



Stockport
NHS Foundation Trust

Stockport NHS Foundation Trust
EMERGENCY & URGENT CARE CAMPUS
Stepping Hill Hospital



CONFIDENTIAL
Full Business Case (FBC)
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Document

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1. Introduction

1.1. Overview

This Full Business Case (FBC) seeks approval for the investment of £30.6m capital funding to reconfigure and extend the existing Emergency & Urgent Care footprint at Stepping Hill Hospital.

The redevelopment of the Emergency & Urgent Care Campus (E&UCC) therefore recognises and addresses the current assessment capacity deficit resulting from the growth in the requirement for urgent and emergency care on behalf of the population of Stockport. It will deliver the physical space and co-location of services, needed to meet the objective of right patient, right time, delivering the key principles and design objectives for a new system of urgent and emergency care.

The FBC has been structured in accordance with HM Treasury (HMT), Department of Health and Social Care (DHSC), NHS Improvement (NHSI) and NHS England (NHSE) guidance and is aligned to the Five Case Business Model.

1.2. Background and Context

An application for STP funding was submitted in May 2018 in recognition of a need to increase capacity and improve efficiency of Urgent and Emergency Care (UEC) services for Stockport NHS Foundation Trust. The application recognised serious risks around the existing estate as well as congestion and delays within the Emergency Department (ED) causing significant patient experience, quality and operational efficiency concerns.

In particular, the STP bid focused on avoiding ED congestion by providing capacity for streaming away of patients who do not require ED but should instead be seen directly by the relevant specialty (including primary care) under a Same Day Emergency Care (SDEC) ethos. The co-location of UEC services with the ED and key diagnostics is critical to achieving the efficiency and productivity gains needed to meet the SDEC agenda and ensure patients experience minimal waiting times and avoiding unnecessary admission.

In August 2019 the Trust's STP bid was formally approved by the DHSC and allocated £30.6m of Public Dividend Capital (PDC) funding to the Trust to deliver the project, subject to business case approval. The letter confirming the funding approval is provided in Appendix 1.1.

The subsequent Outline Business Case was submitted to NHS England and was approved by the Joint Investment Sub-Committee (JISC) on 14 March 2022.

1.3. Developments Since the OBC

In summary, the most significant elements to note between the approval of the Outline Business Case (OBC) and completion of this FBC are:

- The option identified in the OBC as the preferred option continues to be that;
- The Economic Case demonstrates that the benefit-cost ratio is maintained; and
- The risks identified in the OBC remain largely unchanged within the FBC.

Following submission of the OBC there were some aspects of the case on which further clarification was request by NHSE/I and DHSC, and these points have been incorporated into this document.

NHSE/I approval conditions include:

- Further analysis will be required during the FBC stage to further, test and validate the demand and capacity assumptions;
- The CCG Letter of Support must include details on whether the demand and activity triangulation assumptions are deemed reasonable and supported;
- Trust reviews and provides detailed workforce plans to demonstrate the project can be managed within existing WTE levels, supported by the activity, demand and financial modelling;
- For FBC, the Trust to review and add non-cash releasing benefits to the CIA model where possible including whether any of the unmonetisable benefits listed can be monetised;
- Trust to review and confirm ratio of clinical to non-clinical space;
- Full planning permission is achieved before submission of the FBC;

- Professional VAT advice is sought and included in the FBC;
- FBC submission to include provision of a fully costed equipment schedule including details of any equipment to be transferred;
- Professional advice must be sought to support the impairment value included in the FBC;
- A fully costed Risk Register is developed for the FBC to include any contingency figures at that stage;
- Trust provides a full benefits realisation plan at FBC demonstrating how the benefits link to the investment objectives and benefits outlined in the Economic Case; and
- All options are appraised over a 60-year period in the CIA model.

DHSC approval conditions include:

- The SRO is responsible for delivering the scope of work and benefits set out in this business case and should notify DHSC Investment Appraisal (IA@dhsc.gov.uk) immediately if these change;
- The Trust will report to the DHSC Capital PMO monthly regarding delivery milestones, financial performance, and overall progress. They will also provide progress updates outside of this monthly cycle if requested;
- At FBC, the Trust to demonstrate further ongoing value engineering works to ensure scheme costs remain within the £30.6m PDC allocation;
- PDC funding is capped at £30.6m. Any spend in excess of this will be met by Trust internally generated resources and/or the ICS;
- At FBC, the Trust should include all relevant NCRBs in the CIA model. Where applicable, QALY benefits should also be included;
- At FBC, the Trust must be able to evidence full planning approval, noting that the FBC will not be approved without this confirmation;
- The Trust will need to obtain and include a GMP in the FBC in advance of submission;
- At FBC, the Trust should ensure that the business case removes any reference to benefits no longer included in the CIA model;
- GMP to be provided at RIBA 4 stage and any issues in the initial PDC being at risk with increased costs need to be presented to DHSC/NHSEI at initial awareness for discussion;
- Procurement of equipment including IT needs to be in-line with the Trust's SFIs to show compliance and VFM, with processes to be presented in the FBC;
- Planning permission to be fully approved and any conditions to be detailed along with any risk identifiers;
- At FBC, KPI's that will be used to show contractual performance management throughout the scheme through to handover stage should be included to ensure robust contractual delivery;
- At FBC, the Trust to supply a schedule based on an FBC approval through to scheme completion including any risks identified;
- At FBC, the Trust should provide further information on costs mitigation e.g. charitable funds;
- At FBC stage, the Trust to provide what the final % of non-clinical space will be once the scheme is delivered;
- At FBC, the Trust to provide a clear summary of what elements of the scheme will utilise MMC and what the final % will be;
- At FBC, the Trust to provide a total value of the amount of backlog cost removed as a result of this scheme;
- The project team should consider a Gate 3 review ahead of FBC submission and liaise with DHSC Capital Delivery PMO at capitaldeliverypmo@dhsc.gov.uk to arrange this; and
- At FBC, the project team are required to provide a costed risk register.

1.4. Funding Envelope

PDC funding of £30.6m was indicated for the E&UCC Programme based on STP submission in May 2018. The affordable build within the constraints of the award is described within the OBC and FBC and has been taken through quantitative analysis.

A clinical environment that can meet the existing and future demand as part of the E&UCC project is described and the total estimated cost of delivering this preferred option is £30.6m in current day prices inclusive of VAT, contingency and Optimism Bias.

It should be noted that limited value engineering has taken place to date and costs presented are considered to be the maximum expected and might reduce through Full Business Case (FBC) development.

1.5. Approvals and Support

The development of this FBC has received Executive support throughout and was presented to The Trust Board by the SRO; the Director of Finance. The Trust Board has formally approved this FBC, and confirmation is attached at Appendix 1.2.

A Letter of Support has been received from Stockport Metropolitan Borough Council (SMBC), the local council, and is attached in Appendix 1.3.

A Letter of Support has been received from Stockport Clinical Commissioning Group (SCCG), and is attached in Appendix 1.4.

A Letter of Support has been received from Greater Manchester Health & Social Care Partnership, and is attached in Appendix 1.5.

The following checklists have been completed to demonstrate where all the requirements have been met:

- **NHSE&I Business Case Core Checklist** - This FBC complies with the NHSI document “Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts” and specifically “Annex 1: Business case core checklist of November 2016” (referred to as “the NHSE&I checklist”). A copy of the NHSE&I checklist, cross-referenced against the contents of this FBC, is included in Appendix 1.6.
- **NHSE&I Fundamental Criteria** - This FBC complies with the NHSE&I “*Fundamental Criteria*” (2020). A copy of the NHSE&I Fundamental Criteria, cross-referenced against the contents of this FBC, is included in Appendix 1.7.

2. Executive Summary

2.1. Strategic Case

The Strategic Case provides an overview of Stockport NHS Foundation Trust (the Trust) and describes plans to deliver against key internal and external strategic priorities that include the Trust's vision and values, and other national, regional and local priorities. It describes how current service capacity and configuration falls short of meeting demand, performance and quality measures whilst detailing the need for investment to realise local ambitions as well as the aspirations of the NHS Long Term Plan (LTP).

2.1.1 Current Service and System Pressures

The Stockport health and social care economy has been significantly challenged in managing the demand and flow of Urgent and Emergency Care (UEC) in recent years. The Stockport Emergency Department (ED) was originally designed for 50,000 attendances per annum yet in 2019/20 had greater than 100,000 attendances from walk in, ambulances and patients referred from a community setting. This has been further exacerbated as we recover from COVID-19 with unprecedented demand since easing of restrictions. This has resulted in long waits for patients to be seen or admitted, and performance below the 4-hour national standard. This has compromised quality of care through near continuous congestion of ED, especially during winter months, and extended waits for patients before they reach the right specialty bed or team to effectively manage their needs.

Activity through ED has been modelled over the last ten years and demonstrates a relatively consistent increase year on year - admission rates mirrored this increase up until 2020. Attendances and admissions are highest on Monday's, with minor injuries and illness attendances increasing at the weekend.

The Stockport system currently offers little or no other option than ED for patients referred from community to be seen quickly by an appropriate specialty in an acute setting. Approximately 40 patients a day arrive in the ED having been referred by a primary care or community setting. Some patients do not require ED but consequently suffer from long waits due to overcrowding and congestion, and the likelihood of admission increases when normal service hours end for critical discharge pathways. Bringing these patients into hospital earlier and direct to specialty - avoiding ED altogether - is critical to decongesting ED, improvements in quality care and system flow.

In January 2020, the Trust set out a revised strategy aimed at meeting the challenges and to anticipate future healthcare needs. This was reviewed in light of the COVID-19 pandemic and describes the aspirational vision of the organisation. The Trusts high-level commitments are:

- To become a clinically led and managerially enabled organisation;
- To be appropriately recognised for the provision of outstanding care;
- To develop our capacity and capability for transformation; and
- To forge strategic partnerships with neighbouring Trusts and local partners to ensure sustainability and development of services.

The Strategic Case describes the objectives for the planned investment in the reorganisation of the Emergency and Urgent Care Campus (E&UCC) at Stepping Hill Hospital in Stockport. Our ambition is:

- A fit for purpose emergency and urgent care facility;
- Agile and effective space utilisation;
- Reduced backlog maintenance;
- Improved quality of care for patients and staff;
- Improved patient flow and associated operational performance; and
- Improved reputation of the Trust

The Trust Strategy and Clinical Strategy, alongside capital investment, aim to sustain and future proof quality care and performance through reconfigured physical space to meet clinical need.

2.1.2 Strategic Drivers / Case for Change

The Trusts vision continues to be focused on supporting population health by ensuring that, when necessary, access to emergency and urgent care services is readily available and responsive. The design and provision of these services should be simple to navigate both for people requiring using them, and for the staff working within them. The duplication of offers which can be confusing to the public, and inefficient, need to be consolidated to allow clear clinical pathways to be developed which ensure that the right levels of care can be provided effectively at the time and in the manner the patient requires.

The Stockport health and social care economy has been significantly challenged in managing the demand and flow of urgent and emergency care in recent years. This has resulted in long waits for patients to be seen or admitted and performance across the system remaining below the 4-hour national standard. This has compromised quality of care through near continuous congestion of the ED, especially during winter months, meaning extended waits for patients before they reach the right specialty bed or team for their needs.

The current Emergency Department was reconfigured in the 1990's and since then there has been a circa 35% growth in attendances resulting in overcrowding, patients being nursed and assessed in unsuitable areas and a difficulty in achieving the 4-hour quality standard on a consistent basis. The congestion that inevitably results from a lack of physical capacity impacts negatively on patient and staff experience. It also leads to inefficiencies in staffing and process, preventing effective implementation of what is recognised as national best practice.

This proposed regeneration of the E&UCC recognises and seeks to address the current assessment capacity shortfalls resulting from the growth in demand for urgent and emergency care in Stockport and surrounding areas. The new E&UCC will deliver the physical space and co-location of services needed to meet the objective of right patient, right time, thus delivering the key principles and design objectives for a new system of urgent and emergency care.

2.1.3 National and Local Context

The Trust Strategy, Clinical Strategy and E&UCC programme have been aligned to help deliver three key aims of the local systems strategic plan. Our local partnership approach also underpins the strategic aims of Stockport CCG's '*Start Well, Live Well, Age Well, and Die Well*' strategy.

Greater Manchester Health and Social Care Authority has set out expectations for all regional systems to achieve a recognisable Urgent Treatment Centre (UTC) approach to the management of Urgent Care in 2020. The E&UCC Programme provides the additional footprint for this to be implemented for Stockport, within a refurbished area of the campus co-located with ED. This will allow the current UTC pilot project to transfer and fulfil expected potential from being a co-located, primary care led service that deflects and streams patients away from ED.

The LTP gives clear directive about the need for a new service model for the 21st century. The plan specifically commits to reduce pressure on emergency hospital services through reform; from traditional models to a Same Day Emergency Care (SDEC) model. Consequently, every hospital with Type 1 activity must move to a comprehensive model of SDEC service delivery. The commitment to improving hospital-based emergency care reads through from the Trust Strategy and Stockport Locality Plan with partners providing the context for the E&UCC investment for the Stockport System.

2.1.4 Activity and Capacity Modelling

Modelling based on the Summary Emergency Department Index Tool (SEDIT) metrics, which is hosted through the Model Hospital, suggests a gap of 7 trolleys now, whilst further analysis puts this closer to 12 trolleys in order to maintain the 4-hour standard at peak attendance times.

Over a 10-year period a conservative estimate based on averaged historic demographic demand growth estimates a requirement for a total of 14 additional assessment spaces.

Over a 10-year period a more resilient estimate suggests 28 additional assessment spaces would be needed in 10 years.

In conclusion, the following has been integral to the design process and workforce modelling:

- Current capacity gap to manage peak attends;
- Forecast capacity to match a population demand growth (1.6% averaged annual projection);
- Changes in clinical pathways e.g. Healthier Together;
- Influence of transformation schemes such as navigation/streaming, UTC and SDEC; and

- Clinical sense-check.

This project is primarily an estate re-development and re-organisation. However, there will be workforce challenges from managing a larger footprint with increased numbers of assessment spaces, and the workforce model will need to adapt. Concurrently digital solutions and improvements in operational efficiency are also expected to shape the workforce model. Engagement activities have taken place to review the future workforce model in terms of required skills and capabilities in addition to whole time equivalent (WTE) movement.

The workforce strategy will continue to develop beyond the FBC; future growth in workforce will continue to be linked to year-on-year growth in population demand.

2.1.5 Investment Objectives

The strategic and policy context have enabled the Trust to define a clear set of investment objectives, which are set out in the table below.

Figure 1. Investment Objectives

Objective	Investment Objective Description
Future proofing capacity for urgent & emergency care	To provide future proof, modern physical space needed to deliver urgent care access standards
Improved Streaming	To provide co-located facilities for pre-hospital navigated patients to access specialty care directly without the need for prior assessment in ED
Clinical strategy – Same Day Emergency Care	To increase capacity for same day assessment for patients needing urgent services across key specialties
Responding to demand for patients presenting in mental health crisis	Increase capacity for patients in need of mental health support
Clinical strategy – ambulance turnaround	To provide an appropriate environment for the safe and timely handover of patients arriving by ambulance
Economic	To support economic regeneration through reconfiguration of the existing NHS estate
Patient Experience	To modernise services and facilities which will ensure improvement in the overall patient and visitor experience
Staff Health & Wellbeing	To provide modern facilities which will ensure adequate resources to meet demand and enhance staff experience

2.2. Economic Case

The purpose of the Economic Case is to identify and evaluate options that have been considered in response to fulfilling the Investment Objectives and meeting the Critical Success Factors (CSFs). It demonstrates which of the considered options is preferred, by undertaking a qualitative and quantitative economic appraisal. It identifies and considers the options which could address the scope and completes an economic appraisal of those options.

This case:

- Presents the CSFs;
- Develops and considers the long list of options using the *Option Framework* and determines the short list of options and Preferred Way Forward;
- Undertakes a quantitative analysis of each shortlisted option, e.g. a risk adjusted Net Present Value (NPV) calculation and Benefit Cost Ratio; and
- Selects the preferred option.

The appraisal process has enabled the Trust to identify those options which could deliver the Trust's Investment Objectives in the strategic context of the E&UCC programme.

2.2.1 Critical Success Factors

To assess the relative merits of each, the long list of options has been assessed against the Investment Objectives and the CSFs.

The Trust, in considering its Investment Objectives, has identified five CSFs namely:

- Strategic fit and business needs;
- Potential value for money;
- Supply side capacity and capability;
- Potential affordability; and
- Potential achievability.

2.2.2 Options Appraisal

As outlined in the OBC, nine options have been considered. The scope of each option is described as follows:

- **Option A1** Business as Usual (BAU) - UEC services will continue to operate as-is, and capital investment will be limited to essential backlog maintenance and lifecycle costs only;
- **Option A2** Do Minimum – UEC services will continue to operate as they are in Years 1-10 but with a full refurbishment planned in Year 10;
- **Option A3** – Reconfiguration and extension of the existing UEC footprint;
- **Option A4** – UEC services co-located with existing ED and diagnostics in form of SURC and UTC;
- **Option A5** – Reconfiguration and extension of the existing ED footprint and outpatient's area;
- **Option A6** – Combined larger E&UCC with optimal clinical capacity;
- **Option A7** – Reconfiguration and larger extension of the existing UEC footprint;
- **Option A8** – Reconfiguration of existing ED and new build extension within Oak House Plaza on the Stepping Hill site; and
- **Option A9** - New build on Pinewood Car Park.

The table below provides a summary of the longlist of options (combination of all options). Each element of the options has been considered and either Discounted, Carried Forward or deemed to be the Preferred Way Forward.

Figure 2. Identification of the Shortlist of Options through the Options Framework

A. Scope	A1: Urgent and Emergency Care (UEC) services will continue to operate as they are, and capital investment will be limited to essential backlog maintenance and lifecycle costs only.	A2: Current UEC services in existing locations Capital investment will be limited to essential backlog maintenance and lifecycle costs only in Years 1-14 but with a full refurbishment planned in Year 15. This will be limited to the existing footprint and will not address current or future capacity	A3: Reconfiguration and extension of the existing UEC footprint New Build: 1,343m ² Refurb: 2,607m ² Budget Estimate: £30.6m	A4: UEC services co-located with existing ED and diagnostics in form of SURC and UTC New Build: 4,523m ² Budget Estimate: £30.6m	A5: Reconfiguration and extension of the existing ED footprint and outpatient area New Build: 927m ² Refurb: 2,830m ² Budget Estimate: £35.94m	A6: Combined larger E&UCC with optimal clinical capacity Budget Estimate: £37.7m	A7: Reconfiguration and larger extension of the existing UEC footprint New Build: 2,987m ² Refurb: 2,607m ² Budget Estimate: £40m	A8: Reconfiguration of existing ED and new build extension within Oak House Plaza on the Stepping Hill site New Build: 2,867m ² Refurb: 1,790m ² Budget Estimate: £45.61m	A9: New build on Pinewood Car Park New Build: 4,564m ² Refurb: 0m ² Budget Estimate: £47.8m

		issues.							
B. Solution	B1. Address backlog maintenance only	B1. Address backlog maintenance only	B2. Reconfiguration of the Stepping Hill estate	B3. Reconfiguration and extension of the existing ED footprint including addressing backlog maintenance	B4. All new build on greenfield site				
C. Delivery: Construction	C1A. Trust implement	C1A. Trust implement	C2A. Private sector						
C. Delivery: Facilities Management	C1B. In-house hard and soft FM	C2B. In-house hard and soft FM		C3B. Outsource hard FM, in-house soft FM	C5B: Outsource hard and soft FM				
D. Implementation	D1. Staged delivery	D1. Staged delivery	D2. Phased approach		D3: Single phase				
E. Funding	E1. Trust funded	E1. Trust funded	E2. PDC		E3. External finance				

The table above illustrates that, in addition to Option 1 (the BAU or counterfactual option), four further options have been brought forward to the shortlist as follows:

Figure 3. Summary of the Short List of Options

Option	Letter Code	Description
1	A1, B1, C1A, C1B, D1, E1	<p>BAU - UEC services will continue to operate as they are, and capital investment will be limited to essential backlog maintenance and lifecycle costs only</p> <p>The BAU option involves capital investment to reduce the levels of backlog maintenance only. The UEC services will continue to operate as-is and across separate locations. Address backlog only (by the Trust), in-house FM services, staged delivery, paid for by Trust finances.</p>
2	A2, B1, C1A, C2B, D1, E1	<p>Do Minimum - Current UEC services in existing locations</p> <p>Capital investment will be limited to essential backlog maintenance and lifecycle costs only in Years 1-10 but with a full refurbishment planned in Year 10. This will be limited to the existing footprint and will not address current or future capacity issues. Address backlog only (by the Trust), in-house FM services, staged delivery, paid for by Trust finances.</p>
3	A3, B3, C2A, C2B, D2, E2	<p>Reconfiguration and extension of the existing UEC footprint on the Stepping Hill site</p> <p>New build: 1,343m²; refurbishment: 2,607m²</p> <p>Budget estimate: £30.6m</p> <p>Private sector construction, in-house hard and soft FM, phased implementation, PDC funding.</p>
4	A4, B3, C2A, C2B, D2, E2	<p>UEC services co-located with existing ED and diagnostics in form of SURC and UTC</p> <p>New build: 4,523m²; no refurbishment</p> <p>Budget estimate: £30.6m</p> <p>Private sector construction, in-house hard and soft FM, phased implementation, PDC funding.</p>
7	A7, B3, C2A, C2B, D2, E2	<p>Reconfiguration and larger extension of the existing UEC footprint</p> <p>New build: 2,987m²; refurbishment 2,607m²</p> <p>Budget estimate: £40m</p> <p>Private sector construction, in-house hard and soft FM, phased implementation, PDC funding.</p>

This process has provided a short list of viable options to be taken forward for quantitative appraisal. This quantitative analysis has been prepared on a Discounted Cash Flows (DCF) basis using the Capital Investment Appraisal (CIA) model, which is the recommended economic appraisal methodology for investment business cases in accordance with Department of Health & Social Care (DHSC) and HMT Green Book Guidance.

