred Bidder Letter	1 wk	Mon 28/11/05	Fri 02/12/05
95	Inform Bidders	0 days	Fri 02/12/05	Fri 02/12/05
96	Debrief Bidders	2 days	Mon 12/12/05	Tue 13/12/05
97	Prepare Stage Plan for next Stage	6 wks	Mon 19/09/05	Mon 31/10/05
98	Rreview Stage Plan with Bidders	1 wk	Mon 05/12/05	Fri 09/12/05
99				
100	**FINAL STAGE**	**50.8 wks**	**Mon 05/12/05**	**Fri 01/12/06**
101	Review Risk Register	1 wk	Mon 05/12/05	Fri 09/12/05
102	Appointment of Independent Tester	8 wks	Mon 05/12/05	Mon 06/02/06
103	Update Declarations of Interest	2 wks	Tue 21/03/06	Mon 03/04/06
104	**FULL BUSINESS CASE**	**44.8 wks**	**Mon 05/12/05**	**Fri 20/10/06**
105	Detail Structure	10 days	Mon 05/12/05	Fri 16/12/05
106	Draft Document	19 days	Mon 19/12/05	Fri 20/01/06
107	Review	5 days	Mon 23/01/06	Fri 27/01/06
108	Update	5 days	Mon 30/01/06	Fri 03/02/06
109	Submit for Informal Review	0 days	Fri 03/02/06	Fri 03/02/06
110	**Update to reflect Commercial Close**	**3 wks**	**Mon 03/07/06**	**Fri 21/07/06**
111	Main Body & Appendices	1 wk	Mon 03/07/06	Fri 07/07/06
112	Circulate & Review	1 wk	Mon 10/07/06	Fri 14/07/06
113	Production	1 wk	Mon 17/07/06	Fri 21/07/06
114	Update Declarations of Interest	2 wks	Mon 17/07/06	Fri 28/07/06
115	Project Board recommendation to Approve	1 wk	Mon 31/07/06	Fri 04/08/06
116	PCT Approval	1 wk	Mon 31/07/06	Fri 04/08/06



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Split
Progress
Milestone
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External Milestone
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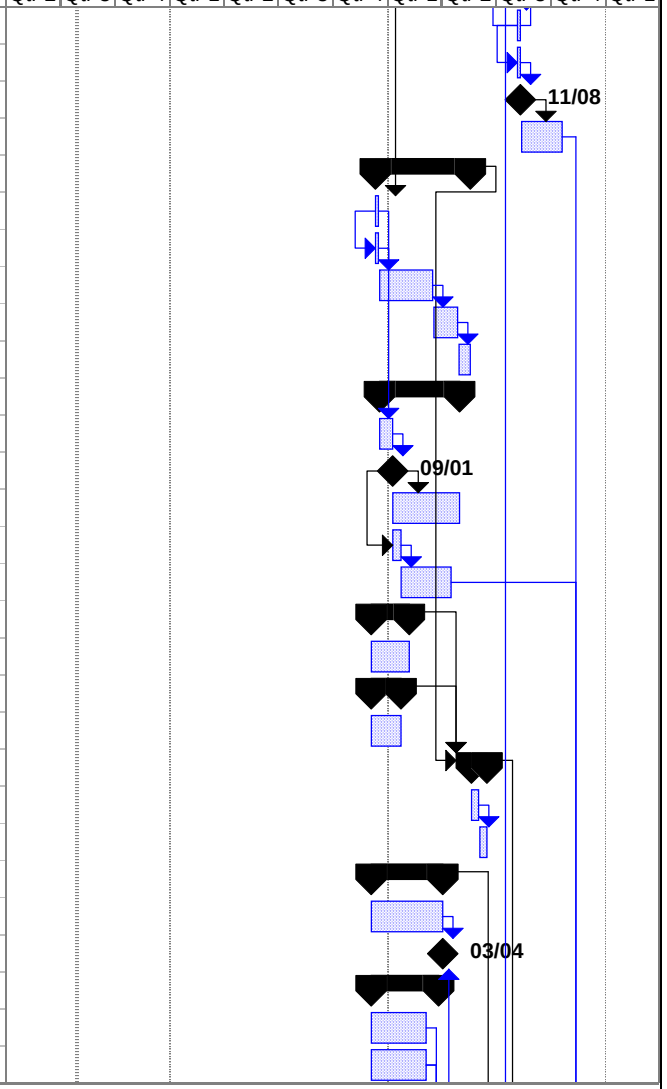
WALSALL HOSPITAL REDEVELOPMENT PROJECT PLAN