2.2.3 Quantitative Economic Analysis

The quantitative analysis involves the following calculations:

- **Discounted Cash Flows:** discounted economic cash flows (capital costs, optimism bias, maintenance costs, revenue expenditure, net contributions, opportunity costs and transitional costs) over a defined project appraisal period.
- **Net Present Social Value:** discounted economic cash flows and quantifiable risks determine a risk-adjusted Net Present Social Value (NPSV) for each option.
- **Benefit-Cost Ratio:** The quantifiable benefits are then assessed against the incremental NPSV to determine a benefit-cost ratio for each option. This metric is used to evaluate the Value for Money (VfM) delivered by options, with DHSC requirements being that at least a 1:1 ratio is achieved and that the NICE 4:1 ratio applied in assessing new medications should be used as a comparator for public capital spending in order to demonstrate VfM.

A summary of the outcome of the quantitative appraisal is presented below, which shows Option 3 remains the preferred option against each criterion, as identified in the OBC.

Figure 4. Quantitative Analysis Summary

£'000	Option 1 (BAU)	Option 2	Option 3	Option 4	Option 7 (in longlist)
Discounted Cash Flow	7,225,276	7,238,829	7,239,502	7,263,495	7,311,566
Rank	1	2	3	4	5
Risk Adjusted NPV	7,278,207	7,279,027	7,246,612	7,277,257	7,321,139
Rank	3	4	1	2	5
Net Present Social Value	-	6,750	97,137	42,253	21,753
Rank	-	4	1	2	3
Benefit-Cost Ratio	-	1.50	7.07	2.06	1.25
Rank	-	3	1	2	4

The above table shows:

- **Discounted Cash Flow (DCF):** BAU has the lowest Net Present Cost (NPC) over the 63-year appraisal period, with an incremental saving of 0.2%, 0.2%, 0.53%, and 1.18% in present value terms when compared to the Options 2, 3, 4, and 7 respectively. BAU has the lowest NPC due to the lack of upfront capital cost, with a present value saving of £14.3m compared to Do Minimum, £14.2m in capital costs when compared to the Option 3, £38.2m compared to Option 4, and £86.3m compared to Option 7. Additionally, the BAU option is advantaged through a savings in revenue costs of £6.4m, £71.2m, and £159.6m when compared to Options 3, 4, and 7 respectively, which result from a lower cost in building running and utility costs, as well as any additional staff requirements as seen in Options 5 and 6. There are no opportunity costs considered due to the development site's lack of appeal and subsequent lack of land value from a developer perspective. Additionally, no dual running is required at any stage in the development of Option 3, 4, and 7, and as a result no transitional costs have been included. Option 2 is expected to incur some transitional costs for modular accommodation in Year 10.
- **Net Present Social Value (NPSV):** Option 3 demonstrates the lowest risk option, with substantial reductions in operational risk achieved through a fully refurbished emergency department. Options 4 and 7 also achieves all of these benefits; however Option 3 is assumed to be able to provide services at a greater capacity on the existing staffing requirements, resulting in savings to revenue costs compared to Options 4 and 7. In general, Options 3, 4, and 7 achieve benefits through a reduced turnover of staff, as well as an overall more efficient staffing model with reduced sickness rates, recruitment costs, as well as supernumerary cover and headcount requirements, and provide economic regeneration to the local economy as a result of the development. This is in addition to a wide number of unmonetisable benefits, which are expected to be achieved for each of the options.
- **Benefit-Cost Ratio (BCR):** While Option 7 delivers a higher level of quantified benefits over the appraisal period than Option 3 and Option 4, Option 3 is significantly more favourable from a BCR perspective. This is due to an Option 3 having an incremental cost of £16.0m in, which is a result of the lower capital cost and lifecycle cost requirements, as well as the cost of staff, plus additional building running and utility costs over the 63-year appraisal period, compared to £113.1m of incremental benefits, which are driven by improvements to staffing and workforce models, patient length of stay, stock wastage, legal fees, and prescription charges, as well as non-cash related efficiencies and value added

to society in various ways as a result of the development. Therefore Option 3, which was the preferred way forward from the qualitative appraisal, presents the highest benefit to cost ratio of the shortlisted options and is deemed to represent value for money for the public sector.

Based on the combined qualitative and quantitative evaluation, Option 3 remains the preferred option from both the qualitative and quantitative appraisal results from OBC stage. This has been subject to further sensitivity and switching analysis in the Economic Case.

2.3. Commercial Case

The purpose of the Commercial Case is to set out how the Trust is procuring the design and build works, enabling and temporary works, equipment, IM&T, and professional services; confirm the commercial and contractual arrangements; set out an appropriate transfer of risk; confirm the negotiated deal with the Trust's ProCure22 PSCP; and confirms that the proposed solution is commercially feasible and deliverable.

In addition, this section sets out the proposed solution in more detail, including all key design and compliance issues; statutory approvals; and the phasing and sequencing.

The project brief is to provide additional capacity, where urgent and emergency care services will be relocated to reduce congestion through the ED and to deliver co-located UTC and SDEC; both key elements for Urgent & Emergency Care in the NHS.

This section describes how the Trust is "Preparing for the Potential Deal", as set out in the HM Treasury "Green Book"; in order to demonstrate that the Trust will secure long-term public value during the operational phase of the project. This Commercial Case is based on the Trust implementing its current Preferred Option.

Procurement of Professional Services: The Trust has an experienced and capable in-house capital project and estates team that will provide ownership, co-ordination, and continuity of the project at both a strategic and a management level. The Trust however requires specialist advice in technical areas to support delivery which will be procured by the Trust. All of these appointments were competitively tendered, awarded through the NHS Shared Business Services (SBS) Framework, appointed through the Trust's ProCure22 PSCP partner, or directly awarded due to their low value. Appointment of further professional services may be required for the construction stage.

Procurement of main works: Further to a detailed procurement exercise, the optimum procurement route for the new E&UCC was determined at OBC stage to be via the NHS P22 Framework. The Trust is using the NHS P22 Framework, and the works are let as a single project to a single PSCP. This will ensure a single point of responsibility for the delivery of the project and means the PSCP will need to manage any interdependencies.

The Trust undertook the **selection of the P22 PSCP** in parallel with developing the OBC; to allow the PSCP to be appointed in time to provide support to the Trust for the OBC and FBC. The Trust selected its P22 PSCP Tilbury Douglas (formally Interserve Construction Ltd), who have been appointed. The P22 procurement process commenced in September 2020 and proceeded in line with the recommended timescales specified within the framework. The Trust has entered into a P22 Scheme Form of Agreement with Tilbury Douglas and issued them with a Project Letter of Instruction for the E&UCC redevelopment. The P22 "Stage 3" contract has been agreed and executed.

Procurement of other works: The E&UCC project is required to be delivered on a phased basis whilst keeping the existing departments open and operational. The vast majority of the required works to be undertaken are procured through the P22 agreement with the Trust's PSCP (Tilbury Douglas). The Trust is however required to undertake a number of enabling, associated, and temporary works. These works will be undertaken as direct pieces of work and are being competitively tendered by the Trust as direct appointments outside of the P22 appointment, all of which is being undertaken in line with the Trust's procurement rules and SFIs.

Land Acquisition: No land is required to be acquired as part of the E&UCC development, and the proposed redline boundary sits wholly within the existing Stepping Hill Hospital site. No additional buildings will be purchased as part of the project. The proposed construction site is owned by the Trust.

Equipment: A significant amount of new furniture, fixtures, and equipment (FF&E) will need to be procured as part of delivering the E&UCC. The FF&E for the new building will be partly on an "all new" basis, with some FF&E transferred from the existing Stepping Hill Hospital estate, where this is considered to be in a

more than reasonable condition. The Trust will procure the new Group 2 and Group 3/4 equipment itself, utilising established NHS Frameworks and other suitable and compliant buying arrangements.

IM&T Strategy and Procurement: The Trust's Digital Strategy 2021-2026 has been developed. As part of the P22 construction works, the PSCP will provide a fully integrated, contained, and cabled IM&T network throughout all the new buildings with sufficient incoming ducts and cable ways for external fibre and communications cabling.

An **IM&T Responsibility Matrix** has been agreed which sets out the responsibilities of all parties. The Trust IM&T department in conjunction with the E&UCC Project Team, will purchase, supply and fit out all the necessary IM&T hardware required to service the new facility. These items will be procured in the same way as the general FF&E via a procurement framework to comply with the Trust's Standing Financial Instructions; or where this is not possible via a tender exercise.

Facilities Management (FM): The majority of the existing facilities management is undertaken in-house by the Trust. This arrangement will be maintained for the newly refurbished building, and all existing SLAs will be extended as required at the end of each phase as it completes. There are no major issues or commercial risks anticipated as a result of this.

ProCure22 Stage 4 Appointment (The Negotiated Deal): In line with Actions 28 and 34 of the HM Treasury Blue Book, the Commercial Case sets out the negotiated "Deal" and the contractual arrangements for the design and build elements of the project, including Tilbury Douglas GMP and Trust review and acceptance; Value engineering and route to affordability; Proposed Stage 4 contract arrangements; Proposed payment basis; and Proposed gain share and incentivisation agreements. Once this FBC is approved, the Trust will enter into a formal P22 Stage 4 Agreement with Tilbury Douglas, authorising the completion of the final design and construction of all the works being completed under the P22 contract.

Guaranteed Maximum Price: The GMP or 'target price' in the NEC3 Contract is the agreed maximum outturn cost between the Trust and IHP for all Tilbury Douglas's costs, including Stage 4 construction works and all design work, based on the defined scope of work at the time the GMP is agreed. Tilbury Douglas are due to issue their GMP submission on 21 June 2022, which is anticipated to be for a sum of approximately £23.75m. Full details of this will be provided to NHSE&I as an addendum to this FBC (to follow). The Trust's Project Managers (Rider Hunt) and Cost Advisors (O'Neill and Partners) will review the Tilbury Douglas GMP submission and confirm they are satisfied the P22 process has been followed and sufficient market testing has been carried out. The GMP will remain valid until the Stage 4 contract is executed, subject to any Trust risks coming to fruition.

Value Engineering and Route to Affordability: Further to the submission of the OBC, and as the FBC stage design has developed, it became evident that increased construction costs would be incurred due to a number of contributing factors, including scope creep and other factors outside of the Trust's control (including the ongoing impacts of Brexit, COVID-19, market instability, material availability, and inflation). A detailed Value Engineering (VE) exercise was undertaken to consider all potential efficiency opportunities. The VE process which was undertaken jointly and collaboratively between the Trust and Tilbury Douglas (supported by Rider Hunt and O'Neill and Partners) sought to reduce or eliminate unwanted project costs by considering the need for, and/or assessing alternative options in order to find the most cost-effective solution, whilst maintaining delivery of the E&UCC project's objectives. All scheduled VE opportunities were captured within a VE register, along with potential savings and potential impact; and were RAG rated, considering the likely consequences if instructed. Several VE sessions were held with key stakeholders, and all VE items considered reasonable were taken forward for further discussion and agreement. The VE process has achieved both a current anticipated GMP which is now within the Trust's affordability envelope, and assurance that the proposed design is cost-effective, offers VfM, meets the Trust's brief, and delivers against its spending objectives.

Accounting Treatment: The accounting treatment of the Emergency Care Campus will be undertaken by applying the current accounting guidance as laid out in the HM Treasury Green Book (2018). The Trust recognises that the new asset will be recognised on the Trust's balance sheet along with the corresponding PDC funding. The Trust suggests that this is a relatively "standard" assumption and that this does not need to be verified through the external auditors, although this can be obtained should this be required.

Commercial Opportunities and Charitable Funding: The Trust has considered both commercial opportunities and charitable funding as part of this FBC.

Market Interest: There is significant interest in the new E&UCC proposal due to its size, profile, and South Manchester location; including significant interest from the supplier and sub-contract market.

Enabling Works, Decanting and Temporary Facilities: The Trust is intending to relocate the existing Pacing Lab - currently within the UEC footprint - to a vacant location elsewhere on the Stepping Hill Hospital site. These enabling works will be undertaken by the P22 PSCP but funded internally as part of the capital programme. Due to poor adjacencies the Trust had planned to carry out this element of work regardless of the E&UCC. Works will be completed before the main construction works for the E&UCC commence.

The **new E&UCC facility** will be a combination of both new real estate extensions and courtyard infills tied into the existing building with a phased approach to the construction periods to ensure that key clinical provisions remain fully functional. Due to the relocation of the pacing suite and the additional footprint created by the new build elements, which will be done first, no temporary accommodation is deemed to be required. A newly refurbished ward on site is also available as a decant space to support the phased programme of works.

Contractual Issues (including standard contract and variations): The Trust has adopted the standard ProCure22 contract “NEC3 Engineering and Construction Contract (E&UCC)” for the project, complemented by the specific project details. There are not anticipated to be any variations from the standard contract. Any direct works procured outside of P22 will use standard forms of contract, such as Joint Contract Tribunal (JCT), NEC3, or NHS Supply of Goods and Services.

Compliance with EU Procurement Law / Find a Tender: The Trust has fully complied with all required procurement legislation, including EU procurement law prior to Brexit, and Find a Tender afterwards, as well as the Trust’s SFIs.

Legal Advice: The Trust has not experienced any significant procurement-related commercial or legal issues arising for the design and construction works to date, due to the Trust utilising the ProCure22 Framework which is the default option for NHS construction projects; and is not anticipating any significant issues arising in the future. Hempsons Solicitors have reviewed the ProCure22 Stage 3 contract prior to this being executed by the Trust and Tilbury Douglas, and are supporting the development of the ProCure22 Stage 4 contract prior to this being agreed.

Engagement with the Trust Procurement Team: The Trust Procurement Team has been involved in the project, and this FBC has been developed in conjunction with them. The Procurement Team are therefore fully on board with the items identified within this Commercial Case.

Personnel Implications: The Trust does not expect there to be any redundancies arising from the preferred option. TUPE regulations will not apply to this investment as no undertakings will transfer between employing entities. For the preferred option no additional staffing is required and so none has been costed within the base revenue costs. A costed risk that extra staff is required has been included which is set out within the economic modelling. Workforce implications due to the change in clinical services have been included within the Management Case.

Commercial Feasibility and Deliverability: The Trust considers that the E&UCC project is commercially feasible and deliverable; and comes with an acceptable level of risk.

Build Scheme and Compliance with Relevant Standards and Guidance: The Commercial Case sets out full details of the proposed design, and compliance with all relevant standards and guidance; including all design and build and clinical quality elements of the proposed E&UCC project at the Stepping Hill Hospital site.

This section also includes details of the proposed phasing, statutory approvals (incl. planning), Modern Methods of Construction, BREEAM/environmental, and enabling works.

Further FBC stage details of all design and build elements are included within the attached Estates Annexe as prepared by the Trust’s P22 Partner, Tilbury Douglas.

2.4. Financial Case

The purpose of the Financial Case is to set out the forecast financial implications of the preferred way forward (as set out in the Economic Case) and the proposed solution and its procurement route (as set out in

the Commercial Case). It describes the impact on the main financial statements of the Trust – the Statement of Comprehensive Income (SoCI) and Statement of Financial Position (SoFP) and the Statement of Cash Flows (SoCF) – and forms a conclusion on the overall affordability and accounting treatment of the options.

2.4.1 Affordability Analysis

An overview of the recurrent cost of each of the options is provided below and detailed breakdown of workings are provided in the appendices to this business case.

2.4.2 Option 1 – Business As Usual (BAU)

The figure below demonstrates the summary SoCI impact of the BAU Option (Option 1) over the period 2020/21 to 2030/31.

Figure 5. Option 1 SoCI

Option 1: Business As Usual	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
Clinical Income	267,976	271,103	274,267	277,468	280,706	283,981	287,296	290,648	294,040	297,472	300,943
Other Income	31,375	31,375	31,375	31,375	31,375	31,375	31,375	31,375	31,375	31,375	31,375
Total Income	299,351	302,479	305,642	308,843	312,081	315,357	318,671	322,024	325,416	328,847	332,318
Pay	(226,074)	(230,569)	(234,950)	(239,414)	(243,962)	(248,598)	(253,321)	(258,134)	(263,039)	(268,036)	(273,129)
Non pay	(100,870)	(100,417)	(101,902)	(103,419)	(104,969)	(106,553)	(108,171)	(109,824)	(111,513)	(113,238)	(115,000)
Depreciation	(10,887)	(12,900)	(12,900)	(12,900)	(12,900)	(12,900)	(12,900)	(12,900)	(12,900)	(12,900)	(12,900)
PDC	(3,914)	(3,914)	(5,618)	(7,479)	(9,505)	(11,705)	(14,174)	(16,752)	(19,533)	(22,527)	(25,744)
Interest	(675)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)
Total Expenditure	(342,221)	(348,460)	(356,029)	(363,872)	(371,997)	(380,416)	(389,227)	(398,271)	(407,645)	(417,362)	(427,433)
Surplus (Deficit)	(42,870)	(45,981)	(50,387)	(55,029)	(59,916)	(65,059)	(70,556)	(76,247)	(82,229)	(88,515)	(95,114)

Whilst the funding regime post 2021/22 remains uncertain, the above makes no provision for central funding previously received as Financial Recovery Funding (FRF) and Covid system support, leading to financial deterioration as a result of escalating costs of financing through additional Public Dividend Capital.

In 2019/2020 the Trust achieved a surplus of £2.6 million. However, this was reliant upon £27.6 million of system support and upon £15 million of non-recurrent savings. In 2020/21 and 2021/22 the finance regime changed with Trusts in receipt of national retrospective top up funding to meet the challenges of the Covid pandemic. The Long-Term Financial Plan model has been prepared consistent with the Trust financial trajectory prior to the Covid finance regime and an underlying deficit coming into 2021/22 of £42.9 million. This illustrates, that the Trust will require continued external funding (FRF or revenue support from DHSC or equivalent) in order to avoid escalating costs of dividend payments, and cash support for the foreseeable future.

2.4.3 Option 3 – Preferred Option

The figure below demonstrates the summary SoCI impact of the Preferred Option (Option 3) over the period 2020/21 to 2030/31.

Figure 6. Preferred Option (Option 3) SoCI

Option 3: Preferred Option	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
Clinical Income	267,976	271,103	274,267	277,468	280,706	283,981	287,296	290,648	294,040	297,472	300,943
Other Income	31,375	31,375	31,375	31,375	31,530	31,530	31,530	31,530	31,530	31,530	31,530
Total Income	299,351	302,479	305,642	308,843	312,236	315,512	318,826	322,179	325,571	329,002	332,474
Pay	(226,074)	(230,370)	(234,747)	(239,207)	(243,272)	(248,383)	(251,064)	(255,834)	(260,895)	(265,849)	(270,896)
Non pay	(100,870)	(100,160)	(101,640)	(103,152)	(104,778)	(106,358)	(107,972)	(109,621)	(111,308)	(113,027)	(114,784)
Depreciation	(10,887)	(12,900)	(12,900)	(12,900)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)
PDC	(3,914)	(3,958)	(6,236)	(8,245)	(10,227)	(12,533)	(14,880)	(17,416)	(20,151)	(23,096)	(26,260)
Interest	(675)	(1,805)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)
Impairment		0	0	0	(4,135)	0	0	0	0	0	0
Total Expenditure	(342,221)	(348,993)	(356,183)	(364,164)	(375,716)	(379,579)	(388,221)	(397,176)	(406,457)	(416,075)	(426,045)
Surplus (Deficit)	(42,870)	(46,514)	(50,541)	(55,321)	(63,480)	(64,067)	(69,395)	(74,997)	(80,886)	(87,073)	(93,571)

All economic modeling assumptions in Option 3 remain consistent with those applied to the BAU option.

The Trust LTFM illustrates that the investment as set out by the preferred Option 3 is deliverable and improves the Trust financial trajectory post build (and excluding impairment of £4.1 million) in 24/25 by £0.5m to £1.5m by 30/31.

Figure 7. Preferred Option 3 v's Option 1 BAU

Option 3: Incremental SOCI BAU v Preferred Option	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
Clinical Income	0	0	0	0	0	0	0	0	0	0	0
Other Income	0	0	0	0	155	155	155	155	155	155	155
Total Income	0	0	0	0	155	155	155	155	155	155	155
Pay	0	199	203	207	1,691	2,215	2,257	2,300	2,343	2,388	2,433
Non pay	0	257	262	267	191	195	199	203	207	211	215
Depreciation	0	0	0	0	(744)	(744)	(744)	(744)	(744)	(744)	(744)
PDC	0	(44)	(618)	(766)	(722)	(828)	(706)	(664)	(618)	(568)	(516)
Interest	0	0	0	0	0	0	0	0	0	0	0
Impairment	0	(945)	0	0	(4,135)	0	0	0	0	0	0
Total Expenditure	0	412	(154)	(293)	416	838	1,006	1,095	1,188	1,297	1,388
Surplus/(Deficit)	0	(533)	(154)	(293)	(3,564)	993	1,161	1,250	1,343	1,442	1,543

Option 3 Preferred Option v BAU £'000	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
PRIOR YEAR SURPLUS / (DEFICIT)	0	0	(533)	(154)	(293)	(3,564)	993	1,161	1,250	1,343	1,441
Inflation	0	0	14	14	14	57	72	74	76	77	79
CIP	0	0	(5)	(5)	(5)	(21)	(27)	(27)	(28)	(28)	(29)
Agency and Bank staffing	0	0	0	0	738	0	0	0	0	0	0
Sickness Rates	0	89	0	0	67	0	0	0	0	0	0
Reduction in training costs	0	29	0	0	47	0	0	0	0	0	0
Recruitment Cost (including international recruitment)	0	39	0	0	51	0	0	0	0	0	0
Superannuary cover costs	0	43	0	0	70	0	0	0	0	0	0
Workforce EUCC Review - RN	0	0	0	0	181	0	0	0	0	0	0
Workforce EUCC Review - UN	0	0	0	0	(182)	0	0	0	0	0	0
Workforce EUCC Review - A&C	0	0	0	0	16	0	0	0	0	0	0
LoS Reduction in isolation beds	0	0	0	0	492	492	0	0	0	0	0
Insurance Premiums	0	257	0	0	0	0	0	0	0	0	0
Prescription Charges Income	0	0	0	0	80	0	0	0	0	0	0
Retail Income	0	0	0	0	75	0	0	0	0	0	0
Reduction in Legal Fees	0	0	0	0	19	0	0	0	0	0	0
ED Medicine Drug Inventory holding	0	0	0	0	7	0	0	0	0	0	0
Additional Estates, Facilities and Utilities costs	0	0	0	0	(107)	0	0	0	0	0	0
PDC	0	(44)	(574)	(148)	44	(106)	122	42	45	49	52
Depreciation	0	0	0	0	(744)	0	0	0	0	0	0
Impairment	0	(945)	945	0	(4,135)	4,135	0	0	0	0	0
SURPLUS / (DEFICIT)	0	(533)	(154)	(293)	(3,564)	993	1,161	1,250	1,344	1,441	1,543

2.4.4 Statement of Financial Position & Cash Flow

The figure below demonstrates the SoFP impact of Option 3 over the period 2020/21 to 2030/31.

Figure 8. Forecast SoFP

STATEMENT OF FINANCIAL POSITION £'000	2020/21 Actual	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan	2025/26 Plan	2026/27 Plan	2027/28 Plan	2028/29 Plan	2029/30 Plan	2030/31 Plan
Opening	159,391	169,709	184,799	200,703	214,121	209,986	209,986	209,986	209,986	209,986	209,986
Additions - Business as Usual	18,455	27,662	12,900	11,995	13,644	13,644	13,644	13,644	13,644	13,644	13,644
Additions ECC - Trust	0	945	0	905	0	0	0	0	0	0	0
Additions ECC - PDC	945	328	15,904	13,418	0	0	0	0	0	0	0
Depreciation	(10,887)	(12,900)	(12,900)	(12,900)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)
Other	1,557	0	0	0	0	0	0	0	0	0	0
Impairment	0	(945)	0	0	(4,135)	0	0	0	0	0	0
Trade & Other Receivables	248	0	0	0	0	0	0	0	0	0	0
Non Current Assets	169,709	184,799	200,703	214,121	209,986	209,986	209,986	209,986	209,986	209,986	209,986
Current Assets											
Cash	34,991	50,453	35,418	35,418	35,418	35,418	35,418	35,418	35,418	35,418	35,418
Debtors	16,499	16,324	16,324	16,324	16,324	16,324	16,324	16,324	16,324	16,324	16,324
Inventories	1,552	1,552	1,552	1,552	1,552	1,552	1,552	1,552	1,552	1,552	1,552
Total Current Assets	53,042	68,329	53,294	53,294	53,294	53,294	53,294	53,294	53,294	53,294	53,294
Liabilities											
Creditors due < 1 year	62,282	78,142	63,107	63,107	63,107	63,107	63,107	63,107	63,107	63,107	63,107
Creditors due > 1 year	19,005	19,005	19,005	19,005	19,005	19,005	19,005	19,005	19,005	19,005	19,005
Provisions	2,935	2,935	2,935	2,935	2,935	2,935	2,935	2,935	2,935	2,935	2,935
Total Liabilities	84,222	100,082	85,047	85,047	85,047	85,047	85,047	85,047	85,047	85,047	85,047
TOTAL ASSETS EMPLOYED	138,529	153,046	168,950	182,368	178,233	178,233	178,233	178,233	178,233	178,233	178,233
Taxpayers Equity											
PDC	145,881	160,960	227,405	296,144	355,489	419,556	488,951	563,948	644,834	731,907	825,478
Revaluation Reserve	46,788	46,788	46,788	46,788	46,788	46,788	46,788	46,788	46,788	46,788	46,788
Retained Earnings	(56,798)	(57,360)	(107,901)	(163,222)	(226,702)	(290,769)	(360,164)	(435,161)	(516,047)	(603,120)	(696,691)
Charitable Fund Reserves	2,658	2,658	2,658	2,658	2,658	2,658	2,658	2,658	2,658	2,658	2,658
TOTAL TAXPAYERS EQUITY	138,529	153,046	168,950	182,368	178,233	178,233	178,233	178,233	178,233	178,233	178,233

An underpinning assumption to the financial modelling that has been undertaken is that cash balances are maintained at 2020/21 outturn levels, with requisite deficit funding being made available to the Trust.

Figure 9. Preferred Option Forecast SoCF

CASH FLOW £'000	2020/21 Actual	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan	2025/26 Plan	2026/27 Plan	2027/28 Plan	2028/29 Plan	2029/30 Plan	2030/31 Plan
Cashflows from operating activities											
Operating surplus/(deficit)	(3,147)	(40,951)	(43,845)	(46,416)	(52,593)	(50,874)	(53,855)	(56,921)	(60,075)	(63,317)	(66,651)
Non-cash income and expense:											
Depreciation and amortisation/Impairments	10,887	12,900	12,900	12,900	13,644	13,644	13,644	13,644	13,644	13,644	13,644
Fixed Asset Impairments	2,543	0	0	0	4,135	0	0	0	0	0	0
(Increase)/decrease in debtors	4,788	175	0	0	0	0	0	0	0	0	0
(Increase)/decrease in inventories	285	0	0	0	0	0	0	0	0	0	0
Increase/(decrease) in Creditors due < 1 year	8,450	(175)	0	0	0	0	0	0	0	0	0
Increase/(decrease) in Creditors due > 1 year	(32)	0	0	0	0	0	0	0	0	0	0
Increase/(decrease) in provisions	556	0	0	0	0	0	0	0	0	0	0
Other movements in operating cash flows - remove underlying forecast deficit 21/22	(1,358)	45,526	0	0	0	0	0	0	0	0	0
Net cash generated from/(used in) operating activities	28,015	17,475	(30,744)	(33,515)	(34,814)	(37,229)	(40,211)	(43,277)	(46,430)	(49,673)	(53,007)
Cashflows from investing activities:											
Interest received	7	0	0	0	0	0	0	0	0	0	0
Purchase of intangible assets	(2,195)	0	0	0	0	0	0	0	0	0	0
Purchase of property, plant, equipment and investment property	(13,024)	(12,900)	(43,839)	(28,318)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)
Purchase of property, plant, equipment - EUCC Development	0	0	0	0	0	0	0	0	0	0	0
Sales of property, plant, equipment and investment property	83	426	0	0	0	0	0	0	0	0	0
Cash from (disposals) of business units and subsidiaries (not absorption transfers)/Charity	90	0	0	0	0	0	0	0	0	0	0
Net cash generated from/(used in) investing activities	(15,020)	(12,474)	(43,839)	(28,318)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)
Cashflows from financing activities:											
Public dividend capital received - revenue	48,055	44	50,541	55,347	59,345	64,067	69,395	74,997	80,888	87,073	93,571
Public dividend capital received - capital EUCC	1,299	0	15,904	13,392	0	0	0	0	0	0	0
Public dividend capital received - capital	11,710	15,035	0	0	0	0	0	0	0	0	0
Loans repaid/received from the Department of Health/Capital element of Finance Leases	(47,721)	0	0	0	0	0	0	0	0	0	0
Other interest paid	(940)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)
PDC dividend paid	(3,192)	(3,958)	(6,236)	(8,245)	(10,227)	(12,833)	(14,880)	(17,416)	(20,151)	(23,096)	(26,200)
Net cash generated from/(used in) financing activities	7,211	10,461	59,549	59,834	48,458	50,874	53,855	56,921	60,075	63,317	66,651
Increase/(decrease) in cash and cash equivalents	15,206	15,462	(15,035)	0	0	0	0	0	0	0	0
Cash and cash equivalents at 1 April	19,785	34,991	50,453	35,418	35,418	35,418	35,418	35,418	35,418	35,418	35,418
Cash and cash equivalents at 31 March	34,991	50,453	35,418	35,418	35,418	35,418	35,418	35,418	35,418	35,418	35,418

2.4.5 Tax and Accounting Considerations

In developing the OBC, the Trust has assumed the treatment of capital and revenue expenditure in line with the Trust's accounting policies. As such, the refurbished ED department and new build extension would be recognised as an asset in the Trust's balance sheet and depreciated over its useful economic life and the Trust would recognise an increase in PDC, representing DH's equity interest. As a result, the net book value of net relevant assets held by the Trust will increase, which, in turn will increase the capital charges that would need to be met by the Trust, provided the Trust has surplus cash.

The Trust has engaged with the design team with regards to determining recoverability of VAT on the scheme and assumes VAT will be reclaimed for areas of the estate being refurbished, along with associated fees of the development. The Trust has engaged BDO, Procure22 VAT advisors, to undertake a VAT review of the E&UCC development which will be updated into the financial modelling with updated capital cost plans as GMP is finalised.

Based on the extent of the design and remodelling of the refurbishment and new build, the Trust assesses that the site valuation post-build will reflect an impairment that has been assessed as the value of professional fees. Financial modelling therefore assumes a £4.1 million impairment arising upon completion. The District Valuer has been engaged to undertake an initial impairment assessment based on the latest cost plan and design. This will be updated in the financial modelling when available. The asset will be professionally valued again on completion to accurately reflect this impairment in the Trust financial statements.

2.4.6 Conclusion

The Trust LTFM illustrates that the investment as set out by the Preferred Option is deliverable and improves the Trust financial trajectory post build and impairment from £0.5 million to £1.5 million to 2030/31.

Under each option, the Trust would require external funding over the life of the investment, which emphasises that even though both options are financially viable, the continued availability of central FRF funding/revenue support from DHSC or System support is vital to long term financial sustainability, whilst the Trust develops further schemes linked to the E&UCC which will further improve the financial return on investment.

2.5. Management Case

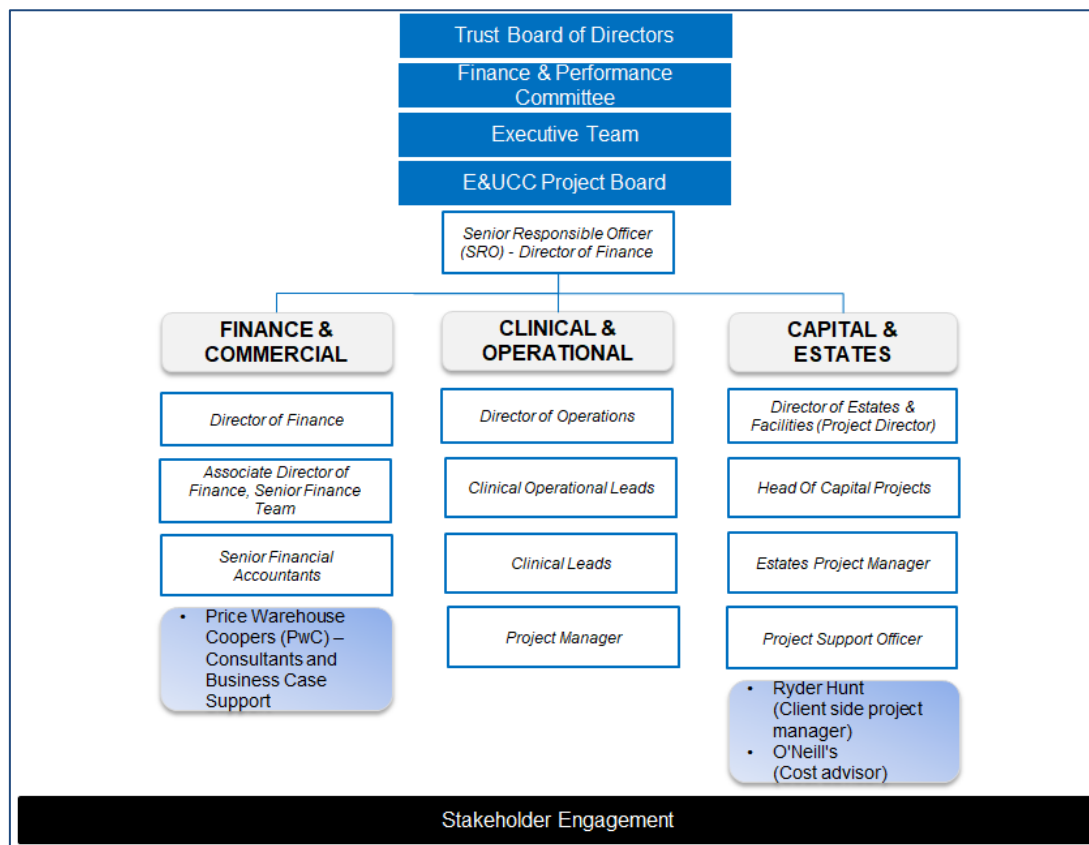
The Management Case sets out the governance arrangements established to successfully deliver the new E&UCC facility. In delivering this the Trust has ensured that the scheme is embedded within existing governance, risk management, service transformation, project management structures and policies within the Trust; thus ensuring the accessibility to all key stakeholders.

The following sections set out the Trust approach to ensure that a robust project management approach has been implemented in order to ensure that the project is well managed and delivers as described.

2.5.1 Project Governance and Management Arrangements

The project management structure to executive level is outlined in the following diagram and demonstrates the high level of executive support across Strategic and Financial priorities with Clinical Leadership at the heart of the project inception and design. The following diagram outlines the governance and reporting structure that supports the scheme.

Figure 10. Overview of E&UCC Project Governance and Management Arrangements



The Trust recognises the complexity of the project which requires a wide range of specialist skills and experience. Where applicable, specialist advice has been sought from external organisations or providers.

The project governance and reporting structure has been developed to align with the principles set out in the NHS Capital Investment Manual, the HMT Green Book and the Trust's extensive experience of developing business cases for large capital schemes.

The Project Team is responsible for the development of the OBC and FBC for the preferred option. It will continue to be accountable through the Executive Team and the Board of Directors for the delivery of the scheme. Regular progress reports are submitted through the strategy and planning team to the Executive Team, Finance & Performance Committee and to the Board of Directors.

The Project Board has in place agreed Terms of Reference and meets to discuss an assessment of progress against plan and updates from the established Clinical and Design Team groups via their operational and clinical identified leads. Each board and sub-group meeting produce minutes, actions with pertinent matters are communicated to the Trust's Executive Team.

The key milestones for the project are as follows:

Figure 11. Key Milestones

Milestone	Date
EUCC Project Board review and approve FBC	07/04/22
ET review and approve FBC	11/04/22
FBC submitted to NHSEI (without GMP)	12/04/22
F&P review and approve FBC	21/04/22

Trust Board review and approve FBC		05/05/22
Refreshed FBC submitted to NHSEI (without GMP)		06/05/22
FBC queries:	First queries to Trust from cash & capital/DHSC/regional team	20/05/22
	Trust responses to queries	27/05/22
	Ongoing review and closing down of queries	27/05/22 – 14/06/22/2
GMP issued to Trust		21/06/22
GMP approved by Trust		06/07/22
Refreshed FBC submitted to NHSEI (with addendums for GMP, Planning and Letters of Support).		06/07/22
JISC review and approve FBC		18/07/22
Build phase:	Site Preparation	September 22
	Enabling Schemes	October 22
	Phase 1	<i>December 22</i>
	Phase 2	<i>June 23</i>
	Phase 3	October 23
	Phase 4	March 24
	Phase 5	April 24
Commissioning & Opening		April 24
Post Project Evaluation commences		April 24

2.5.2 Key Risks

The key risks currently include:

- Failure to secure the funding from NHSE/I to undertake the works;
- Affordability - inflation and impact of the Russian-Ukrainian War;
- Maintaining operational performance during reconfiguration works;
- Approval delay of the FBC exceeding the expected timeframes; and
- Changes in demand for emergency & urgent care.

It should be noted that the current unprecedented COVID-19 pandemic restrictions continue to impact on the ability to engage with stakeholders.

3. Strategic Case

The purpose of this Strategic Case is to provide an overview of the Trust and set out the context of the business case. It describes how current service capacity and configuration falls short of meeting demand, performance and quality measures whilst detailing the need for investment to realise local, regional and national targets. It describes the objectives for the planned investment in the reorganisation of the emergency and urgent care estate at Stepping Hill Hospital. The resulting ambition being to provide:

- A fit for purpose emergency and urgent care facility;
- Agile and effective space utilisation;
- A reduction in backlog maintenance;
- Improved quality of care for Stockport patients and staff; and
- Improved flow as well as operational performance and reputation of the Trust.

The overarching Trust and clinical strategy are described that, alongside capital investment, will sustain and future proof quality care and performance through reconfigured physical space to meet clinical need.

3.1. Trust Overview

3.1.1 About Us

Stockport NHS Foundation Trust holds a unique position in the local community as the lead provider of healthcare to the local population, and it is one of the area's largest employers. The main site is Stepping Hill Hospital. Stockport NHS Foundation Trust offers a number of specialist services and plays a key partnership role within the Greater Manchester region, the local borough of Stockport, and bordering East Cheshire and North Derbyshire.

Some key facts and figures about the Trust are as follows:

- 5,000 staff - second largest employer in Stockport after Stockport Metropolitan Borough Council;
- Circa 580,000 patient contacts per year of which c.100k are ED attends;
- 160 consultants and around 1,500 nurses (hospital and district nurses in community);
- A budget of around £360m;
- On average, around 40% of patients in our hospital are aged 80 years and over (50% aged 75 or over); and
- The Trust is an associate teaching hospital, helping to train doctors and nurses for the future.

Figure 12. Strategic Geographical Position



Figure 13. Stepping Hill Hospital



3.1.2 Our Local Population

The Stockport locality has a population of over 291,000 residents, yet 313,610 people are registered at one of Stockport's 37 GP Practices. The population is growing by around 1,000 people per year and is expected

to continue to grow at this rate over the next ten years. Stockport has the oldest age profile in Greater Manchester. 19.8% of people are aged 65+ and this is likely to rise to 21% by 2024, with an additional 5,800 people aged 65 or over. This presents a significant challenge to our community and acute services often resulting in more frail elderly patients requiring hospital admission with increasing complex care needs.

Overall, Stockport is one of the healthiest places to live in Greater Manchester, and the wider North West, with health outcomes broadly in line with national averages. Rates for deaths from cardio-vascular disease, road injuries, childhood obesity and physical activity in adults are all better than national averages. However, rates of alcohol harm, breast feeding initiation, and infant mortality are all below the national average.

These borough wide figures mask significant health inequalities between different parts of the borough, for example life expectancy is 11 years longer for men in the most affluent parts of the borough than for those living in the most deprived. Declining health starts earlier in the more deprived parts of the Borough; 55 years compared to 71 years.

As well as the Stockport locality, we deliver healthcare services to meet the needs of the populations of neighbouring areas of North Derbyshire and East Cheshire.

The Cheshire East Council Borough profile for 2019/20 estimates the population of Cheshire East to be 378,900.

- 67,400 (17.8%) are aged 0-15
- 226,100 (59.7%) are aged 16-64
- And 85,300 (22.5%) are aged over 65.

Between 2017 and 2027 the population is expected to increase by 11,400 (a 3% increase), but this figure masks the fact that the working age population is expected to fall by 6,100 (a 2.7% decrease) and the number of people aged 65 and above is expected to increase by 17,000 (a massive 20% increase). These figures indicate an increasing demand on health and care services from an ageing population.

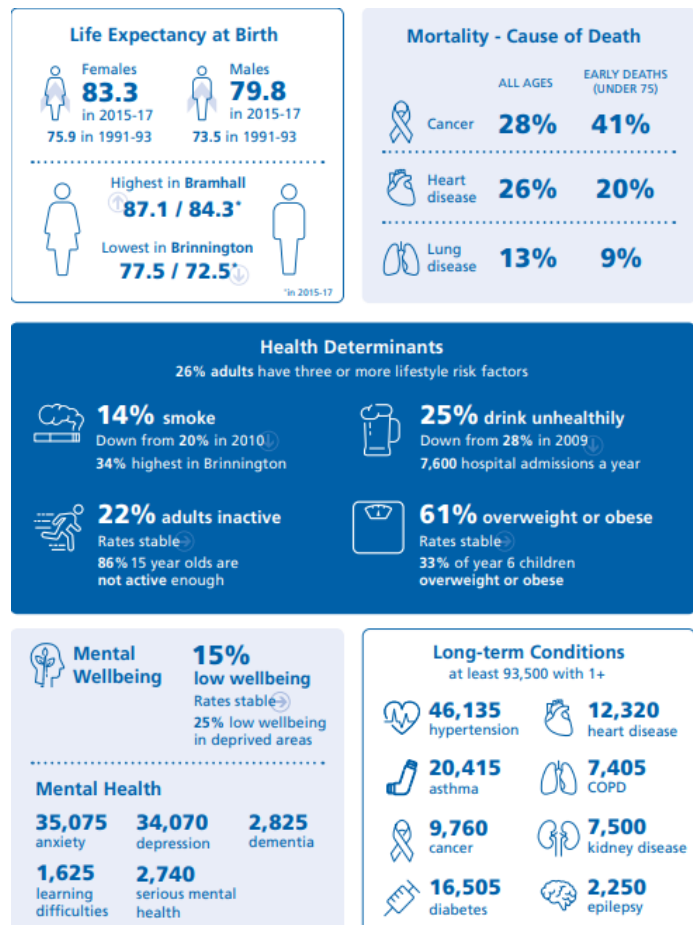
Overall Cheshire East is a relatively affluent area; however, there are a number of pockets of deprivation – where health and wellbeing are likely to be worse than the average – whose figures are often masked by borough wide statistics. Latest (2015) data indicates there are 18 small areas in the most deprived 20% nationally; six of these areas are in the most deprived 10% of areas nationally. We see approximately 26,000 patients from East Cheshire which equates to 7% of the population.

Approximately 786,000 people are estimated to live in the county of Derbyshire. The population is older than the England average. The population is expected to increase by 79,000 (10%) over the next 20 years and the number of people aged over 90 years old will treble.

Average life expectancy and healthy life expectancy for both men and women are significantly lower than the England average. There is a large difference in healthy life expectancy between men and women living in the most and least deprived communities.

The High Peak area of North Derbyshire borders Stockport. It is this area where most of the patients we see and treat from Derbyshire live. As with other parts of Derbyshire, the population is generally older than the England average. We see over 50,000 patients from this area annually, which is more than 10% of our annual patient activity.

Figure 14. Stockport's Population Range of Health Needs



3.1.3 Our Mission: “Making a Difference Every Day”

Amazing things happen across our services every day. We will always work hard to ensure that we deliver safe, seamless patient-centred care, to the highest standards. We have ambitious plans for major changes to how and where care is delivered. In responding to the unprecedented challenge of the Covid-19 pandemic staff have demonstrated their commitment to provide the best possible care for our patients. Staff have also been innovative in adopting new ways of working and changing how some of our services are delivered. Building back better and harnessing the enthusiasm and commitment from the way the Trust responded to Covid-19 is at the heart of how the Trust will shape the delivery of our recovery, our future plans and for making a difference every day.