ID	Task Name	Duration	Start	Finish
117	Trust Approval	1 wk	Mon 07/08/06	Fri 11/08/06
118	Strategic Health Authority Approval	1 wk	Mon 07/08/06	Fri 11/08/06
119	Submit to PFU for Approval	0 wks	Fri 11/08/06	Fri 11/08/06
120	Receive Approval	10 wks	Mon 14/08/06	Fri 20/10/06
121	**Clinical & Design Requirements**	**21.8 wks**	**Mon 12/12/05**	**Fri 19/05/06**
122	Confirm 1:200 Plans	1 wk	Mon 12/12/05	Fri 16/12/05
123	Confirm Architectural Proposal	1 wk	Mon 12/12/05	Fri 16/12/05
124	Signed off RDS & 1:50s	59 days	Mon 19/12/05	Fri 17/03/06
125	Signed off Design Construction Requirements	6 wks	Mon 20/03/06	Fri 28/04/06
126	Construction Programme & Interfaces	3 wks	Mon 01/05/06	Fri 19/05/06
127	**Planning Approval**	**18 wks**	**Mon 19/12/05**	**Mon 01/05/06**
128	Finalise Planning Application	2 wks	Mon 19/12/05	Mon 09/01/06
129	Planning Application Submission	0 wks	Mon 09/01/06	Mon 09/01/06
130	Planning Approval	16 wks	Tue 10/01/06	Mon 01/05/06
131	Section 106 Agreement	2 wks	Tue 10/01/06	Mon 23/01/06
132	Judicial Review Period	3 mons	Tue 24/01/06	Mon 17/04/06
133	**Services**	**8 wks**	**Mon 05/12/05**	**Mon 06/02/06**
134	Signed off Method Statements & Specifications	8 wks	Mon 05/12/05	Mon 06/02/06
135	**Equipment**	**6 wks**	**Mon 05/12/05**	**Mon 23/01/06**
136	Signed off Method Statement	6 wks	Mon 05/12/05	Mon 23/01/06
137	**Co-ordination of Services, Design, Equipment**	**4 wks**	**Mon 22/05/06**	**Fri 16/06/06**
138	Review to ensure comparable	10 days	Mon 22/05/06	Fri 02/06/06
139	Revise Proposals	2 wks	Mon 05/06/06	Fri 16/06/06
140	**Legal**	**16 wks**	**Mon 05/12/05**	**Mon 03/04/06**
141	Complete Project Agreement & Schedules	16 wks	Mon 05/12/05	Mon 03/04/06
142	Place in Escrow	0 days	Mon 03/04/06	Mon 03/04/06
143	**Financial**	**15 wks**	**Mon 05/12/05**	**Mon 27/03/06**
144	Payment Mechanism Regime & Measurement	12 wks	Mon 05/12/05	Mon 06/03/06
145	Unavailability Regime	12 wks	Mon 05/12/05	Mon 06/03/06



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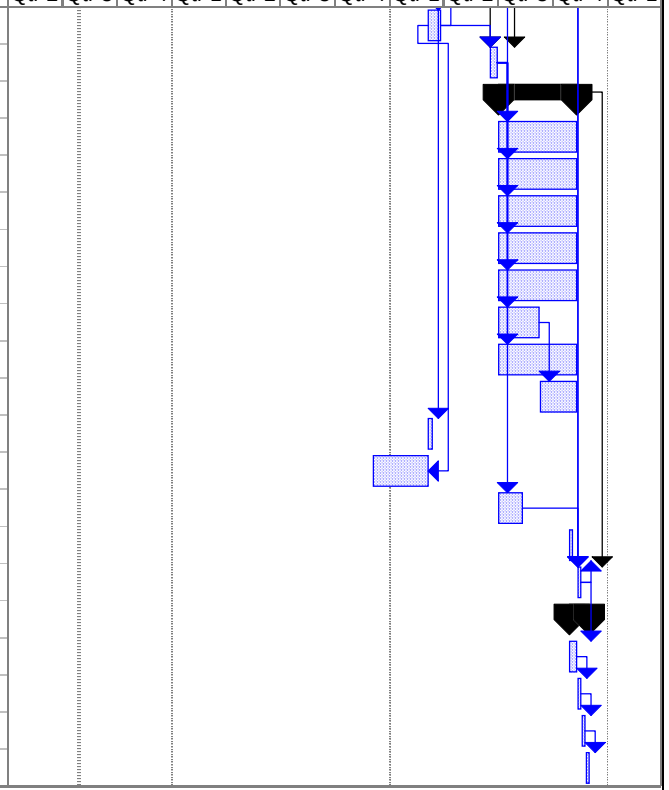
WALSALL HOSPITAL REDEVELOPMENT PROJECT PLAN

ID	Task Name	Duration	Start	Finish
146	Finalise Financial Arrangements	3 wks	Tue 07/03/06	Mon 27/03/06
147	Commercial Close	10 days	Mon 19/06/06	Fri 30/06/06
148	**Bidder Activity**	**19 wks**	**Mon 03/07/06**	**Fri 10/11/06**
149	Service Providers CoOperation Agreement	19 wks	Mon 03/07/06	Fri 10/11/06
150	Services Sub Contracts	19 wks	Mon 03/07/06	Fri 10/11/06
151	Insurances	19 wks	Mon 03/07/06	Fri 10/11/06
152	Funders' Due Diligence	19 wks	Mon 03/07/06	Fri 10/11/06
153	Shareholders Approvals/Corporate Structure	19 wks	Mon 03/07/06	Fri 10/11/06
154	Approval of Bond Circular	10 wks	Mon 03/07/06	Fri 08/09/06
155	Funding Documents	19 wks	Mon 03/07/06	Fri 10/11/06
156	Bond Rating Agency's Close Out	9 wks	Mon 11/09/06	Fri 10/11/06
157	Review Risk Register	1 wk	Tue 07/03/06	Mon 13/03/06
158	Gateway (3) Review	12 wks	Mon 05/12/05	Mon 06/03/06
159	Due Diligence	6 wks	Mon 03/07/06	Fri 11/08/06
160	Project Agreement Briefing to Trust Board	1 wk	Mon 30/10/06	Fri 03/11/06
161	Contract Signature	1 wk	Mon 13/11/06	Fri 17/11/06
162	**Financial Close**	**5 wks**	**Mon 30/10/06**	**Fri 01/12/06**
163	Investors Meetings	2 wks	Mon 30/10/06	Fri 10/11/06
164	Bond Marketing Roadshow	1 wk	Mon 13/11/06	Fri 17/11/06
165	Book build	1 wk	Mon 20/11/06	Fri 24/11/06
166	Receive Bond Receipts	1 wk	Mon 27/11/06	Fri 01/12/06



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APPENDIX N

BENEFITS REALISATION PLAN

Heading

Benefits for the project have been considered under the following 9 headings:

- A: Improved Clinical Quality
- B: Improved Customer Care
- C: Improved Staff Resourcing
- D: Improved Patient Flow and Throughput
- E: Accessibility of Hospital to Local Population
- F: Flexibility of Accommodation
- G: Improved Quality of Accommodation
- H: Ability to Respond to Commissioner's Current and Future Strategy and Commissioning Intentions
- I : Financial Benefits

Attached are draft schedules setting out, under each heading:

- The Specific Indicators chosen;
- The way in which the indicator will be monitored;
- Any assumptions underpinning the targets;
- The dates at which review of performance will take place.

The draft schedules represent the current progress in developing the comprehensive range of indicators that will be used to assess the benefits from this project. Further work is being undertaken by the Trust following the completion of the Outline Business Case and the agreement of the Local Delivery Plan for 2004/05 to confirm the full list of indicators that will be used.

Details of current performance against the indicators and proposed targets for the project will then be completed as part of the preparation of the Full Business Case. The Benefits Realization Plan will then be monitored as part of the Trust's overall approach to Post Project Evaluation.