The overarching Trust and clinical strategies will guide the organisation through the required transformation and change required to deliver our ambitious future, underpinned by the values of the organisation developed by our staff and patients. The new values for our Trust, as shown below, are: **We Care**; **We Respect**; and **We Listen**.

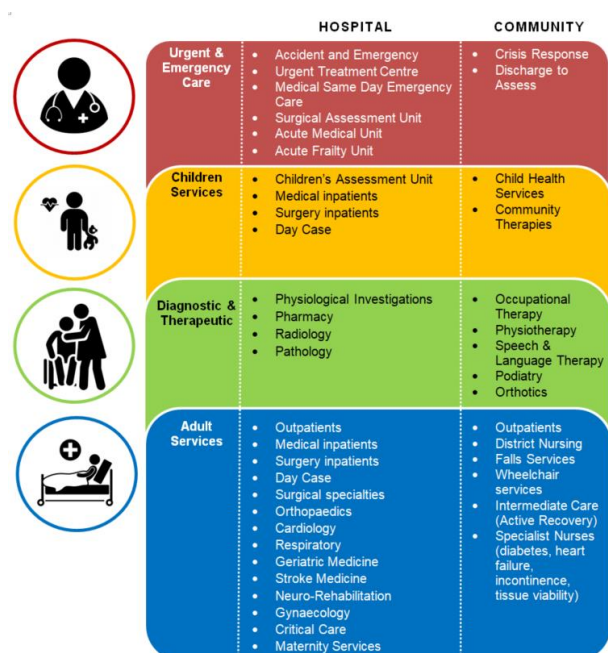
Figure 15. Trust Values



3.1.4 Our Services

The Trust provides a range of community based and hospital based services – examples illustrated in the figure below.

Figure 16. Examples of Services Provided



The Trust provides emergency and general, surgical, medical, women's, children's and community services for people living in Stockport and surrounding areas.

The Trust's stroke services have been officially ranked as the best in England and urology and orthopaedics are highly rated nationally.

In Greater Manchester (GM), the Trust is one of four specialist hospitals for emergency and high-risk general surgery; one of three specialist stroke centres; and one of only two orthopaedic departments delivering cervical spine surgery. The organisation is also part of the GM hub and spoke model of delivery for urological services.

Away from the acute hospital site the Trust also operates services at Bluebell Ward at The Meadows, as well as Bramhall Manor, which are discharge to assess and intermediate care community bed based facilities. In addition is Swanbourne Gardens which provides overnight breaks for children and young people with severe learning disabilities.

The Trust delivers community health services that run across 24 health centres and community clinics in Stockport with new community models of care addressing the challenges of rising demand and supporting the growing number of people with complex and long-term conditions.

3.1.5 Our Service Improvements

We are committed to providing the highest quality and safest care for patients, as well as contributing to the health and wellbeing of the people we serve. Our performance is examined critically so that we can build on good practice and keep on learning. Achieving key national and local clinical and performance standards is a priority as the visible measurable of the quality of our services. Like many other NHS organisations, we face challenges in consistently achieving these standards, and our performance has followed national trends, but our aim is always to improve. Stockport CCG has identified six delivery programmes in their recently published strategy; four of these directly align to our services: Community Care; Maternity & Children; Elective Care; and Urgent Care.

In terms of Urgent Care the Stockport health and care economy has been significantly challenged in managing urgent care in recent years. This has resulted in emergency and urgent care performance across the system remaining below the national standard. The introduction of Same Day Emergency Care (SDEC), whereby patients with some medical concerns can be assessed, diagnosed, treated and safely discharged home the same day rather than being admitted, has been introduced. This is being delivered through, our Clinical Decision Unit, Urgent Treatment Centre, Surgical Assessment Unit, Medical SDEC unit, our multidisciplinary Frailty Intervention Team, and community-based Crisis Response Team, all providing a collaborative approach with partners working together to respond to system challenges.

Like many other NHS organisations, Stockport NHS Foundation Trust has experienced quality, performance and financial challenges. However, the Trust has made improvements to many services over the last few years, and whilst sustaining these changes has been hard-fought in some areas, the outcome of the Care Quality Commission (CQC) inspection in November 2021 reflected our tangible achievements within Emergency and Urgent Care services.

Our ambition is to renew focus on Urgent and Emergency Care (UEC) in light of recent less than desirable performance against national standards and scrutiny. Whilst principal attention will be given to UEC, the organisation will continue to deliver excellent core and specialists services, and progress a more integrated care model in partnership with primary care and social care services.

3.1.6 Our Financial Performance

The Trust's Statement of Comprehensive Income (SoCI) for the past two years and the underlying position for current year is detailed in the table below.

Figure 17. Statement of Comprehensive Income

	Actual 2019/20 £'000	Actual 2020/21 £'000	FOT 2021/22 £'000
Operating income from patient care activities	277,373	311,990	364,563
Other operating income	63,300	72,320	37,653
Operating expenses	(334,481)	(387,464)	(397,608)
Operating surplus/(deficit) from continuing operations	6,192	(3,154)	4,608
Net finance costs	(3,554)	(3,338)	(4,604)
Other gains/(losses)	(42)	391	424
Reported Surplus/(Deficit) for the year	2,596	(6,101)	428
Less: Impairment Reversal	(2,658)	-	-
Less: PSF, FRF, MRET	(27,633)	-	-
Less: Non-Recurrent CIP & Operational Performance	(15,195)	-	-
Underlying Surplus/(Deficit) for the year	(42,890)	(6,101)	428

Note that the 2019/20 figures above reflect the pre-COVID-19 underlying financial outlook and that the 2020/21 and 2021/22 reflects actuals including COVID-19 system support

The underlying financial performance from 2021/22 excluding Covid system support funding is as follows:

Figure 18. Underlying SoCI 2021/22 Excluding Covid System Support Funding

	Underlying 2021/22 £'000
Operating income from patient care activities	267,976
Other operating income	31,375
Operating expenses	(337,631)
Operating surplus/(deficit) from continuing operations	(38,280)
Net finance costs	(4,590)
Underlying Surplus/(Deficit) for the year	(42,870)

In the context of a financially strained NHS, where many providers are in deficit, as a Trust which has historically benchmarked favourably against the national Reference Cost Index (<100 RCI), an underlying deficit of c.£43m reported in 2019/20 is disproportionately high when compared to total income of c.£300m (excluding central funding).

There are five key drivers of the Trust's financial position:

- **Local demographics** - Stockport has the oldest age profile in Greater Manchester and the population continues to age. Currently 19.8% of people are aged 65+ and this is likely to rise to 21% by 2024, with an additional 5,800 people aged 65 or over;
- **Premium rate staffing costs** - Local competition with neighbouring Trusts across GM, smaller specialties, transport links to the Stepping Hill Hospital site, and unavoidable cost pressures linked to investment in quality & safety, supported by CQC recommendations;
- **Structural drivers** – GM-wide loss-making services borne by the Trust, Tariff shortfalls & dis-economies of scale, CNST premium increases only partly offset by tariff, and historic strategic service transfers;
- **Delays to local health economy initiatives** – the Trust continue to actively work with partners across the local health economy in the delivery of strategic programmes of work; and
- **Legacy of historic financial deficits** - Prior to central funding support received during 2019/20, the Trust had accumulated losses totalling £72m between 2015/16 – 2018/19, thereby exhausting all historically generated cash resources available for re-investment, and a requirement to take on external borrowing.

The E&UCC development is a key step for the Trust in addressing the drivers of the financial position, by improving the emergency and urgent care estate for patients and staff; and introducing streamlined and expanded services to manage the increasing demand in the most efficient way possible.

The Trust also continues to plan for the release of external capital funding associated with being designated a 'specialist site' for urgent and acute general surgery as part of the Greater Manchester Healthier Together Programme.

Stockport CCG accounts for around 70% of total Trust Income, with Derbyshire CCG being the second biggest commissioner (10%). Cheshire CCG accounts for around 6%, Specialist Services 5% and Tameside & Glossop 4%. The Trust holds contracts with 19 commissioners in total, and a number of other commissioners from many areas not under a contract providing the Trust with its income.

Approximately 72% (around £245m) of total expenditure is spent on staffing. Ensuring the most effective spending and use of resources on staffing is crucially important, and the Trust is committed to reducing the amount incurred on agency and bank staff each year – this remains a major priority.

Each year the Trust invests around £9m on internally funded capital improvements to the Stepping Hill site and community locations - this includes upgrades to Estate and IT infrastructure and new and replacement medical equipment.

Since 2014, NHS funding has grown much more slowly than historic long-term trends. NHS providers are facing significant financial challenges, and very little central investment in transformation and capital is available. Local authority budgets are under significant pressure, affecting social care and public health provision. The Trust continues to experience a high proportion of patients in hospital beds who are medically fit for discharge and awaiting social care packages or placements, which results in a delay to their discharge from hospital. In line with the publication of the NHS LTP, the Government announced an increase in NHS funding to support the development of a new 10-year long-term plan for the NHS. While this funding is welcomed, it is widely acknowledged that this will not match the levels of increased demand the NHS is expecting to see. Providers will therefore be increasingly required to redouble efforts to ensure funding is used as efficiently and effectively as possible to increase productivity, reduce waste and face the challenges ahead. The ageing population and increasing demand for services at the Trust places a significant financial strain upon acute and community services at the Trust.

The underlying financial deficit is currently in excess of £43m, and the Trust's Long Term Financial Plan therefore indicates that the Trust will require continued support through the Financial Recovery Funding (FRF), and efficiency savings at levels in excess of the national requirement. Having delivered £47m in efficiency savings over the previous 5 years, the Trust is finding the continued delivery of savings in excess of the national requirement extremely challenging.

3.1.7 Our Strategy

In January 2020, the Trust set out a revised strategy aimed at meeting the challenges and to anticipate future healthcare needs. The Trust's Strategy 2020-2025 can be found in Appendix 3.1.

The Trusts vision is to be a well-led organisation delivering safe, high-quality care for local people. Our Trust Strategy was reviewed in light of the Covid-19 pandemic, and thus we have strengthened our commitments:

- To become a clinically led and managerially enabled organisation;
- To be appropriately recognised for the provision of outstanding care;
- To develop our capacity and capability for transformation; and
- To forge strategic partnerships with neighbouring Trusts and local partners to ensure sustainability and development of services.

To support our vision, the Trust is committed to the following objectives described in the table below.

Figure 19. Trust Objectives

Objective		Examples of Success	Target
A great place to work	<ul style="list-style-type: none"> ➤ To deliver the five aims of the People Strategy ➤ Provision of resources; culture and engagement; education and development; high performing – striving for excellence; leadership development ➤ To improve the health and wellbeing of staff ➤ To provide equally positive employment experience for our staff from all backgrounds and communities 	<ul style="list-style-type: none"> • Staff Survey 	March 2025
Always learning, continually improving	<ul style="list-style-type: none"> ➤ To embed a culture of safety and create an environment of continuous quality improvement, research and innovation ➤ Increase our levels of innovation, increasing the pace of change and improving long term decision making ➤ Positively act upon learning (e.g. learning from deaths/morbidity & mortality/improving flow) and learning what goes well 	<ul style="list-style-type: none"> • Incidents • Complaints • Mortality • Appraisal & Training rates • Patient flow metrics • Leadership development 	March 2025
Investing for the future by using our resources well	<ul style="list-style-type: none"> ➤ Optimising our clinical outcomes through effective clinical leadership ➤ Clinical service line strategies will have to achieve financial and clinical sustainability ➤ Achieve a break even financial position in line with expectations ➤ Invest in the development and wellbeing of our staff, to support retention and recruitment ➤ Ensure a shared vision for a fit for purpose environment 	<ul style="list-style-type: none"> • Quality metrics • Financial position • Turnover • Patient Surveys 	March 2025
Working with others for our patients and communities	<ul style="list-style-type: none"> ➤ Contribute to narrowing health inequalities and supporting health and well-being. ➤ Develop strong partnerships with organisations in Stockport ➤ Engage with local communities and neighbourhoods to shape services around local needs ➤ Develop strong partnership working with Trusts in GM and East Cheshire to support sustainable clinical networks ➤ Positively influence our reputation 	<ul style="list-style-type: none"> • Demographic studies • PPI • Partnership ventures 	March 2025
Helping	<ul style="list-style-type: none"> ➤ To embed an approach of realistic care in order to deliver better outcomes for our patients before, during and after their treatment and to 	<ul style="list-style-type: none"> • Staff Survey • Patient Surveys 	March

people live their best lives	<ul style="list-style-type: none"> ➤ meet the preferences of our patients at the end of life ➤ Improve the health & wellbeing and experience for our staff and patients ➤ Play a key role in supporting the priorities of the Locality Plan and CCG strategy ➤ To provide an equally positive experience of services for patients and carers from all backgrounds and communities 	<ul style="list-style-type: none"> • Patient Outcome Measures • Patient & carer experience feedback 	2025
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Delivering the Strategy

Clinicians are at the heart of delivering the overall Trust strategic aspirations. A clinical strategy is in design from service to divisional level which will meet the future needs of the local population and national expectations. The clinical strategy will place clinicians as leaders of specific patient focused pathways (e.g. frailty, heart failure, diabetes) and the organisation will provide excellence in training and support for all clinical leaders to aid in recruitment and retention activities.

The challenging environment currently facing the Stockport system presents a unique opportunity to use investment to deliver services in new ways, embracing emerging technologies and working across traditional boundaries to seek innovative solutions to long standing pressures and problems.

What our Trust will look like in 2025

We aim to achieve our objectives by 2025 and in doing so fulfil the following for our patients and their communities, our staff and our partners.

For our patients and their communities:

- ✓ We will improve the role patients, their families and carers have in their care and decision making ensuring they have a great experience, which matches their expectations
- ✓ We will improve our urgent and emergency care access standards performance and build a brand-new E&UCC
- ✓ We will improve flow in the hospital ensuring we reduce days away from home for our patients
- ✓ We will improve accessibility to our services, ensuring equality for our diverse local communities, making sure our services meet the needs of all our patients
- ✓ We will be in the lowest quartile nationally for clinical errors
- ✓ We will embrace the latest technology and modernise key parts of our estate to improve our services
- ✓ We will develop more joined up services ensuring patients receive the right care, in the right place and at the right time.

For our staff:

- ✓ Our organisation will be a great place to work
- ✓ Staff from all backgrounds will have an equally positive experience of working for us
- ✓ We will strive to have happy staff and satisfied patients making us an attractive place to work
- ✓ Our leaders will better reflect the diversity of our workforce and local communities
- ✓ We will have a stable, highly motivated workforce, with the skills and expertise to deliver improvements
- ✓ We will lead improvement and innovation across the local patch in line with national and regional delivery programmes
- ✓ We will improve the wellbeing and resilience of our staff.

For our partners:

- ✓ We will forge strategic partnerships with neighbouring Trusts and local partners to ensure clinically led, sustainable services
- ✓ We will lead and contribute to aspects of developing a different system model which further integrates health & social care for patients, making the best use of our collective resources
- ✓ We will work with local partners to deliver a borough wide approach to improve health and social care, so that Stockport is known for its areas of excellence and not its challenges.

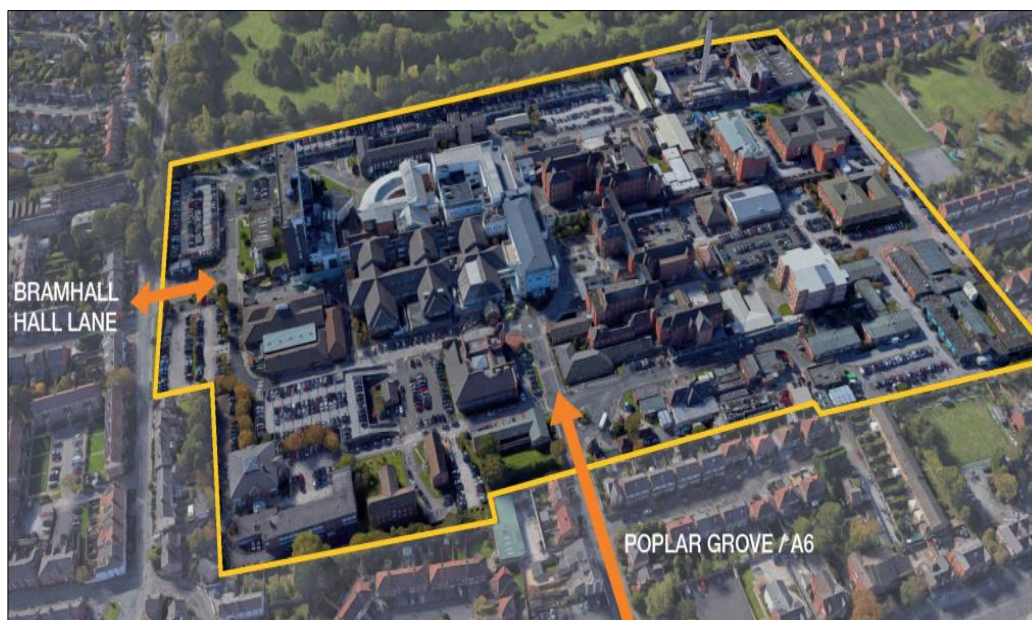
3.2. Case for Change

The Trust vision continues to be focused on supporting population health by ensuring that, when necessary, access to emergency and urgent care services is readily available and responsive. The design and provision of these services should be simple to navigate both for people requiring use of them, and for the staff working within them. The current arrangements are inefficient and can be confusing to the public. More needs to be done to allow clear clinical pathways to be developed and ensure that the right levels of care can be provided effectively at the time and in the manner the patient requires.

3.2.1 Estate

The Stepping Hill Hospital complex is extensive and comprises an area of approximately 14.5 hectares bounded by the southern boundary of properties lining Aber Avenue in the north, Bramhall Moor Lane in the east, the railway line to the south and Great Moor Park to the west. The site contains a network of both detached and connected buildings of varying age, style and height developed over a period of circa. 119 years interspersed with vehicular and pedestrian routes and car parking.

Figure 20. Stepping Hill Hospital Site Aerial View



Many existing buildings are simply not fit for purpose. Necessary improvements in these areas, including the short term, need to be mindful of the longer-term estate strategy to avoid problems of the past. For example, ensuring adequate expansion space for the future, avoiding isolating particular service provision when co-locating services would be more efficient and effective, and ensuring that each development at the very least does no harm to future strategic developments and at best enables future developments to deliver optimal value for money through development synergies.

The current ED, reconfigured in the 1990's, is undersized and poorly configured. It was originally designed for circa 50,000 attendances per year which has now increased to over 100,000 - physical space is now a major constraint. The department frequently experiences levels of demand which compromises the ability to assess patients in a suitable environment in which privacy and dignity can always be maintained and examinations undertaken in a timely manner. This lack of physical capacity impacts across the department including those areas in which the sickest and most vulnerable patients are cared for.

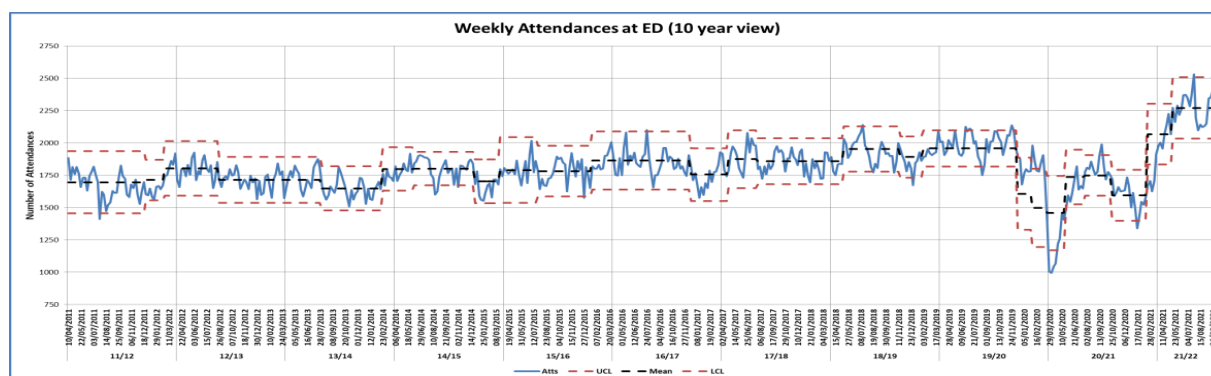
The Carter report '*Productivity in NHS Hospitals*' (2017)¹ highlighted the importance of managing estates for financial efficiency and more importantly to provide an environment conducive to positive patient experience as well as positive staff experience.

3.2.2 Activity

Over the last ten years there has been a relatively consistent increase in ED activity year on year. Admission rates have mirrored this increase up until 2020 - possibly related to system activities prioritising frailty care in the community, and discharge direct from the ED wherever possible. Attendances are highest on a Monday, as are admissions within minor injuries and illness attendances increasing at the weekend.

¹ <https://www.gov.uk/government/publications/productivity-in-nhs-hospitals>

Figure 21. 10-Year Trend of Attendances to ED



The table below taken from the GIRFT summary emergency department indicator demonstrates the unique nature of the demand into the emergency department with a higher proportion of the Stockport population presenting compared versus the national positions, with an older age range but lower deprivation.

Figure 22. GIRFT Summary Emergency Department Indicator Table (SEDT)

Metric Name	Site Value	Eng Mean	LQ	Median	UQ	Dotted lines indicate 5th and 95th percentiles. RAG rating based on quartiles
Proportion of catchment population attending per year	% 36.0	% 24.4	22.3	25.2	29.9	
% of ED admissions aged 75+	% 33.2	% 32.0	28.6	32.6	37.9	
% ED attends in highest deprivation quintile	% 21.9	% 26.9	10.7	23.6	36.5	

This being indicative of the changing population is changing, key features being:

- Current population is circa 290,000 residents which will grow by over 1,000 people per year;
- Ethnic diversity is changing. The percentage of people identifying as being from ethnically diverse backgrounds in the census increased from 4.3% in 2001 to 7.9% in 2011. In the School Census, the percentage of young people from ethnically diverse backgrounds in 2011 was 10.1% which has increased to 19.6% in 2021.
- Stockport has the oldest age profile in Greater Manchester and the population continues to age. Currently 19.8% of people are aged 65+ and this is likely to rise to 21% by 2024, with an additional 5,800 people aged 65 or over. This presents a significant challenge to the Trusts community and acute services often resulting in more frail elderly patients requiring hospital admission with increasingly complex care needs.
- The disparity in health outcomes across the locality are stark with an inequality in health outcomes across for example Bramhall vs Brinnington. These borough-wide figures mask significant health inequalities between different parts of the borough, for example life expectancy is 11 years longer for men in the most affluent parts of the borough, than for those living in the most deprived. Declining health starts earlier in the more deprived parts of the Borough; 55 years compared to 71 years.