Benefit Category: A: Improved Clinical Quality							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
Patients facilities and services	**Patients Charter Standards: key indicators:** Waiting in OPD – 30 mins Cancelled operations (not re-scheduled within one month) Waiting Times:- *- elective: within three months* *- elective: within 6 months* *- 1st out-patients: within 13 weeks* Accident & Emergency: *- Patients waiting more than 12 hours for admission* *- Patients admitted to hospital within 4 hours of decision to admit* *- Patients waiting less than 4 hours in A&E from arrival to admission, transfer or discharge* Urgent Cancer referrals seen within 2 weeks *- Breast* *- Other*			Routine Monitoring	Activity levels and referral rates consistent with FBC projections		Quarterly

Benefit Category: A: Improved Clinical Quality							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
Clinical Performance	SMR death rates for Walsall per 100,000 population Deaths from all causes aged 16 - 64 Deaths from accident all ages Deaths from Malignant Neoplasms age < 75 Mortality from all circulatory diseases age < 75 (directly age standardised mortality rates) Avoidable deaths - % above England average 5 year survival rates following breast or cervical cancer - % above England average Premature deaths in hospital - % above England average Infant Deaths - % above England average			Public Health Common Data Set Monitoring	Integrated approach to LDP Plan delivery		1 year after open

Benefit Category: A: Improved Clinical Quality							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
Performance Targets	Performance against targets established within the Business Case: *Elective Surgery Rates* *Day Case Proportion* *Percentage booking of day cases* *Inpatient Average length of stay* *Percentage Inpatient Bed occupancy* *Cancelled Operations* *Theatre Utilisation* *Pre-operative length of stay* *Percentage of patients whose transfer of care was delayed* *Hospital Acquired Infection Rates* *Patient privacy and dignity targets met*			Routine Monitoring returns	Activity levels and referral rates consistent with FBC projections		Quarterly

Benefit Category: A: Improved Clinical Quality							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
Availability of Clinical Services	% of outpatients scheduled Monday to Friday 0900 to 1700			Outpatient Scheduling Information	Patient acceptability of out-of-hours appointments		Quarterly
	Availability of clinical support services "out of hours": *- Pathology* *- Radiology* *- Clinical Investigation* *- Therapy*			Departmental Records			Quarterly
	Availability of Critical Care Facilities: *- Number of transfers out of hospital for Critical care, due to non availability of service* *- Number of appropriate requests for Critical care not accommodated on designated unit*			Departmental Records			Quarterly
	Direct access services for GPs: *- Pathology* *- Radiology*			Departmental Records			Quarterly

Benefit Category: A: Improved Clinical Quality							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
	- Clinical Investigation *- Therapy*						

Benefit Category: B: Improved Customer Care							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
Patient & Visitor Satisfaction	Outpatient / A&E Survey data for each of the 5 domains of patient experience: *- Access & Waiting* *- Better information, more choice* *- Building relationships* *- Clean, comfortable, friendly place to be* *- Safe, high quality, co-ordinated care*			Annual Survey			Annual
Patient Complaints	Percentage of written complaints for which a local resolution was completed within 20 working days			Complaints Register			Annual
Patient Environment Action Teams	Whole Trust score for PEAT visits: *- Hospital Cleanliness* *- Better Hospital Food*			PEAT Visit Records			Annual

Benefit Category: B: Improved Customer Care							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
Patients & Relatives Facilities	Improvements in availability of dedicated facilities for Patients and Relatives:			Review of available accommodation	Commissioning of new facilities		12 months after open
	a. Central reception and information point						
	b. Bereavement suite						
	c. Equity of access for all service users - compliance						
	- physical						
	- ethnicity						
	d. Relatives overnight accommodation						
	f. Breast feeding / baby changing facilities available						
	g. Patient information help points						
	h. Garden facilities accessible to relatives						

Benefit Category: C: Improved Staff Resources							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
Workforce Expansion	Contribution to the achievement of national targets for increases in NHS workforce Medical Staff Nurses Therapists Other Healthcare Staff	Existing Staff Numbers		Annual Staff Census			12 Months after opening
Recruitment & Retention	Improvement in the recruitment t and retention of staff as measured by: Turnover Rates Stability Rates Agency Staff numbers	Existing Staff Numbers		Annual Staff Census			12 Months after opening
Sickness / absence rates	Percentage of time lost through absences			Routine Monitoring			Quarterly
Staff Survey	Improvement in results from Annual Staff Survey			Annual Survey			12 Months after opening
Improving working lives initiative	Better working conditions and environment in challenging deprived area for staff	Existing Service Provision		Annual Survey			12 Months after opening
Agenda for change	Implementing the NHS Plan: New ways of working with latest equipment and facilities	Existing Service Provision		Annual Survey			12 Months after opening

Benefit Category: C: Improved Staff Resources							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
Investment in training	Provision of new or improved training and education facilities in local centres to contribute towards NHS Plan targets for investment in training for staff and improving working lives	Existing Service Provision		Annual Survey			12 Months after opening

Benefit Category: D: Improved Patient Flow and Throughput							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
Access/linkages to departments, directorates and services	Travel times between departments for patients and staff: *- Day Case Theatres and Main Theatres* *- Main Theatres and Women & Children's Theatres* *- Day Case Unit and Theatres* *- Theatres and Critical Care* *- Interventional Procedure Rooms and Critical Care* *- Outpatient Clinics and Imaging* *- Outpatient Clinics and Pathology* *- Outpatient Clinics and Therapy support* *- Between components of Imaging* *- Between Endoscopy Facilities* *- Between Therapy Facilities*			Ergonomic study of final design			6 months after opening

Benefit Category: D: Improved Patient Flow and Throughput							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
Fragmentation of services	All patient areas accessible without leaving the main hospital building			Ergonomic study of final design			6 months after opening
Access from Building Entrances	Travel times from entrance to principal clinical facilities: *- Women's, Children & Younger People* *- Routine Diagnosis and Treatment* *- Inpatient Care* *- Emergency Care*			Ergonomic study of final design			6 months after opening
Accommodation relevant to clinical requirements	Detailed designs signed-off by clinical staff against models of care and operational policies: *- Children & Younger People* *- Gynaecology & Breast Services* *- Routine Elective Diagnosis & Treatment* *- Episodes of care in excess of 48 hours* *- Emergency Care*			Clinical Sign-off of plans			6 months after opening

Benefit Category: E: Accessibility of Hospital to Local Population							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
Convenience by public transport	Number of buses with drop off / pick up on site						
Site Traffic congestion	Time taken from entering site to accessing facilities Time taken to exit site from leaving facilities						
Car parking spaces	Number of Visitor spaces available Number of Disabled spaces available Number of staff spaces available						
Access to departments and services on site	Proximity of Car Parks to Hospital Entrances Proximity of Public Transport Links to Hospital Entrances Appropriate Site Signage						

Benefit Category: F: Flexibility of Accommodation							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
Ability to respond to changes in commissioning policies	In-patient accommodation can be readily changed into different sized nursing units that maintain patient privacy and dignity Operating theatres can be readily reconfigured between in-patients and daycase			Evaluation of final design			12 months after open
Space to expand	Inpatient facilities Outpatient Clinics Theatres Diagnostic Support			Evaluation of final design			12 months after open
Ability to contract: potential to utilise space for alternative purposes (including 3rd Parties)	Inpatient facilities Outpatient Clinics Theatres Diagnostic Support			Evaluation of final design			12 months after open

Benefit Category: G: Improved Quality of Accommodation							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
National Targets Met	Development of a dedicated Diagnostic and Treatment Centre			Building Complete and ready for occupation	Conformance of facilities to Trust Requirements		Building Occupation
	Reduction in the level of Statutory, Health & Safety and Backlog Maintenance Liability			Annual Backlog Maintenance Review	Conformance of facilities to Trust Requirements		Disposal of existing premises
IM&T	All facilities providing comprehensive network and IM&T capability in line with local IM&T Strategies			Annual IM&T Strategy Review	Conformance of facilities to Trust Requirements		Annual from Opening
Building Physical Condition	Percentage of building graded A (new: expected to perform adequately)		100%	Initial / Annual Condition Survey	Conformance of facilities to Trust Requirements		Building Completion and Annual thereafter
	Percentage of building graded B (sound with minor deterioration)		0%				
	Percentage of building graded C (needs major repair soon) or D (serious risk of breakdown)		0%				
Functional Suitability	Percentage of building graded A (high degree of satisfaction)		100%	Initial / Annual Condition Survey	Conformance of facilities to Trust Requirements		Building Completion and Annual thereafter
	Percentage of building graded B (acceptable)		0%				
	Percentage of building graded C (below acceptable standard) or D (unacceptable)		0%				