A number of services have been developed across the locality to support the management of the less clinically complex patients within the community. These have been well-evaluated and have demonstrated that deflection from hospital-based services is possible through innovative community-based model to avoid attendance and admissions. Despite the positive impact that these models have clearly demonstrated there are circumstances in which there is a rising and indisputable need for access to emergency and urgent care.

The overall level of admissions following presentation at the emergency department can be seen in the figure below, and represents an increasing picture over the 10 year modelling period. Over three-quarters of all admissions to the acute beds are through the emergency department. This is circa 1.5% higher than the national average as per the GIRFT SEDT, and may be indicative of the population challenges. However, what is also apparent is that whilst levels of attendances are increasing the conversion rate is within an acceptable control limit.

The Trust has implemented mitigation schemes to reduce the risks to patients and maintain good standards of care, however as demand continues to grow and is forecast to increase further, these opportunities reduce.

Figure 23. 10-Year Trend of Admissions from ED

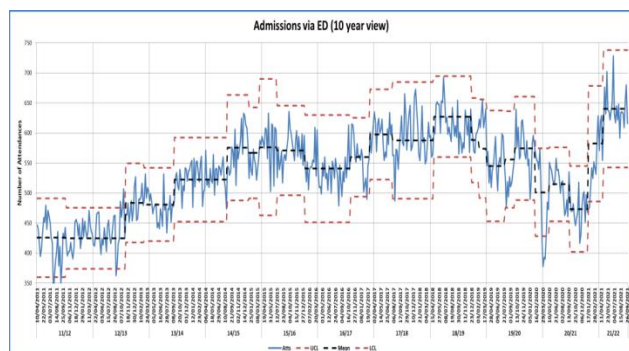
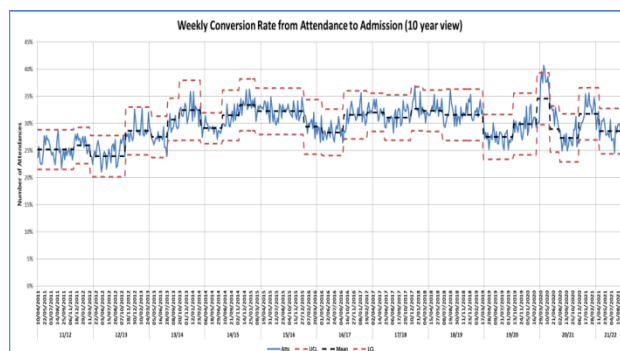


Figure 24. 10-Year Trend ED Attendance to Admission



In considering the current and future requirements of the E&UCC, understanding historic demand, the nature of that demand and the required response has been central to the design and allocation of space and resources.

3.2.3 Workforce

Our local shortage of emergency department workforce reflects the national position. We are actively mitigating workforce risks through identifying opportunities for a model that includes a mixed clinical workforce including Advanced Care Practitioners, Trainee Nurse Apprenticeships, Physician Associates and the use of remote digital consultations with GPs. Workforce highlights:

Turnover rate – we currently have a turnover rate of 12.27%. 4.5% of our staff chose to leave within 12 months. Within ED, our medical staff average turnover is 12 staff per annum.

- **Vacancy rate** – we have more gaps in our establishment than we would like, and a vacancy rate of 7.23%
- **Sickness rates** - 2020-21 Model Hospital Highest Quartile 4.61% (20/21)
- **Nurse agency and bank staffing** - expenditure/cost per WAU is 10.9% higher than peer median.
- **Medical agency and bank staffing** - 35% of pay is bank & agency costs. Of agency costs middle grades = 32%.
- **Staff Survey results** – examples where the Trust was below national average include health & wellbeing, morale and safe environment.

We know that happy staff equal happy patients, which is why we have made a firm commitment to **#TeamStockport** to create a great place to work. Our People Strategy 2021-2023, found in Appendix 3.2, sets out our people priorities and with an integrated delivery plan to meet this ambition. This strategy seeks to create a positive and sustainable future for our staff; some of our initiatives include:

- Increased staff led improvement
- Developing a multi-professional approach to clinical skills acquisition
- Creating high performing teams
- Embedding innovation and effective e-solutions

Whilst the Trust has invested in a variety of initiatives, in some areas the physical working environment still remains an issue.

3.2.4 Operational Performance

The Stockport health and care economy has been significantly challenged in managing the demand and flow of urgent and emergency care in recent years. This has resulted in long waits for patients to be seen or admitted and performance across the system remaining below the 4-hour national standard. This has compromised quality of care through near continuous congestion of the ED, especially during winter months, meaning extended waits for patients before they reach the right specialty bed or team for their needs.

The current ED has seen a circa 35% growth in attendances since it was reconfigured in the 1990's, and now experiences regular overcrowding resulting in patients being nursed and assessed in unsuitable areas, and a difficulty in achieving the four-hour quality standard on a consistent basis. The congestion that inevitably results from a lack of physical capacity negatively impacts on patient and staff experience. It also leads to inefficiencies in staffing and process, preventing effective implementation of what is recognised as national best practice.

This redevelopment of the E&UCC recognises the shortfalls of the current estate, and the demand placed up on the current emergency and urgent care services. It will deliver the physical space and co-location of services, needed to meet the objective of right patient, right time, delivering the key principles and design objectives for urgent and emergency care.

3.2.5 Transformation

There is potential for greater efficiency in a modern and larger working environment. It is well known that ED congestion can also result in less effective navigation/streaming, the wrong types of patients in the wrong types of assessment space, inconsistent clinical decision making, and more inpatient admissions.

The Five Year Forward View and NHS Long Term Plan both outlined commitments to radically transform the way in which the NHS provides urgent and emergency care to our population. The Trust has undertaken a considerable amount of transformation work towards integrated care, and redesigned urgent care pathways as much as possible within the constraints of the estate. In addition, the Covid-19 pandemic has made the Stockport locality refocus our collective priorities for transformation and has forced us to work harder and faster to develop alternative models of care that reduce the flow of people in to and out of the Emergency Department such as:

- Urgent Treatment Centre adjacent to ED - open 12 hours a day
- Acute Frailty – dedicated assessment unit providing care for frail patients
- Crisis Response Team – investment in ACPs
- Discharge to Assess (D2A) – facilitating patient flow
- Same Day Emergency Care (SDEC)

3.2.6 Same Day Emergency Care

NHS England recognised that a significant proportion of adult patients requiring emergency care can be managed safely and appropriately on the same day. Uptake of this same day model, previously under the guise of Ambulatory Emergency Care (AEC), has rapidly accelerated in the last five to ten years, and is now delivered in the majority of acute trusts². NHS England research suggests that 89% of acute providers have a designated unit where most of the same-day emergency care (SDEC) occurs³.

The Royal College of Emergency Medicine (RCEM) and Society for Acute Medicine (SAM) clearly define *what is* and *what is not* same-day emergency care⁴, and endorse the provision of same day emergency care services as outlined in the [NHS Long Term Plan](#) which states all hospitals with a 24 hour ED (type 1) will:

Provide same-day emergency care at least 12 hours a day, 7 days a week;

- Deliver an acute frailty service at least 70 hours a week, with the aim to complete a clinical frailty assessment within 30 minutes of arrival; and
- Record all patient activity via the SDEC emergency care data set.

In March 2021 Stockport NHS Foundation Trust commissioned NHS Elect to identify good practice and opportunities for improvements for SDEC pathways via their AEC Accelerator Programme, and to undertake a diagnostic assessment of the virtual ward opportunity. Highlights from analysis of data (*Oct19 - Mar20 i.e. pre-transformation*) for medical patients:

On average 67% of SDEC patients are referred from ED:

- Peak arrival time to ED of patients referred on to SDEC was 11:00;
- 19% of SDEC patients were in ED > 4 hours;

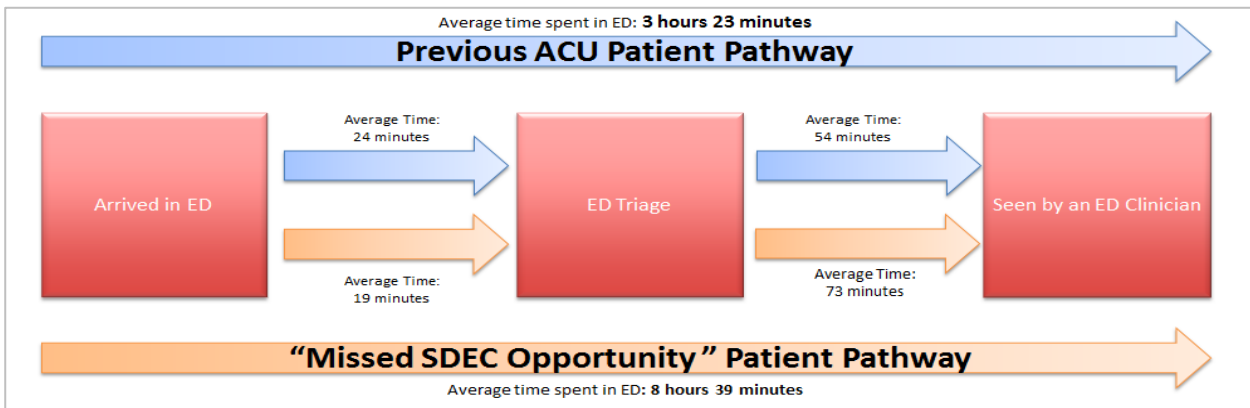
² [Ambulatory Care Services - AEC Programme \(ambulatoryemergencycare.org.uk\)](#)

³ [Joint statement from RCEM and SAM regarding same day emergency care \(SDEC\) | Society for Acute Medicine](#)

⁴ [Joint statement from RCEM and SAM regarding same day emergency care \(SDEC\) | Society for Acute Medicine](#)

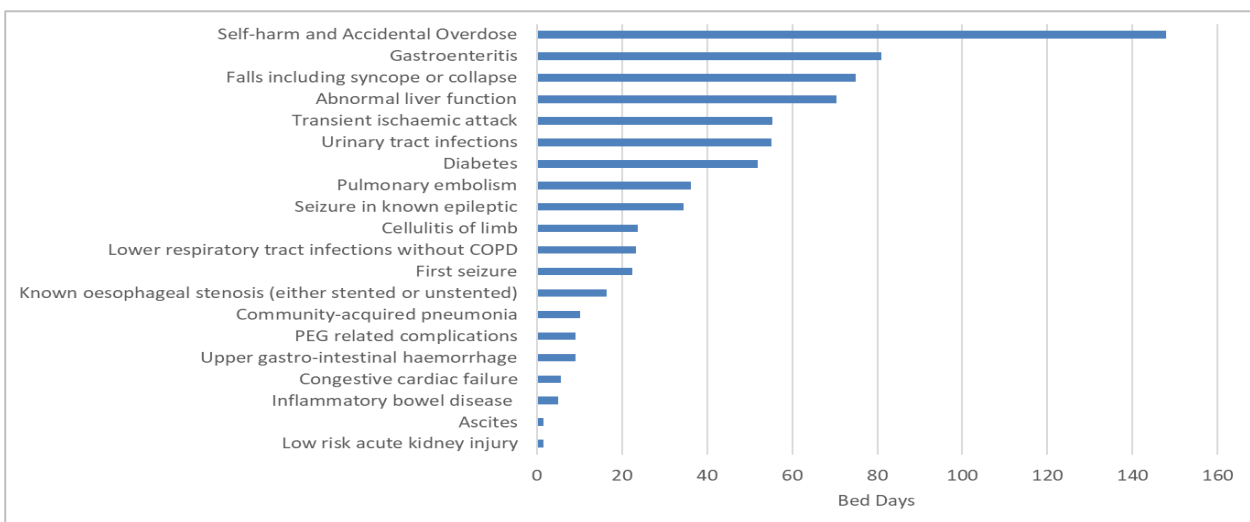
- 12% of SDEC patients required inpatient admission – national benchmark is 15%; and
- Average of 48 patients per week matching an AEC scenario were admitted – “missed opportunity”.

Figure 25. SDEC Patient Journey



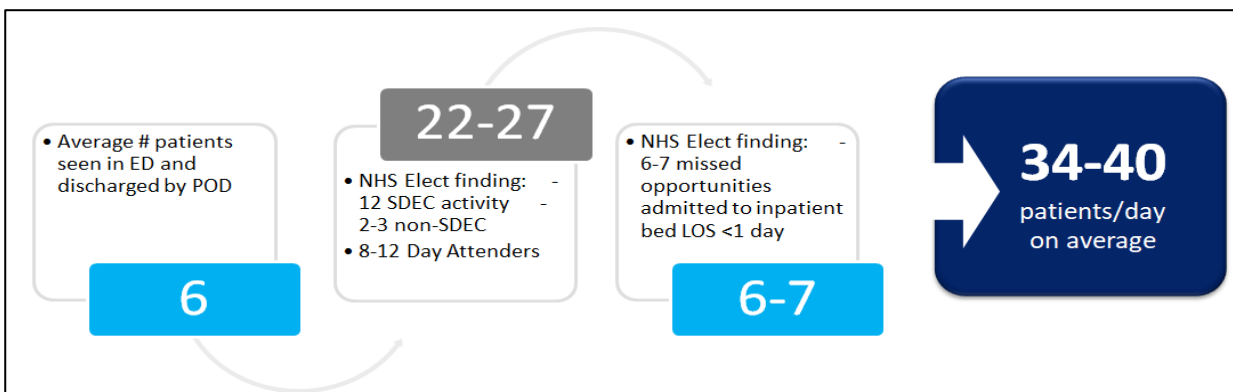
The graph below illustrates the potential impact on bed days for the 6-month period from October 2021 to March 2021 within Medicine at Stepping Hill Hospital, if each of the clinical scenarios met the recommended percentage being seen through a Medical SDEC unit.

Figure 26. Impact of SDEC on Bed Days



There are similarities between NHS Elects findings, some previous analysis undertaken by SFT, and observations made by a 2019/20 GIRFT review. This information has been used to inform the Medical SDEC future state daily capacity & demand modelling illustrated below.

Figure 27. Modelling Medical SDEC Demand



On average the unit sees up to 30 attends per day. In the afternoons it is often full in the clinical area & waiting room.

Based on current estate, with capacity of 12 trolley/chair spaces, peak demand hours of 08:00-17:00 (70% activity) and a ALOS of 5hrs, daily capacity can receive approximately 21 patients during peak demand hours (assuming no staffing limitations or social distancing implications).

If patients seen by POD in ED were streamed to Medical SDEC sooner, and we addressed the missed opportunities identified by NHS Elect (conservative figure), there would be a requirement to receive approx. 13 more patients per day i.e. 34-40 patients in total per day.

To be able to see a further 13 patients in Medical SDEC in peak demand hours (based on ALOS 5 hours) requires up to a further 7 assessment spaces, i.e. a unit with 19 assessment spaces, which is not feasible in the current estate. Furthermore, this doesn't account for changes in referral practice, implementation of triage, or transferring 'planned activities' such as the day attenders, from the Medical SDEC clinical area to an outpatient or virtual consultation arrangement.

3.3. Modelling

Whilst localities and ICSs are still forming, the national direction continues to look to remove the traditional professional and organisational barriers to care and provide joined up integrated health and social care services which better meet the needs of our changing population. This is fundamental to our modelling and the success of local urgent and emergency care services.

3.3.1 Clinical Pathways

The table below explores the likely movement in future capacity by clinical pathways. Further information can be found in Appendix 3.3.

Figure 28. Potential Future Capacity Needs

Clinical Area / Pathway	Likely change in Pathway?	Potential influences on Activity?	Likely Capacity Movement
RATS	No change	- Demographic	↔
Navigation / Streaming	No change	- Demographic - Scope for technology/digital solutions	↔
Triage	No change	- Demographic - Scope for technology/digital solutions - System solutions - alternatives to ED	↔
Minors	No change	- Demographic - System solutions - alternatives to ED - Improvements in streaming	↔
Mental Health	No change	- Unmet demand, potential growth.	↑
Paediatric ED	No change	- Only demographic unless strategic developments i.e. provider partnership(s)	↔ / ↑
Resus	No change	- Demographic - Healthier Together	↑
Majors	No change	- Demographic - Alternative types of assessment space provision from other zones and flow through admitting assessment units	↔
SDEC	New pathways	- Demographic - Likely growth area	↑
CDU	No change	- Demographic	↔
HASU	No change	- Demographic - Unmet demand	↑

3.3.2 Capacity & Demand

Three different approaches have been taken to help define future state capacity requirements:

1. Modelling using Summary Emergency Department Index Tool (SEDIT) metrics
2. Modelling based on Growth
3. Modelling based on Peak Attends

Each of the modelling approaches demonstrate the need for reconfiguration of the estate in order to make the emergency and urgent care services fit for purpose and sustainable to meet the predicted demand in a way in which is able to deliver new and emerging models of care.

Modelling using SEDIT metrics

An alternative approach to capacity & demand modelling involved the SEDIT metrics which is hosted through the Model Hospital.

SEDIT is part of NHSE/I's analytics suite, providing benchmarking and national context for ED activity and capacity. Whilst SEDIT alone does not quantify the capacity an Emergency Department should have; it allows a comparison against average national values for ED admissions.

The ratio based on 24 total Resus/Majors trolleys puts Stockport higher than the national median value. SEDIT suggests that if Stepping Hill ED had 7 more Resus/Majors trolleys ie 31 total Resus/Majors trolleys, then Stockport's ratio of admissions to capacity would be close to the national median value.

Please also see Appendix 3.4: Capacity Modelling of the Emergency Department.

Modelling based on Growth

Between 2015-16 and 2019-20, attendance volumes grew. However, activity growth is not evenly distributed across the different areas within ED. For example, Resus/Majors growth was 2.5%, 2% for Paeds, and Minors flat.

Based on 1.6% (flat average) and 3% (worst case) linear growth year on year:

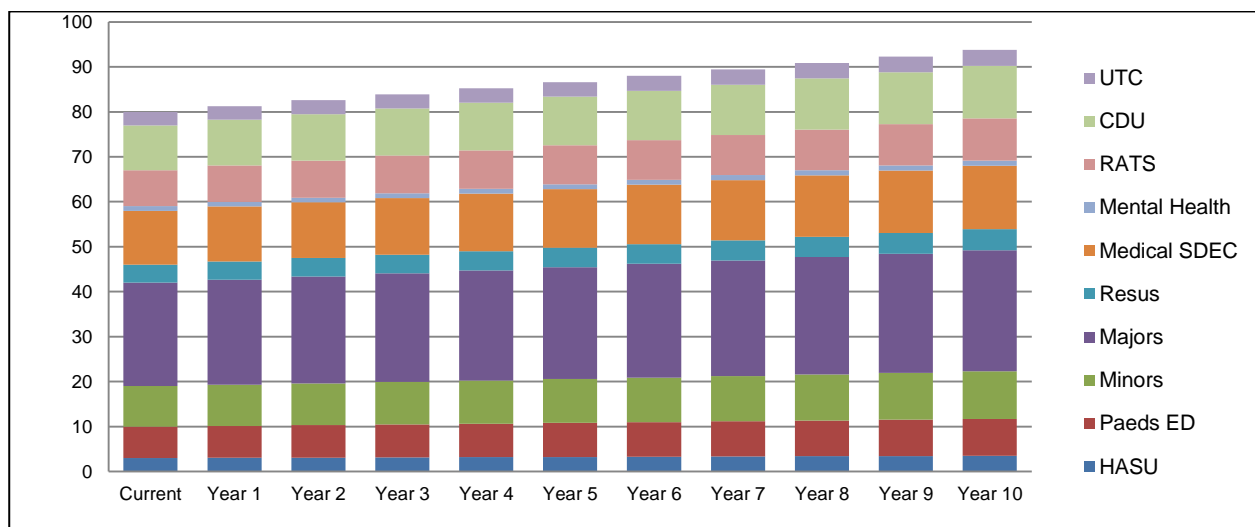
Figure 29. 10-Year Trend by Growth Rate

Growth	Current	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
1.60%	80	81	83	84	85	87	88	89	91	92	94
3.00%	80	82	85	87	90	93	96	98	101	104	108

Note: Baseline of 80 assessment spaces includes mental health and UTC.

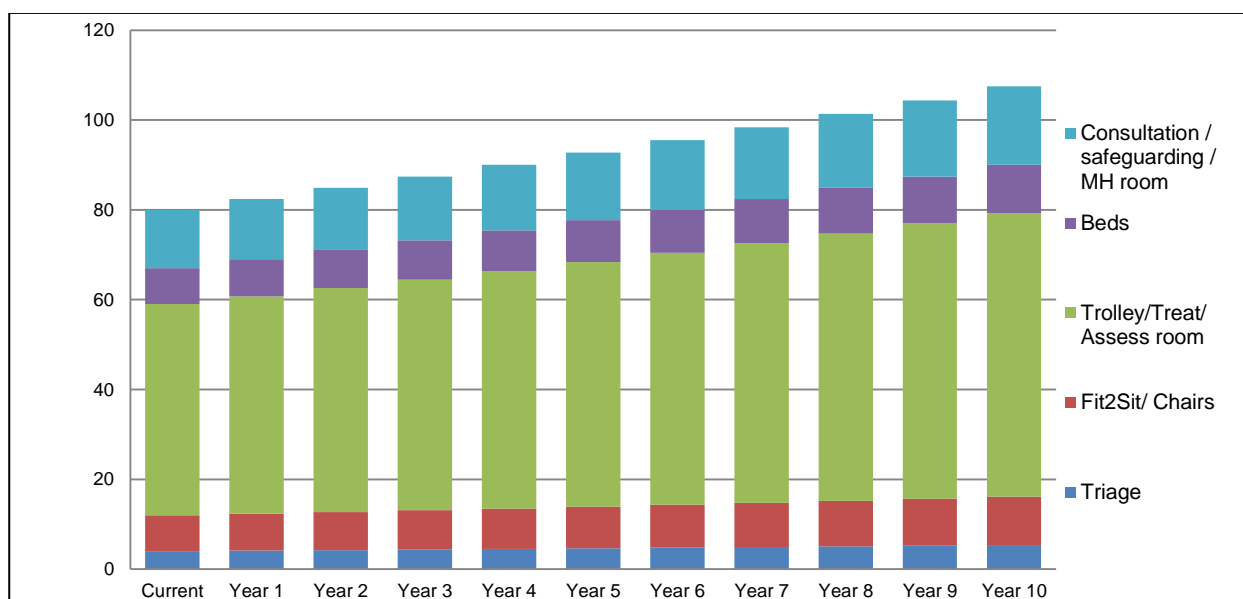
Thus, the likely capacity required in the future by clinical zone or type of assessment space can be modelled as illustrated in the figures below

Figure 30. 10-Year Trend in Assessment Space Capacity by Zone (1.6% annual growth)



The graph above is based on 1.6% year on year growth. Effectively by Year 10, 14 additional assessment spaces would be needed, which is conservative estimate. This methodology doesn't account for the lack of spaces today which SEDIT suggests to be approx. 7 trolley spaces alone, nor does it take into account any possible inefficient clinical and operational processes.