Benefit Category: G: Improved Quality of Accommodation							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
Space Utilisation	Percentage of building graded 1 (empty) Percentage of building graded 2 (underused) Percentage of building graded 3 (adequate) Percentage of building graded 4 (overcrowded)		0% 0% 100% 0%	Initial / Annual Condition Survey	Conformance of facilities to Trust Requirements		Building Completion and Annual thereafter
Statutory and Safety Requirements	Percentage of building graded A (new buildings complying with statutory and firecode guidance) Percentage of building graded B (existing buildings complying with statutory and firecode guidance) Percentage of buildings graded C (buildings falling below statutory and firecode guidance) or D (buildings falling dangerously below guidance)		100% 0% 0%	Initial / Annual Condition Survey	Conformance of facilities to Trust Requirements		Building Completion and Annual thereafter
Energy Performance	Percentage of building graded A (new buildings complying with guidance) Percentage of building graded B (buildings with co-ordinated programme) Percentage of buildings graded C (buildings with some ad-hoc energy		100% 0% 0%	Initial / Annual Condition Survey	Conformance of facilities to Trust Requirements		Building Completion and Annual thereafter

Benefit Category: G: Improved Quality of Accommodation							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
	conservation measures) or D (buildings where no energy conservation measures have been carried out)						

Benefit Category: H: Ability to respond to Commissioner' current and future Strategy and Commissioning Intentions							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
Local Delivery Plan Targets	Targets to be inserted following completion of agreement to 2004 LDP						

Benefit Category: I: Financial Benefits							
Description	**Specific Indicator**	**Performance**		**Activity to confirm realisation**	**Assumptions**	**Responsibility for review**	**Review Date**
		Baseline	**Target**				
Trusts Financial Position	I&E Balance			Budget Monitoring			Quarterly
	Proportion of Creditors settled within 30 days			Financial Returns			Quarterly
	Proportion of Debts recovered within 30 days			Financial Returns			Quarterly
PFI Targets	Building Variations to PFI Contract			PFI Contract Monitoring			Quarterly
	Changes to Unitary Payment						
	Achievement of Energy Budgets						
	Achievement of Re-profiling of Budgets						
Financial Indicators	Performance against National Tariffs			Annual Tariff Analysis			12 months after open

APPENDIX O

COMMISSIONER SUPPORT LETTER

A letter of support from Walsall Primary Care Trust as major commissioner of services from the Trust is attached here.

Chairman: Sukhijinder Singh Khera
Chief Executive: Alistair Howie

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Our ref: AH/SF

24 June 2004

Mrs S James
Chief Executive
Walsall Hospitals NHS Trust
Manor Hospital
WALSALL
West Midlands
WS2 9PS

Dear Sue

Hospital Redevelopment Scheme
Outline Business Case

As an important outcome of the work of the Black Country Review, which set out an agreed model of care for our health economy, I am delighted to set out the tPCT's wholehearted support for the project to redevelop the Manor Hospital as set out in your Outline Business Case (OBC) currently being considered by the Strategic Health Authority.

On behalf of the tPCT Board I would confirm our full support for the approval of this scheme and the implementation of the project programme, noting in particular:

- That the forecasts of workload made within the OBC are consistent with the tPCTs Local Delivery Plans for 2003/04 to 2005/06 and the outline strategy for future years, as well as the concordat set out between us and the SHA for changing patterns of care.

- The models of care and planned level of facilities to be developed on the Manor Hospital site reflect a reasonable approach to planning the performance requirements of the scheme and are consistent with the future plans of the local health economy.

- The additional costs proposed are affordable over the period based upon the forecast resources available to the tPCT.

- The Trust and the tPCT will work together to develop further joint working arrangements to ensure efficient and effective use of all facilities encompassing the Walsall Health Economy.

We look forward to the OBC being granted approval to enable the Trust to launch the Private Finance Development of the project later this year, and the delivery of this much needed investment in local health facilities.

Yours sincerely

ALISTAIR HOWIE
CHIEF EXECUTIVE