Figure 31. 10-Year Trend by Type of Assessment Space (3% annual growth)



The graph above is based on 3% year on year growth and suggests 28 additional assessment spaces would be needed in 10 years – again this doesn't account for the lack of assessment capacity today, nor does it take into account any possible inefficient clinical and operational processes.

Whilst modelling based on 3% would support future proofing, further analysis has been undertaken below to understand the capacity required to cope with surges in demand (peak attends).

Modelling based on Peak Attends

To ensure that the congestion in ED was not arising from inefficient clinical and operational processes detailed capacity modelling of the ED department was undertaken (Appendix 3.4) looking at peaks in attendance and occupancy. The assertion is that lack of physical space results in inefficiencies.

Considering utilisation of each area in ED, the analysis reviewed:

- The number of people over key hours of the day were plotted alongside the wait times for the corresponding periods; and
- The ratio of total patients waiting to the number of bays were also modelled to determine a 'tipping point' where overcrowding starts.

This information was then used to determine:

1. What the current requirement of trolley assessment spaces would be (to achieve waiting times) compared to current capacity; and
2. What the future requirement of trolley assessment spaces would be (to achieve waiting times) after factoring in historical growth.

To reassure the Trust of the approach taken and its outputs, the Trust sought external business intelligence support from another organisation. In addition, a specialist advisor in the form of a health planner, was also engaged to identify the required schedule of accommodation which driven the final design; this ensured that the clinical operating models and flows were aligned and met the current and future needs of the population.

The table below, summarised from the modelling approach detailed in Appendix 3.4, demonstrates the shortfalls in current trolley assessment spaces which would be required to maintain the 4-hour standard at peak attendance times. A 10-year forecast has also been generated to provide an indication of the required number of trolley assessment spaces (at peak attend times) based on annual growth.

Figure 32. Trolley Assessment Spaces

Stream / Area	Current no. trolleys	Optimum ratio (patients:trolleys)	Additional trolleys currently needed	Total trolleys required by Year 10	Additional trolleys required by Year 10
Paeds	2	5:1	0	4	2
Minors	3	3.5:1	0	4	1
Majors (20 trolleys)	24	2:1	12	45	21
Resus (4 trolleys)					

The modelling detailed in Appendix 3.4 predicts that the current trolley assessment space capacity within the emergency department footprint is insufficient to meet existing demand during peaks in attendances. For Majors/Resus 12 additional trolley assessment spaces are currently required and 21 additional trolley assessment spaces in 10 years' time.

Conclusion of Capacity Modelling

In summary SEDIT suggests a gap of 7 trolleys now, whilst further analysis puts this closer to 12 trolleys in order to maintain the 4-hour standard at peak attendance times.

Over a 10-year period a conservative estimate based on averaged historic demographic demand growth estimates a requirement for a total of 14 additional assessment spaces.

Over a 10-year period a more resilient estimate suggests 28 additional assessment spaces would be needed in 10 years.

In conclusion, the following has been integral to the design process and workforce modelling:

- Current capacity gap to manage peak attends;
- Forecast capacity to match a 1.6% averaged population demand growth;
- Changes in clinical pathways e.g. Healthier Together;
- Influence of transformation schemes such as navigation/streaming, UTC and SDEC; and
- Clinical sense-check.

Figure 33. Impression of Future Assessment Space Needs by Clinical Zone

Zone	Existing	Future needs	Movement
Paeds ED	1 triage 3 trolleys 2 consult rooms 1 treatment room	Additional trolley/consultation space	↑↑
Minors	3 triage 1 treatment room 5 consult rooms	No change	↔
Majors	20 trolleys 1 treatment room 2 Fit2Sit	Agile assessment space	↑
Resus	4 trolleys	Additional trolleys	↑↑
RATS	6 trolleys 2 handover spaces	6 trolleys 2 handover spaces	↔

CDU	8 beds 2 consult rooms	Fit2Sit area	↑
HASU	3 trolleys	Additional trolleys	↑↑
Medical SDEC	6 trolleys 6 Fit2Sit	Additional assessment space, triage/consultation rooms	↑↑
Mental Health	1 de-escalation room	Fit for purpose space	↑
UTC	3 consult rooms	No change	↔
Total spaces	80		

3.3.3 Workforce Modelling

This project is primarily an estate re-development and re-organisation. However, the workforce model will need to adapt to the change in layout (e.g. line of sight, new receptions), movement in capacity (e.g. HASU), changes in clinical pathways (e.g. SDEC) and improvements in operational efficiency; the Trust must consider the required skills and capabilities in addition to any movement in whole time equivalent (WTE).

Engagement activities have taken place to review the future workforce model. The Trust has already undertaken a range of initiatives related to the development of the workforce. Service transformation continues to pursue improvements in service delivery as well as exploring innovation in support of future models of care.

Figure 34. Baseline Workforce WTE

Staffing Type	2021/22 Baseline Budget WTE	Contracted WTE	Contracted more/(less) Budget	Worked WTE	Bank / Agency Worked (WTE)	TOTAL Worked WTE	Worked more/(less) Budget
Consultant	14	13.7	-0.3	11.94	0	11.94	-2.06
Junior Doctors (incl. ACP/PA)	56.78	51.22	-5.56	35.44	13.4	48.84	-7.94
Registered Nurses	135.14	104.66	-30.48	83.34	29.82	113.16	-21.98
Unregistered Nursing	63.02	39.88	-23.14	45.87	13.76	59.63	-3.39
A&C (excl. Management)	24.38	22.78	-1.6	21.52	1.38	22.9	-1.48
Total	293.32	232.24	-61.08	198.11	58.36	256.47	-36.85

Undoubtedly there will be workforce challenges from managing a larger footprint with increased numbers of assessment spaces.

In addition to the investment objectives (below) which make assumptions of efficiencies the revised E&UCC footprint will have on the workforce and operational efficacy, the following points provide examples of how the WTE needs identified above will be mitigated within the funded establishment:

- Historically the ED workforce has been short-staffed and highly dependent on bank and agency staffing which is less efficient and greater cost than a substantive workforce. Even after supplementing the substantive workforce with bank and agency staff, there is still a considerable shortfall of worked WTE compared to budgeted WTE. Improving the environment and efficiency in process will help the Trust to recruit, retain the existing workforce, and reduce staff sickness; not only a happier workforce but also a more cost effective and more efficient workforce, operating at full establishment.
- The current shortfall in assessment space capacity has already been accounted for in the existing staffing model; patients' needs are being met by the workforce as best as possible within the constraints of the current estate – the CQC recognised this challenge and still rated ED as 'Good', a significant achievement from its previous rating despite the pressures faced by staff.
- There is an opportunity to work more collaboratively with NWS and EMAS Ambulance Services to support timelier handover and rapid turnaround of crews in RATS, thus allowing the Trust to redistribute nurse staffing.

- Introduction of electronic kiosks for check in purposes, in addition to changes in footfall will support changes to the main ED reception staffing model, allowing for reception cover to new reception areas in RATS and Paediatrics.
- Introduction of electronic kiosks for triage purposes, and navigation to UTC or SDEC allowing for release of nurse staffing from Triage to other zones.
- Skill mix review of unregistered nurse workforce, for example in SDEC, to allow for an increase in scope of practise and greater delegation of tasks not required to be undertaken by a registered nurse
- Co-location of SDEC and Emergency Department allows for further integration in relation to supporting national SDEC best practice, which further allows staff to rotate and develop their skills in a range of areas across emergency and urgent care.
- The mental health care provider, Pennine Care NHS Foundation Trust, proposes to consolidate its workforce into the new zone which will be managed by them.
- The growth in HASU will be matched by efficiency in the stroke pathway from not having to respond to stroke outliers.

The workforce strategy will continue to develop beyond the FBC to response to lessons learned from new ways of working through the Covid-19 pandemic and to consider feedback from our stakeholders and key clinical and operational leads, lessons learnt from other projects where workforce issues have been prevalent, and learning from staff surveys, and after closely monitoring changes in population demand year on year.

Apart from future growth in workforce linked to an average 1.6% year on year growth in population demand, the only remaining clinical areas where there is expected to be significant growth in assessment space capacity over the coming years are:

- Resus - linked to Healthier Together (a separate business case and programme altogether); and
- Paeds – dependant on strategic developments with other providers (potential for workforce re-alignment).

Changes in the delivery of emergency and urgent care services has been and continues to be analysed at locality level via the Urgent and Emergency Care Delivery Board, in close collaboration with system partners such as the SMBC and SCCG.

3.4. National, Regional and Local Priorities

3.4.1 National Drivers

The national drivers underpinning this case for change include:

- The Carter Report (2015);
- The Naylor Review (2017);
- NHS Long Term Plan (2019);
- NHS People Plan (2019);
- Integration and innovation: working together to improve health and social care for all (2021); and
- GIRFT.

The Carter Review looked at the productivity and efficiency of English non-specialist acute hospitals, which account for half of the total health budget, using a series of metrics and benchmarks to enable comparison. The report concluded that there is significant unwarranted variation - estimated as a £5bn opportunity - and although there are many examples of good practice, no one hospital is good at everything. There are 15 recommendations designed to tackle this variation. Example focus areas include:

- Preventing delayed transfers of care; and
- All Trusts should operate at a maximum of 35% non-clinical floor space.

The Naylor Review set out the extent of the issues and problems facing NHS estate. Key highlights include the requirement to:

- Invest £10bn in NHS estate; £5bn (at least) for backlog maintenance; and
- Review the needs of estate in the context of emerging models of care, increased demand, and advances in technology.

The emergency care system under real pressure, in the midst of profound change. Although a patient's chance of having to be admitted to hospital as an emergency has fallen by 12%¹⁵, the number of A&E patients successfully treated within four hours is 100,000 per month higher than five years ago. The NHS Long Term Plan (LTP) provides the framework for local systems to develop plans over a ten-year period, based on the principles of collaboration and co-design. Over the period of the NHS LTP, by expanding and reforming urgent and emergency care services the practical goal is to ensure patients get the care they need fast, relieve pressure on A&E departments, and better offset winter demand spikes. New ways of delivering urgent care such as UTCs are growing far faster than hospital A&E attendances, which are up by around 1.5% year-to-date. Emergency admissions requiring an inpatient stay are increasingly being replaced by Same Day Emergency Care (up by 10.5%).

The NHS People Plan identifies that workforce development has fallen sharply, with a national requirement for an additional £85m to return to previous funding levels. Whilst the importance of expanding the workforce across all clinical groups is recognised, there is also a need for the NHS to be more digitally capable to allow clinicians and those in support roles to work more efficiently, releasing more time to care.

Integration and innovation: working together to improve health and social care for all, sets out the UK Governments legislative proposals for a Health and Care Bill. It aims to build on the incredible collaborations seen through the Covid-19 pandemic and shape a system that's better able to serve people in a fast-changing world. The proposal is to build back better after Covid-19, first by removing the barriers that stop systems from being truly integrated. Local NHS and Local Government organisations will form dynamic partnerships to address some of society's most complex health problems, and support the UK Governments' Manifesto Commitments, including 50,000 more nurses and 40 new hospitals.

The design of the new E&UCC will need to draw upon national good practice identified through the GIRFT review for emergency medicine in addition to the benchmarking data available via Model Hospital to support productivity and efficiencies for the new development.

3.4.2 Alignment with STP and Estate Plans

The Trust is currently developing a new Estate strategy and Development Control Plan (DCP) for future development/ management of our estate over a 10-year period. The estate strategy will identify the current and future healthcare service needs of our local population and the current condition of existing healthcare estate. It will also identify service-led changes to the estate over the same 10-year period and define high-level estate performance requirements.

The estates strategy and DCP will ultimately provide the following benefits:

- Identify premises developments that support service/capacity requirements;
- The provision of safe, secure and appropriate buildings;
- The provision of high-quality healthcare environments, which may aid staff retention/morale and patient outcomes/satisfaction levels;
- Plan for change that enables progress towards goals to be measured;
- A clear commitment to complying with sustainable development and environmental requirements/initiatives;
- A means of targeting investments to minimise the risks associated with the built environment;
- An opportunity to dispose of surplus and/or poorly used assets and reinvest released resources; and
- An opportunity to optimise occupancy costs.

Ryder Architecture, architects on the E&UCC, have also been appointed for the above piece of work due to their site wide knowledge of Stepping Hill Hospital. The first draft has been received by the Trust and is currently under review. The Development Control Plan (DCP) is included in Appendix 5.9. The E&UCC will form Phase 2 of the DCP.

3.4.3 Levelling Up

Development of the emergent and urgent care campus on the hospital site in Stockport is necessary to deliver a number of required improvements to service users, staff, key stakeholders and the overall health economy. These can be summarised as follows:

- The redesign of the site will enable greater GP presence for paediatrics in particular

- Improvements to the sustainability and delivery of the national Emergency Department standard and primary urgent care standards.
- A new front door will support the receipt, offloading and turnaround of multiple ambulances, including that requiring fast track access to stroke thrombolysis treatment;
- Facilitate patients being streamed away from Emergency Department into a more suitable care setting. This will reduce the current overcrowding as the current department is too small for the volume of attendances;
- Increase in resus capacity to deliver demand and support the site as a major trauma unit;
- More greatly recognising the demand from children and young people including those presenting in mental health crisis or with learning difficulties;
- Provide some additional suitable space for the assessment of adults due to mental health issues or learning disability issues;
- Co-location, integration and augmentation of ambulatory care and planned investigations will increase the percentage of patients accessing these services and therefore avoiding the requirement to admit them to an inpatient bed; and
- Driving admission avoidance through the expansion of same day emergency care services will positively impact on bed occupancy, thus negating the requirement for additional hospital inpatient beds in line with Stockport's over 70's population growth.

The localities population demand for urgent and emergency care cannot be effectively serviced in line with national standards and regional expectations without intervention; this being due to the lack of adequate space and assessment capacity. The estate is old and in need of significant modernisation to support current and future population demand, required clinical operating models to stream patients to the appropriate clinical team (including those presenting in a mental health crisis) and ensure the timely turnaround of North West Ambulance Service and East Midlands Ambulance Service arrivals.

3.4.4 Local Support

The organisation has worked closely with partners on the Stockport Locality Plan to identify three key aims for the borough's health and care strategic plan.

- Working with partners to build new models of integrated person-centred care;
- Ensuring best outcomes from hospital services; and
- Addressing population health and access inequalities.

The Trust Strategy, clinical strategy and E&UCC programme have been aligned to help deliver these from the acute provider perspective.

The partnership approach is also underpinned by the strategic aims set out in Stockport CCG's strategy of *Start Well, Live Well, Age Well, and Die Well*. The Stockport system has an Urgent & Emergency Care Delivery Board (UECDB) which brings together partners from across health and care to support the achievement of the Borough's key aims. This has included delivering the following:

- GP Practice first – 24/7 making it easier for patients to access care when they need it;
- Primary care led streaming services in place that move people away from emergency department and into more appropriate services. This using the Manchester Triage System. This bid will provide the space to e-triage as patients arrive will accelerate the triage process and ensure people get to the right place and receive the right care as quickly as possible
- Development of local clinical assessment processes to support "Call First" and the NHS 111 programme
- An Urgent Treatment Centre that will receive referrals from General Practice, the Emergency Department, NWS, NHS 111 and 'walk ins' – it must be primary care led and open 12 hours a day;
- Access to diagnostics including near patient testing, available in each urgent treatment centre.
- Reduced Admissions/Readmissions - The increased space within the Emergency Department will provide an improved environment to support admission avoidance teams.

Expansion of the facilities through a capital investment to develop the integrated urgent treatment offer at the Trust will enable this to take place and deliver the opportunities to integrate wider primary care with urgent

care, to rationalise the service offer, reduce duplication and flex the workforce to provide urgent and primary care services which meet the needs of the local population.

The locality UECDB and consequently wider Stockport system have been kept apprised of the E&UCC programme through the Executive Trust Chair and Trust CEO, as well as through direct stakeholder engagement.

In line with NHSE/IT's Fundamental Criteria checklist, specifically Annexe 12 of planning-assuring-delivering-service-change⁵, Letters of Support have been obtained from SMBC, SCCG, and the Greater Manchester Health & Social Care Partnership, which can be found in Appendices 1.3, 1.4 and 1.5 respectively.

The Stockport health and social care economy has been significantly challenged in managing the demand and flow of Urgent and Emergency Care (UEC) in recent years. The current Emergency Department was reconfigured in the 1990's and since then there has been a circa 35% growth in attendances resulting in overcrowding, patients being nursed and assessed in unsuitable areas and a difficulty in achieving the 4-hour quality standard on a consistent basis.

Stakeholders acknowledge and support the following:

- The E&UCC proposal broadly comprises the internal reconfiguration and refurbishment of the existing accommodation housing emergency and urgent care services, as well as some modest extensions to the existing building; the most notable of which is the enlargement of the ambulance / patient reception area and the associated improvement of the building façade;
- The purpose of the extensions and alterations is to bring the accommodation up to modern standards where the clinical excellence of the operations can be protected. The aim is to provide a modern, efficient and effective campus that can continue to serve the existing community for years to come;
- The proposals will not impact on current access and parking arrangements, and nor will it change the pattern of traffic to and from the site, or the existing demand on parking facilities in the wider hospital or the locality; and
- The works are required to take place in a phased manner whilst the emergency and urgent care services remain operational at all times.

The capacity and demand modelling assumptions are supported for the following reasons:

- There is recognition that there is a lack of physical assessment space capacity;
- This proposal seeks to address the issues resulting from growth in demand;
- Stakeholders have not issued any intention to consider divesting in emergency and urgent care services; and
- The new E&UCC will deliver the physical space and co-location of services required to achieve Stockport CCGs strategic aims for improving the delivery of urgent and emergency care.

After consideration of statutory duties in line with the NHS Act 2006 and Equality Act 2010, as well as NHSEs 2018 guidance *'Planning, assuring and delivering service change for patients'*, the Trust and Stockport CCG agree that formal public consultation is not required for the following reasons:

- There will be no substantial change over how services will be delivered; and
- There will be no change in geographical location from where services will be delivered.

However, the Trust intends to undertake wider engagement as part of the planning process which this is endorsed by stakeholders.

3.5. Investment Objectives and Benefits

The strategic, partnership and policy context as above have enabled the E&UCC programme to define a clear set of investment objectives and the associated benefits, which are set out in the table below:

Figure 35. Investment Objectives and Summary of Key Priorities

Objective	Description	Expected Benefits	Measurable SMART
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⁵ <https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf>

			Objectives
Future proofing capacity for urgent & emergency care	To provide future proof, modern physical space needed to deliver urgent care access standards	a) To secure recent improvements in urgent care hospital flows in line with national and regional LTP expectations b) Reduction in delays and waiting time for patients needing E&UCC services c) To limit the amount of time patients spend in hospital	Improved and sustained delivery of the Urgent Care access standards
Improved Streaming	To provide co-located facilities for pre-hospital navigated patients to access specialty care directly without the need for prior assessment in ED	a) To effectively deflect patients suitable for direct access to specialty along pre-defined clinical pathways away from the Emergency Department and direct to the right clinical workforce and environment for their need b) To provide best possible opportunity for admission avoidance for these E&UCC patients and to limit time spent in acute care	Increase in number of patients seen in a SDEC environment (30% increase in patients managed via SDEC) Reduction in ED attends for patients subsequently referred to a specialty (10% reduction)
Clinical strategy – Same Day Emergency Care	To increase capacity for same day assessment for patients needing urgent services across key specialties	a) Reduction in admissions due to earlier decision making from senior specialists working to pathway designed delivery models b) Improvements in performance against clinical standards for SDEC from rapid transfer out of the ED specialty	Increase zero length of stay admissions from 30% to 45% Increase in direct admissions from GP by 20%
Responding to demand for patients presenting in mental health crisis	Increase capacity for patients in need of mental health support	a) To improve the environment for patients presenting in mental health crisis b) To provide an efficient pathway for patients that reduced length of stay in the E&UCC service	Improve the Urgent Care access standard performance for patients presenting with mental health crises
Clinical strategy – ambulance turnaround	To provide an appropriate environment for the safe and timely handover of patients arriving by ambulance	a) To ensure ambulances can promptly handover care ensuring ambulance availability in the community for emergencies b) To ensure patients are cared for in an appropriate, safe environment	To sustain ambulance turnaround times within national standards Zero tolerance for handovers over 60 minutes
Economic	To support economic regeneration through reconfiguration of the existing NHS estate	a) Reduction of estate footprint, in turn releasing key estate for potential future development b) Reduction of back log maintenance c) Improved transport infrastructure, car parking facilities and access to the hospital site	Reduction of backlog maintenance by 1.5%
Patient Experience	To modernise services and facilities which will ensure improvement in the overall patient and visitor experience	a) Enhanced staff and patient environments that improve the experience of urgent care through sensitive design and clear patient pathways for acute presentations b) Capacity to ensure waiting times are reduced in line with urgent care access standards	Improved and sustained delivery of the Urgent Care access standards Improved FFT scores by 20%
Staff & Wellbeing	To provide modern facilities which will ensure adequate resources to meet demand and enhance staff experience	a) Enhanced staff and patient environments that improve the experience of urgent care through sensitive design and clear patient pathways for acute presentations b) Support positive health and wellbeing through environment design	Improvement in staff survey and perceptions of the Trust as an employer – top quartile for workplace recommendations in national survey Urgent care recruitment and retention metric improvement – turnover reduced by 10%

3.5.1 Expected Impact

In summary, we expect to deliver:

- Improved patient flow through urgent & emergency care services;
- Improved outcomes for patients through integrated working across urgent care services including acute, primary care, mental health, social care, pharmacy and the Local Authority;
- Reconfiguration of the estate to reduce backlog maintenance, making best use of the hospital site;
- Improved patient experience through enhanced patient environment in the Emergency Department;
- New expanded ambulance offloading area which will positively impact on ambulance handover and turnaround time. The shelter will also address the issue of patient exposure to inclement weather conditions;
- Improved staff experience through enhanced patient environment and clear patient pathways;
- Enables care that is patient centred and tailored to meet the needs of the individual through access to integrated urgent care services across organisational boundaries;
- Supports increased delivery of national standards in Emergency Department performance;
- Reconfigured single urgent care services for patients at the hospital's front end;
- Acute admissions avoidance through effective streaming to alternative appropriate health and social care services;
- Reduction of back log maintenance; and
- Improved layout which allows the Trust to have the agility to adapt to meet revised Infection Prevention Standards in the wake of the COVID-19 pandemic.

3.5.2 Beneficiaries

Most importantly the local population will experience timely access to urgent and emergency care that is simple to navigate, delivered by teams working to appropriate clinical pathways within high quality clinical facilities.

Organisational beneficiaries of the scheme are Stockport NHS Foundation Trust, SCCG, SMBC and the Greater Manchester ICS. The benefits detailed above would be significant for each of these organisations and would have the potential to significantly impact on health outcomes and performance standards for Greater Manchester.

3.6. Project Risks & Constraints

A more detailed summary of the project risk register and risk management arrangements has been provided in the Management Case.

3.6.1 Project Risks

The key project risks associated with this investment are outlined below. A more detailed summary of the project risk register is provided in Appendix 7.6.

- **Funding** - The most significant key risk at the FBC stage of the proposal is failure to secure the funding to undertake the redevelopment works.
- **Scope** – Risk that the controls in place do not manage project creep
- **Performance** - Maintaining operational performance during construction
- **Benefits Realisation** - Risk that the benefits and workforce efficiencies will not be achieved –
- **Demand** - Changes in urgent care demand, both pre-Covid19 and as a result of the pandemic.

3.6.2 Project Constraints

The key constraints to this project are set out below:

- **Business Continuity**– Construction phases will be managed in a similar way to previous on-site capital work in the live environment which have been successfully and sensitively managed with clinical engagement throughout

- **Site Restrictions** – there is limited space on the Stepping Hill Hospital estate. The only viable options have been explored in the economic options appraisal.
- **Affordability** – there have been unexpected constraints on the existing budget due to inflation since original cost estimates and emerging guidance on capital builds since the Covid19 pandemic that will impact on costings. Every effort has been made to maximise clinical space to ensure value for money as well as safe environment for patients and staff. Administrative and clerical offices have been limited in the design to ensure optimal clinical utilisation of funding available.

3.6.3 Project Dependencies

The key dependencies to this project are as follows:

- **Regulatory Approval** – this business case is subject to receiving approval from NHSE/NHSI in order to draw down the £30.6m PDC funding secured as part of the STP Wave 4 capital bidding round.
- **Other Capital Projects** – this business case runs in parallel with a previous STP Wave 1 capital bid to provide new capacity in the management of patients presenting with an Acute Abdomen as the Trust is the GM South East sector specialist hospital for emergency and high-risk general surgery under the Healthier Together programme. Although the provision of an ED Resus area is a common element, both capital projects are mutually exclusive. Please refer to Appendix 3.5 for further information.

4. Economic Case

4.1. Introduction

The Strategic Case has set out the case for change within the context of the national, regional and local healthcare agenda and identified a clear set of investment objectives. In accordance with HMT's Green Book (Central Government Guidance on Appraisal and Evaluation – HM Treasury 2020) and the Capital Investment Manual, this section of the FBC documents the identification and evaluation of the various options that have been considered in response to fulfilling the scope of the E&UCC programme as identified within the Strategic Case.

The purpose of the Economic Case is to establish which of the proposed options is preferred, by undertaking both a qualitative and quantitative (financial) economic appraisal of the options. This demonstrates the relativities between the options and the way forward that demonstrates Value for Money (VfM).

HMT issued an updated Green Book and associated guidance in 2020 which incorporates the use of the Options Framework⁶ to define the longlist of options which will be assessed by how well each option meets the investment objectives and the Critical Success Factors (CSFs).

Key stakeholders of the Trust, architects, healthcare planner and business consultants held a series of workshops in October and November 2021 to consider the CSFs and to undertake the options appraisal. The long list of options was appraised against a set of qualitative CSFs and investment objectives within evaluation workshops, which were held to obtain the views and support of key stakeholders. The outcome of this qualitative evaluation was used to determine the short list of options to be taken forward for quantitative economic appraisal. These options were reviewed at FBC stage and were considered to be appropriate.

Following the qualitative appraisal and short listing of options, a quantitative economic appraisal was carried out which uses a Discounted Cash Flow (DCF) analysis to assess the relative economic costs of the various options to the public sector. This is a means of expressing, within a single criterion, the Net Present Cost (NPC) of the proposed shortlisted options when summed over a 60-year appraisal period (exclusive of the construction period) and discounted to reflect the public sector time preference. By applying a discount rate to anticipated future cash flows, the 'present cost' of the proposed options can be assessed and considered on a cost-benefit basis in conjunction with the qualitative scoring provided in the previous phase of evaluation and in the context of the societal benefits that have been identified from implementing that option.

This appraisal process has enabled the Trust to identify a preferred option which delivers the most effective and value for money solution in the context of each investment objective. This preferred option will be taken forward as part of the financial and affordability analysis.

The key components of the Economic Case include:

- Overview of CSFs
- The Options Framework
- Identification of the short-listed options
- Capital and net revenue costs associated with the short-listed options
- An economic (value for money) appraisal of short-listed options
- Cost-benefits appraisal
- Option appraisal/rankings
- Sensitivities

4.2. Overview of CSFs

CSFs are a small number of criteria used at the long-list stage to make strategic choices about options. They support an assessment of how well an option is likely to succeed across the five areas of the business case and deliver the project's SMART objectives. The key CSFs (from the *Options Framework*) used to appraise public spending interventions are noted in the table below.

⁶ Source: Page 29 of *HM Treasury, The Green Book, Central Government Guidance on Appraisal and Evaluation*

Figure 36. Critical Success Factors

Key CSF	Description
Strategic fit and meets business needs	<p>How well the option:</p> <ul style="list-style-type: none"> • Meets the agreed investment objectives, related business needs and service requirements • Provides holistic fit and synergy with other strategies, programmes and projects • Meets the requirements of national and local directives and guidance • Delivers the Trust's Strategic Ambitions and objectives as outlined in the Trust's Strategy • Supports patient-centred care delivered in the most appropriate setting • Addresses the need to replace ageing estate • Addresses workforce needs • Ability to change and be agile to future, such as in the face of a pandemic, or other unexpected crises.
Potential value for money	<p>How well the option:</p> <ul style="list-style-type: none"> • Optimises social value in terms of the potential costs, benefits and risks • Support the use of technologies or processes which promote efficiencies in operating costs • Support an enhanced patient, users, carers, staff, volunteers' and visitors' environment which promotes health and wellbeing • Deliver dynamic spaces that are adaptable and can support changes to services and transformation
Supply side capacity and capability	<p>How well the option:</p> <ul style="list-style-type: none"> • Provide a clear, NHSE/I and Treasury approved procurement route • Matches the ability of the marketplace and potential suppliers to deliver the required services • Sufficiently addresses supplier side risks to ensure sufficient supplier appetite
Potential affordability	<p>How well the option:</p> <ul style="list-style-type: none"> • Can be financed from available funds • Aligns with sourcing constraints • Delivers a solution affordable to the Trust, ICS and wider health economy
Potential achievability	<p>How well the option:</p> <ul style="list-style-type: none"> • Is likely to be delivered given an organisation's ability to respond to the changes required • Can provide a solution which is deliverable and minimises disruption to the Trust's operations during construction • Matches the level of available skills required for successful delivery • Has the support of partner organisations, senior team and clinicians

The CSFs and examples of the approach to assessment of the options was discussed in further detail at the options workshops. Details of the discussions are outlined in the tables below and in Appendix 4.1.

4.2.1 Strategic Fit and Meets Business Needs

During the workshop, it was considered and challenged how well the options meet agreed objectives and fit with wider organisational objectives, as follows:

Figure 37. Strategic Fit and Meets Business Needs

Approach to assessment of the options	Examples
<p>Does the option:</p> <ul style="list-style-type: none"> ✓ improve the quality of service and clinical outcomes for patients, staff, families, and carers, whilst providing a 	<ul style="list-style-type: none"> • Improves accessibility of services and patient pathways through careful design development • Supports the transformation of clinical services and enables the Trust to improve standards

pleasant environment?	<ul style="list-style-type: none"> Supports the Trust to deliver a positive experience for patients, families and carers as reflected in the Friends & Family Test
Does the option: <ul style="list-style-type: none"> ✓ provide a sustainable long-term solution, which meets the present and future needs of the Trust's clinical services ✓ support economic regeneration? 	<ul style="list-style-type: none"> Provides a long-term solution which consistently meets the Trust's investment objectives Improves clinical sustainability providing a future estate solution that enables delivery of optimal services now and in the future
Does the option: <ul style="list-style-type: none"> ✓ make best use of the Trust's workforce? 	<ul style="list-style-type: none"> Builds and maintains staff satisfaction and morale Provides opportunities to attract and maintain a high-quality workforce
Does the option: <ul style="list-style-type: none"> ✓ support the adoption of new technologies ✓ support innovative ways of working? 	<ul style="list-style-type: none"> The configuration of the facility may allow for a more integrated, streamlined service with interdependent services co-located To encourage new ways of working and greater use of technology

4.2.2 Potential Value for Money

This CSF considers if the option is likely to deliver social value in terms of costs, benefits and risks.

Figure 38. Potential Value for Money

Approach to assessment of the options	Examples
Does the option: <ul style="list-style-type: none"> ✓ support additional employment opportunities ✓ encourage regeneration opportunities ✓ bring economic growth ✓ drive opportunities for further collaboration with partners 	<ul style="list-style-type: none"> Makes land and buildings surplus to requirements and available for alternative use Creates employment opportunities

4.2.3 Supplier Capacity and Capability

This CSF considers how well the option matches the ability of potential suppliers to deliver the required services and appeals to the supply side.

Figure 39. Supplier Capacity and Capability

Approach to assessment of the options	Examples
Is the option: <ul style="list-style-type: none"> ✓ Deliverable by potential suppliers, i.e. does the construction market have capacity to deliver, and do market participants have the necessary capability and experience? 	<ul style="list-style-type: none"> Experience of market participants to deliver the option specification Economic and financial standing of market participants

4.2.4 Potential Affordability

This CSF considers how an option will be financed and if it is affordable within existing budgets.

Figure 40. Potential Affordability

Approach to assessment of the options	Examples
Does the option: <ul style="list-style-type: none"> ✓ make best use of the Trust's limited financial resources ✓ make efficient use of the Trust's estate, including efficient use of surplus estate, and provide more operationally efficient 	<ul style="list-style-type: none"> Reduces duplication of resource e.g. staff, equipment Makes efficient use of estates floor space Develops clinical efficiencies across teams Supports the delivery of care closer to home and increases out of hospital care

spaces and streamlined patient pathways?	<ul style="list-style-type: none"> • Access available to required capital funds
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4.2.5 Potential Achievability

The following table outlines the considerations regarding how likely it is that an option can be delivered given organisational capability and available skills.

Figure 41. Potential Achievability

Approach to assessment of the options	Examples
Is the option: ✓ deliverable within the land area available ✓ minimising the disruption to services?	<ul style="list-style-type: none"> • Anticipated footprint likely to fit within available land • Limits disruption to service delivery • Expected timeliness and ease of implementation • Obtains support from external stakeholders e.g. NHSE/I, local health system partners, GPs and local authorities

4.3. The Options Framework

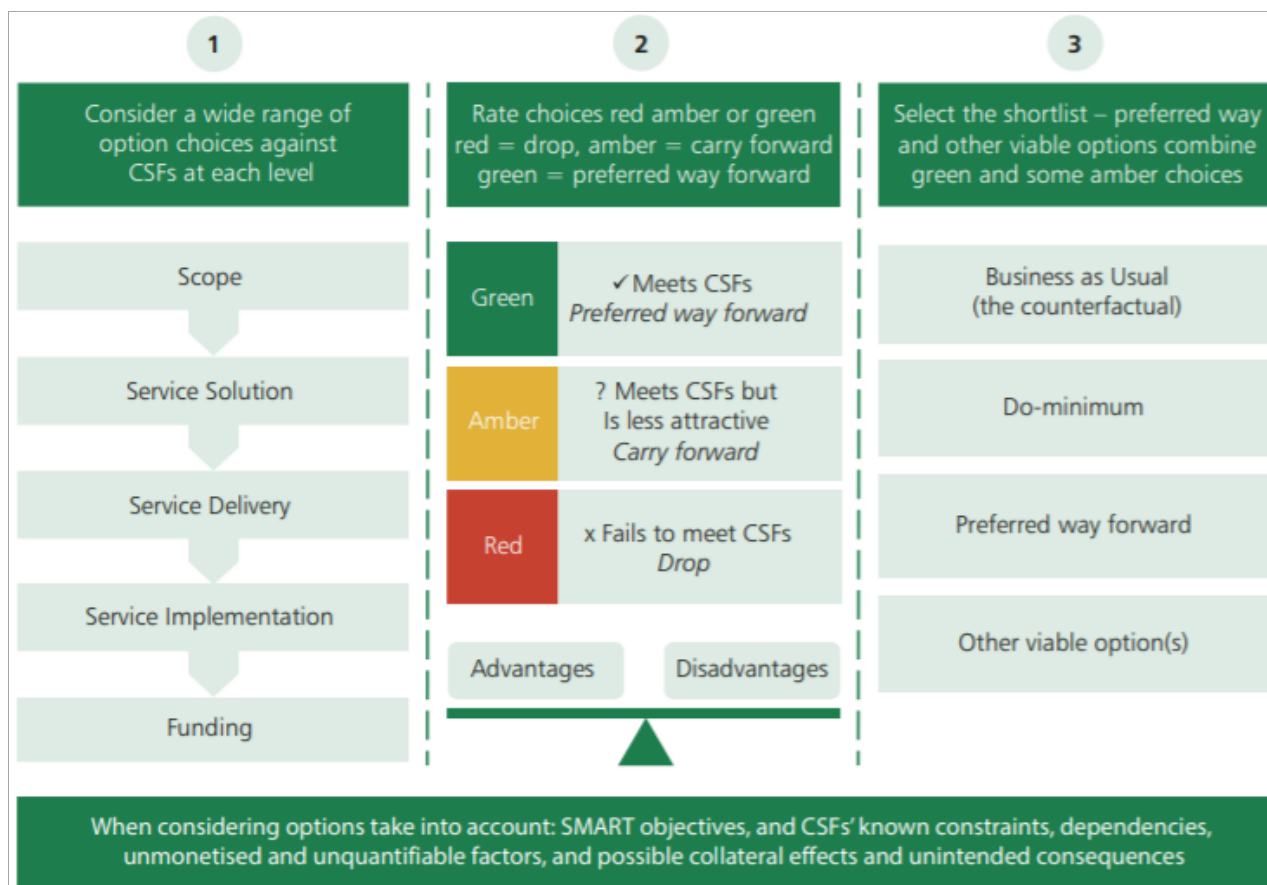
The Options Framework provides a structure to consider choices made in sequence. These choices are presented as questions around the proposed scope, solution, delivery, implementation and funding. The framework considers these choices from the perspective of the public services an intervention is intended to deliver. The table below summarises the methodology.

Figure 42. Options Framework Approach

Letter Code	Areas for Consideration	Topic	Question
A	Scope	WHAT?	What is the potential coverage of the project- selecting the “preferred” scope?
B	Service Solution	HOW?	How to deliver the “preferred” scope?
C	Service Delivery	WHO?	Who will deliver the “preferred” scope and the service solution?
D	Implementation	WHEN?	When will the “preferred” scope and service solution be delivered?
E	Funding (capital)	HOW FUNDED?	How will the “preferred” scope and service solution be funded?

A short-list can be identified when the long list has been generated and a small number of viable options have been assessed. Within each category (e.g. scope), a number of alternative options have been considered and challenged according to how well they meet the CSFs. The process is summarised in the diagram below:

Figure 43. Options Framework Summary



Source: HM Treasury, The Green Book, Central Government Guidance on Appraisal and Evaluation

Each area for consideration in the figure above has been given a “letter code” (A-E) and then each option at each level has been given a number to assist with the summary explanation.

The “why” question, the rationale for the intervention, has been provided in the *Case for Change* set out within the Strategic Case. The government has confirmed support for the scheme and as such the overarching strategic need for investment has been agreed.

Each area for consideration has been considered in order to identify and test options. A detailed description and overview of each option can be found in Appendix 4.2. Details of the options appraisal attended by key stakeholders, which sets out each area of consideration, option and conclusion is found in Appendix 4.1.

As outlined in the OBC, nine options have been considered. The scope of each option is described as follows:

- **Option A1** Business as Usual (BAU) - UEC services will continue to operate as-is, and capital investment will be limited to essential backlog maintenance and lifecycle costs only;
- **Option A2** Do Minimum – UEC services will continue to operate as they are in Years 1-10 but with a full refurbishment planned in Year 10;
- **Option A3** – Reconfiguration and extension of the existing UEC footprint;
- **Option A4** – UEC services co-located with existing ED and diagnostics in form of SURC and UTC;
- **Option A5** – Reconfiguration and extension of the existing ED footprint and outpatient's area;
- **Option A6** – Combined larger E&UCC with optimal clinical capacity;
- **Option A7** – Reconfiguration and larger extension of the existing UEC footprint;
- **Option A8** – Reconfiguration of existing ED and new build extension within Oak House Plaza on the Stepping Hill site; and
- **Option A9** - New build on Pinewood Car Park.

The table below describes the 'BAU' option, which primarily addresses backlog maintenance issues. This has been carried forward as the counterfactual option as required by the guidance. It should be noted that the Case for Change in the Strategic Case demonstrated that this option is not viable as it does not address the efficiency and effectiveness of the E&UCC or current or future capacity requirements, nor does it offer opportunities for improved streaming or expand SDEC services to support reduced length of stay.

Figure 44. Description of Option 1 (BAU)

Options Considerations BAU	
Scope	A1: UEC services will continue to operate in existing locations at Stepping Hill Hospital. Capital investment will be limited to essential backlog maintenance and lifecycle costs only.
Solution	B1: Address backlog maintenance only
Delivery	C1A: Trust responsible for maintaining site and addressing backlog maintenance, but leaving the rest as-is C1B: Trust provide hard and soft FM services
Implementation	D1: Staged delivery
Funding	E1: Revenue and capital cost funded by Trust

The table below provides a summary of the longlist of options (combination of all options). The longlist would be the combination of the options against the areas of consideration. Each element of the options has been considered in Appendix 4.1 and is either Discounted (in red), Carried Forward (in amber) or deemed to be the Preferred Way Forward (in green). The table below summarises the options that were analysed.

Figure 45. Summary of Options Analysis

A. Scope	A1: Urgent and Emergency Care (UEC) services will continue to operate as they are, and capital investment will be limited to essential backlog maintenance and lifecycle costs only.	A2: Current UEC services in existing locations Capital investment will be limited to essential backlog maintenance and lifecycle costs only in Years 1-14 but with a full refurbishment planned in Year 15. This will be limited to the existing footprint and will not address current or future capacity issues.	A3: Reconfiguration and extension of the existing UEC footprint New Build: 1,343m2 Refurb: 2,607m2 Budget Estimate: £30.6m	A4: UEC services co-located with existing ED and diagnostics in form of SURC and UTC New Build: 4,523m2 Budget Estimate: £30.6m	A5: Reconfiguration and extension of the existing ED footprint and outpatient area New Build: 927m2 Refurb: 2,830m2 Budget Estimate: £35.94m	A6: Combined larger E&UCC with optimal clinical capacity. Budget Estimate : £37.7m	A7: Reconfiguration and larger extension of the existing UEC footprint New Build: 2,987m2 Refurb: 2,607m2 Budget Estimate : £40m	A8: Reconfiguration of existing ED and new build extension within Oak House Plaza on the Stepping Hill site New Build: 2,867m2 Refurb: 1,790m2 Budget Estimate: £45.61m	A9: New build on Pinewood Car Park New Build: 4,564m2 Refurb: 0m2 Budget Estimate : £47.8m
B. Solution	B1. Address backlog maintenance only	B1. Address backlog maintenance only	B2. Reconfiguration of the Stepping Hill estate		B3. Reconfiguration and extension of the existing ED footprint including addressing backlog maintenance		B4. All new build on greenfield site		
C. Delivery: Construction	C1A. Trust implement	C1A. Trust implement	C2A. Private sector						

C. Delivery: Facilities Management	C1B. In-house hard and soft FM	C2B. In-house hard and soft FM		C3B. Outsource hard FM, in-house soft FM	C5B: Outsource hard and soft FM
D. Implement	D1. Staged delivery	D1. Staged delivery	D2. Phased approach		D3: Single phase
E. Funding	E1. Trust funded	E1. Trust funded	E2. PDC		E3. External finance

4.4. Identification of the Short-listed Options

The table above illustrates that, in addition to the BAU (counterfactual) option, four further options are brought forward to the shortlist as follows:

Figure 46. Summary of the Short List of Options

Option	Letter Code	Description
1	A1, B1, C1A, C1B, D1, E1	<p>BAU - UEC services will continue to operate as they are, and capital investment will be limited to essential backlog maintenance and lifecycle costs only</p> <p>The BAU option involves capital investment to reduce the levels of backlog maintenance only. The UEC services will continue to operate as-is and across separate locations.</p> <p>Address backlog only (by the Trust), in-house FM services, staged delivery, paid for by Trust finances.</p>
2	A2, B1, C1A, C2B, D1, E1	<p>Do Minimum - Current UEC services in existing locations</p> <p>Capital investment will be limited to essential backlog maintenance and lifecycle costs only in Years 1-10 but with a full refurbishment planned in Year 10. This will be limited to the existing footprint and will not address current or future capacity issues.</p> <p>Address backlog only (by the Trust), in-house FM services, staged delivery, paid for by Trust finances.</p>
3	A3, B3, C2A, C2B, D2, E2	<p>Reconfiguration and extension of the existing UEC footprint on the Stepping Hill site</p> <p>New build: 1,343m²; refurbishment: 2,607m²</p> <p>Budget estimate: £30.6m</p> <p>Private sector construction, in-house hard and soft FM, phased implementation, PDC funding.</p>
4	A4, B3, C2A, C2B, D2, E2	<p>UEC services co-located with existing ED and diagnostics in form of SURC and UTC</p> <p>New build: 4,523m²; no refurbishment</p> <p>Budget estimate: £30.6m</p> <p>Private sector construction, in-house hard and soft FM, phased implementation, PDC funding.</p>
7	A7, B3, C2A, C2B, D2, E2	<p>Reconfiguration and larger extension of the existing UEC footprint</p> <p>New build: 2,987m²; refurbishment 2,607m²</p> <p>Budget estimate: £40m</p> <p>Private sector construction, in-house hard and soft FM, phased implementation, PDC funding.</p>

The previous sections of this Economic Case have considered a long list of potential options that go some way to addressing the strategic requirements of the scheme. Having qualitatively appraised these options and engaged with a broad range of key stakeholders to compile these views, the evaluation has resulted in discounting those options that are either undeliverable or fail to address the key priorities of the Trust and the local economy.

This process has provided a short list of viable options to be taken forward for quantitative appraisal. Option 3 remains the Preferred Option, as identified in the OBC. This option meets the investment objectives and CSFs and provides the best solution for the delivery of public value within a clinical affordable estate.

4.5. Quantitative Evaluation of Options

This section outlines the quantitative appraisal of the short-listed options identified above. The analysis has been prepared on a Discounted Cash Flows (DCF) basis using the Capital Investment Appraisal (CIA) model, which is the recommended economic appraisal methodology for investment business cases per DHSC and HM Treasury Green Book Guidance.

The appraisal considers all costs associated with each option over a 63-year appraisal period (including up front capital costs, optimism bias (OB), lifecycle maintenance costs, revenue expenditure, net contributions, opportunity costs and transitional costs) and discounts these at a rate equivalent to expected inflation over the appraisal period. At OBC stage, the Trust used a 33-year appraisal period, which was based on the useful life of the asset within the Preferred Option (i.e. 30-year useful life from 2024 post construction of the asset), resulting in no residual value for this option.⁷ Following feedback and subsequent request from NHSE/I, the Trust amended the appraisal period to 63 years to allow for direct comparison of the options with a new build option (Option 4), the latter of which expected to have a significantly greater lifespan of 60 years from the completion of construction works in 2024.

The quantifiable risks of each option are then taken into consideration to inform the risk-adjusted Net Present Social Value ('NPSV') of each option. Finally, the quantifiable benefits (comprising cash-releasing, non-cash releasing and societal benefits) will be assessed against the incremental NPSV to determine the benefit-cost ratio (BCR) and value for money of each option. Results of the quantitative analysis have been subject to sensitivity and switching analysis to ensure robustness in the selection of the preferred option.

The sections below outline each stage of the quantitative appraisal process. Results of the analysis have been subject to sensitivity and switching analysis to ensure robustness in the selection of the preferred option to be taken forward. Note that the CIA Model has been developed by the Trust with the support of PwC and can be found in Appendix 4.3.

4.5.1 Shortlisted Options

The shortlisted options considered within this quantitative appraisal are summarised as follows:

- **Option 1 BAU:** UEC services will continue to operate as-is, and capital investment will be limited to essential backlog maintenance and lifecycle costs to sustain the existing facilities for another 60 years.
- **Option 2 Do Minimum:** UEC services will continue to operate as they are in years 1-10, with capital investment in this period limited to essential backlog maintenance and lifecycle costs only. The facilities then undergo significant refurbishment every 20 years thereafter.
- **Option 3:** This option involves reconfiguring and extending the existing E&UC footprint. All UEC services will be provided between the existing footprint and new extension.
- **Option 4:** This option involves UEC services co-located with existing ED and diagnostics in form of SURC and UTC.
- **Option 5:** (This relates to Option 7 in the longlist of options and will be referred to as Option 5 from here onwards). This option involves reconfiguring and a larger extension of the UEC footprint.

4.5.2 Key Modelling Principles

The following key financial modelling principles have been established to enable an assessment of the DCF for each of the short-listed options:

- The DHSC Capital Investment Appraisal (CIA) Model has been used to appraise each of the options;

⁷ At OBC stage, Options 1, 2, 3, and 5 were assumed to complete their anticipated lifecycle profiles earlier than Option 4. Therefore a residual value at the end of the appraisal period was anticipated for Option 4, which is estimated through the aggregate capital and lifecycle costs associated with maintaining the estate in this option for the 33-year appraisal period, and is based on the assumption that the new build in Option 4 having a remaining life of c. 30 years at the end of the appraisal period. However, this is no longer applicable following the change to a 63-year appraisal period, as the assets included within Option 4 are assumed to have fully depreciated and reached the end of their lifespan by the end of the appraisal period.

- All amounts are expressed in £'000 unless otherwise stated;
- The appraisal period for all options is assumed to be 63 years (inclusive of the 3-year construction period in Option 3);
- A price base of 2021/22 has been used for all costs;
- The discount rate is 3.5% real for years 1 to 30 and 3.0% real for years 31 to 64;
- All economic cash flows (impacts of the investment decision) have been modelled;
- Amounts shown in the subsequent tables are demonstrated in present value (discounted) terms;
- OB has been developed using the OB forms included within the CIA Model;
- Capital cost and lifecycle cost estimates developed with support of Trust's technical advisers; and
- Revenue costs developed based on the Trust's existing budgets, premises and known critical backlog maintenance requirements.

As required by Treasury and DHSC guidance, all internal public sector and accounting transactions (such as public sector income, depreciation, capital charges, PDC payments and VAT) have been excluded from the appraisal. In addition, all values have been provided in real (uninflated) terms. Amounts shown in the subsequent tables are demonstrated in present value terms.

4.5.3 Summary of Opportunity Costs

Opportunity costs represent the value that could have been obtained if the resources committed under an option were used for their next best alternative purpose, or the benefits that are foregone from undertaking alternative options.

For the purposes of this economic appraisal, the opportunity costs have been based on the land sale value which could be achieved by the Trust if the site being occupied under each option were instead vacated and sold for repurposed use.

An options appraisal process has identified the most applicable build site for the new E&UCC on the Stepping Hill Hospital estate. This site is bound on all sides by other clinical services and patient areas critical to the normal running of the hospital. The site would have no other potential non-clinical use nor would the site appeal to a commercial use. Therefore, there is no opportunity cost to be considered for any of the proposed options.

4.5.4 Summary of Capital Costs

Detailed capital cost forms have been prepared for each option under by the Trust's cost advisors, O'Neil & Partners. Capital costs are also exclusive of VAT and inflation. The cost forms are included within Appendix 4.4.

The table below provides an illustration of the assumed build period and timings across each of the options.

Figure 47. CIA Modelling Assumptions Overview

£'000	Option 1	Option 2	Option 3	Option 4	Option 5 (Option 7 in long list)
Construction start	-	-	01/04/2022	01/04/2022	01/04/2022
Construction finish	-	-	01/04/2024	01/04/2024	01/10/2024
Build period	-	-	24 months	24 months	32 months

In line with CIA modelling principles, adjustments to the LTFP were required to ensure that all cost inputs were exclusive of VAT, Capital Charges, PDC charges and inflationary increases.

A summary of the undiscounted capital costs for each option is presented in the figure below. A further breakdown of the capital cost summary for each option is included within Appendix 4.5.

Figure 48. Capital Cost Summary £'000

£'000	Option 1	Option 2	Option 3	Option 4	Option 5
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(Option 7 in long list)					
Initial Capital Costs	-	-	25,042	20,714	35,513
Lifecycle Costs	36,560	52,996	9,985	21,490	11,256
Other Capital Costs	1,619	1,725	623	964	650
Residual Value	-	-	-	-	-
Total	38,179	54,721	35,650	43,168	47,419

As detailed above, Option 5 has the highest level of initial capital costs and lifecycle costs due to the significant reconfiguration and extension of footprint associated with this option, whilst Option 1 has the lowest due to the scope of works being limited to backlog maintenance and lifecycle works only.

The lifecycle costs for Option 1 are based on the most recent 6 facet survey undertaken by the Trust, and represents the average minimum spend required to maintain continuity of services. Option 2 consist of an immediate reduction in backlog maintenance for Oak House (Block 47) and the link corridor (Block 53), as well as Blocks 81 and 94, with Option 2 also including a significant like-for-like replacement of the ED facility in Year 10, with significant refurbishment anticipated every 20 years thereafter. The lifecycle costs for the remaining options relate to replacements, refurbishments plus extension (Options 2 and 4), for a new build on Oak House Plaza (Option 4) new build, as well as any ongoing scheduled maintenance estimates for each.

In the Do Minimum option, both Block 47 (Oak House) and Block 53 (Link Corridor) undergo an immediate reduction in backlog maintenance with a cost of £3.5m associated with Oak House, and £1.6m for the link corridor, totalling £5.1m of initial lifecycle works for both blocks. Similarly, Block 81 and Block 94 will undertake a reduction in existing backlog maintenance, which is estimated in a previous facet survey to be £1.7m. Both sets of blocks then incur costs resulting from lifecycle maintenance on a 5-year basis thereafter.

For Options 3 and 5, a minimal level of lifecycle expenditure has been assumed, due to the significant capital investment up front reducing the need for significant refurbishments and replacements at mid-life. This is in addition to the fact that the reconfigured ED under both options being assumed to have a relatively short lifecycle period (30 years) before demolition or replacement in c. 2054, albeit the lifecycle costs have been adjusted and increased for the FBC version to reflect the fact that the lifespan for Options 3 and 5 is assumed to be 60 years in the CIA model, in order to allow for like-for-like comparison with Option 4.

The lifecycle cost profiles for each of the options are included within Appendix 4.6.

The potential for residual value across the options has been considered within the development of the Economic Case. All options (with the exception of Option 4) are assumed to have a post-construction or remaining operational life of 30 years, with demolition or replacement of each option assumed to happen in c. 2054. For Option 4, which represents a new build on the Stepping Hill Hospital estate, a 60-year life has been assumed, which results in a greater requirement for lifecycle spend to sustain the facility and the services provided within for the entire duration of the appraisal period. At OBC stage, this option was assumed to have significant residual value at the end of the appraisal period in 2034, due to the fact that the new build was expected to have a remaining life of 30 years at that point in time; however, adjusting the appraisal period from 33 to 63 years results in the facilities in this option being fully depreciated by the end of the appraisal period of 63 years, therefore no residual value is included within the economic appraisal.

The optimism bias (OB) forms a percentage of capital costs across each option. OB percentages have been calculated and the OB allowances are deemed consistent with the profile of each option at this stage. For the Do Minimum option, the design has progressed sufficiently to allow formation of a fixed SOA and requisite surveys have been undertaken to identify and delineate key project risks. Allowances have been made within the overall budget to reflect each of the recognised risks. Adding to this, construction costs currently included within the budget are consistent with foregoing market rates for comparable works. In addition to the OB allowance, the budget contains separate inclusions for design and Trust specific risk.

For clarity, the OB uplift detailed in the table below is calculated by using an assumed % of the total capital costs over the entire appraisal period (including lifecycle and eventual demolition costs) for a given option.

Figure 49. Optimism Bias Summary

£'000	Option 1	Option 2	Option 3 ⁸	Option 4	Option 5 (Option 7 in long list)
Optimism Bias	23.0%	23.0%	15.0%	9.4%	15.0%
Capital Costs (excl. OB)	38,179	54,721	35,650	43,168	47,419
OB uplift	8,781	12,586	5,347	4,058	7,113
Capital Costs (incl. OB)	46,960	67,307	40,997	47,226	54,532

As detailed in the table above, Options 1 (BAU) and 2 (Do Minimum) have the greatest level of OB due to the uncertainty resulting from limiting capital investment to backlog maintenance of Blocks 47 and 53 only, while Option 4 has the lowest level of OB as a result of also having the lowest assumed OB% of 9.4%.

While the Option 3 is assumed to have an OB uplift of £5.3m, this is expected to be partially released in the future as the Trust looks to secure a guaranteed maximum price from their primary contractors for this option's initial capital cost requirement. However, some uplift for OB is expected to remain in the longer term, primarily around the uncertainty of long-term lifecycle and maintenance costs, which is reflected in the outputs of the CIA modelling example.

4.5.5 Summary of Revenue Costs

In assuming the same level of activity across options, it is important to note that differentiation of options relating to operational cost savings and efficiencies have been primarily captured through the quantification of benefits. As a result, the revenue costs presented in this section are presented exclusive of these savings and efficiencies and the variances across the options are as a direct result of changes to the revenue cost base and profiling assumptions as considered further below. A number of exceptions to this apply, and include:

- For Option 3, it is assumed that the Trust will be able to achieve savings on staff costs as a result of detailed workforce planning undertaken for this option. This relates specifically to changes in the required mix of nursing staff between Band 2 and Band 5, with a saving of c. £16k per year realised following completion of the works for this option. This is not included as a reduction as a revenue cost, and instead is included as a cash releasing benefit and discussed in more detail further below.
- There is an additional requirement for 26.87 WTE staff in Option 4. In Option 4 the identified risk associated with inability to include all clinical services within the 2 story build results in a requirement for additional clinical staff whereas in the clinically optimal, Option 3, a relatively reduced staff base is required to provide a dual function in one multispecialty assessment and ambulatory care area. For consistency, the Trust has considered a risk for additional staff in Option 3 should the assumption around maintaining the existing level of resource prove unfeasible.
- In Option 5, it is assumed that the Trust will require a greater level of staffing as a result of the increased floorplan and scale associated with this option; as a result, a greater level of revenue cost associated with Staffing has been considered for this option, which is assumed to consist of 36.67 WTE of band 3, 5, and 6 staff.
- Facilities management and utilities costs for each option are considered to vary depending on the active gross internal floor area for each.

A summary of the undiscounted costs for each option is presented in the tables below. Further detail of the revenue cost assumptions for each option is included within Appendix 4.7.

Figure 50. Revenue Cost Summary £'000

£'000	Option 1	Option 2	Option 3	Option 4	Option 5 (Option 7 in long list)
Clinical	17,020,458	17,020,458	17,020,458	17,082,408	17,159,244

⁸ A fixed level for OB of 15% has been included for both Options 3 and 5, as requested by NHSE/I. OB for Options 1, 2 and 4 have been provided by the Trust's cost advisors.

Services Costs ⁹					
Non-Clinical Costs	5,976	5,976	8,907	10,158	15,465
Building Running Costs	7,122	7,122	10,617	12,108	18,433
Other revenue costs	-	-	-	-	-
Total	17,033,556	17,033,556	17,039,982	17,104,674	17,193,142
Variance to BAU option	-	-	+ 6,426	+ 71,118	+ 159,586

Building running costs are expected to increase in Options 3, 4, and 5 as a result of the increase in footprint of the builds. This includes cost of facilities management, cleaning, waste management & disposal, as well as utility costs (gas, electricity, and water).

4.5.6 Net Contributions

All income generated by the Trust through public sector bodies has been excluded from the CIA model, given that this income represents a transfer payment which is a circular flow from an economic appraisal standpoint.

An exercise was undertaken by the Trust to identify all non-public sector income forecast under each option within the LTFP. For Options 3, 4, and 5, it is understood that the greater footprint will allow the ED facility to provide a coffee pod to staff and visitors, of which the forecasted profit is estimated to be £75k per year. It was concluded that the coffee pod is not feasible for the BAU due to the existing issues around space requirements; therefore no net contributions have been considered in this option.

4.5.7 Summary of Transitional Costs

Transitional costs are those costs which are incurred in order to maintain current services until the refurbished/new facilities are operational.

It is not expected that the E&UCC will incur any significant transitional costs. No service will be expected to double run, nor will additional staff be required for patient care to continue uninterrupted during development of any of the options.

It is also envisaged that for each option, with the exception of Option 2 (Do Minimum), no temporary accommodation will be required for decant as the relocation of the existing pacing suite will free up space within the current E&UCC footprint to enable the proposed phasing plan. An existing ward may also be used to relocated additional urgent and emergency services on a temporary basis to free up more space if required; however, a further phasing review is required.

For Option 2, it is assumed that modular accommodation would be required during the significant like-for-like replacement at the mid-life point, which is anticipated to cost £1.25m per year over a 2-year period.

On completion of the capital build, certain elements of the current E&UCC footprint will transfer to the new facilities relieving existing congestion and allowing new clinical pathways to be implemented.

4.5.8 Net Present Cost Analysis

The results of the quantitative appraisal of options are summarised in the table below. It outlines the NPC broken down by cost line for each of the short-listed options. The options have been ranked from lowest to highest NPC to illustrate the relativities of options on a quantitative basis.

⁹ Clinical services costs for each option represent the cost across the Stepping Hill Hospital Estate. The Trust has provided the wider clinical services cost due to the difficult in providing a clear estimate for the equivalent cost for only ED, due to an overlap in services in many of the staff and costs within.

Figure 51. Net Present Cost Analysis £'000

£'000	Option 1	Option 2	Option 3	Option 4	Option 5 (Option 7 in long list)
Opportunity Costs	-	-	-	-	-
Capital Costs (including OB)	18,156	30,831	31,620	29,999	43,041
Revenue Expenditure	7,207,120	7,207,120	7,209,664	7,235,278	7,270,306
Net Contributions	-	-	(1,782)	(1,782)	(1,782)
Transitional Costs	-	877	-	-	-
Total	7,225,276	7,238,829	7,239,502	7,263,495	7,311,566
Rank	1	2	3	4	5
Distance from #1 Rank		+ 13,553	+ 14,226	+ 38,219	+ 86,290

The results demonstrate that, solely on an NPC basis, Option 1 is the lowest cost over the appraisal period whilst Option 5 is the most expensive. This outcome is primarily driven by the significant difference in planned capital investment under the other options versus Option 1 (BAU) as well as due to the additional staffing requirements specifically required in Options 4 and 5.

Figure 52. Net Present Cost Analysis (excluding Capital Costs) £'000

£'000	Option 1	Option 2	Option 3	Option 4	Option 5 (Option 7 in long list)
Total NPC (excluding Capital)	7,207,120	7,207,997	7,207,882	7,233,496	7,268,524
Rank	1	3	2	4	5
Distance from #1 Rank		+ 877	+ 762	+ 26,376	+ 61,404

As demonstrated in the table above, once the capital costs of each option have been excluded, Option 1 provides the lowest cost over the appraisal period as a result of the reduced building running and utilities costs, although these costs do not take into account the lifecycle replacements required to ensure the buildings within this option remain fit for purpose.

It should also be noted that these results do not take into consideration the quantified risks and wider quantified benefits of each option, which have been examined further in the sections below.

4.5.9 Quantitative Risk Assessment

As part of the options appraisal process, the Trust has considered the potential risks inherent in each option. A number of workshops were held with key Trust stakeholders. The purpose of these workshops was to consider the anticipated risks across the options, with risks being identified across a number of operating risk areas. These risks were then considered further with the support of senior finance leads to identify those which could be quantified and the relevant cost drivers of each of the risks.

The methodology applied to quantify risks was a multi-point probability analysis in line with CIA modelling requirements. For each risk, a range of possible outcomes was estimated. An output probability distribution provides a more complete picture of the possible outcomes and recognises that some of these outcomes are more likely to occur than others. The 'expected outcome' is the average of all possible outcomes, taking into account their varying probabilities.

For each risk and for each option the Trust considered and agreed on the following parameters:

- The appropriate cost driver for the risk (e.g. cost of performing repeat blood tests);
- The likely impact if a risk occurs - low, medium, high (e.g. +/-% of cost driver);
- The likelihood of occurrence – low, medium, high (total 100%); and
- The years for which the risk could occur and therefore for which it should be quantified.

With the support of senior finance leads from the Trust, the cost drivers, probability, impact and phasing assumptions for each risk were determined and calculated. The key cost drivers and assumptions that led to determining the above parameters for each risk are captured in the CIA model. The table below summarises the risks that were identified and their associated cost drivers.

Figure 53. Quantified risk and cost drivers

Risk Identified	Cost driver	Type
Incorrect cost of maintenance	Lifecycle and FM	Operating
Incorrect cost of energy used	Utility costs	Operating
Patient infection caused by poor facilities management	Cleaning costs	Operating
Poor performance of services	Staff costs	Revenue
Changes in the volume of demand for patient services	Staff costs	Revenue
Unexpected sudden increases in demand, due to major incident	Staff & income	Revenue
Insurance premiums	Insurance premiums	Additional
Medical Recruitment	Agency fees	Additional
Nursing Recruitment	Recruitment cost	Additional
Sickness	Staff costs	Additional
Supernumerary	Staff costs	Additional
Training	Staff costs	Additional
Additional staff requirement (Option 2 only)	Staff costs	Additional
Additional consumables (Option 2 only)	Non-pay costs	Additional
Pandemic response	Operating costs	Additional

The outcome of the risk quantification is summarised in the table below and considered in further detail within Appendix 4.8.

Figure 54. Risk quantification £'000

£'000	Option 1	Option 2	Option 3	Option 4	Option 5 (Option 7 in long list)
Operating Risks	37,957	6,524	597	5,025	5,671
Revenue Risks	17,296	4,775	3,156	11,266	6,042
Additional Risks	71,193	56,226	9,097	13,757	6,622
Total	126,447	67,525	12,850	30,047	18,335

Options 1 and 2 both carry a significant level of risk due to increased risk on staff turnover deteriorating, as well as additional cost pressures associated with occupying the current facilities. Option 2 is expected to marginally reduce these risks through significant replacement in year 10. By contrast, the other options are less exposed to a number of these risks, particularly around staffing and quality of services as the implementation of a refurbishment with extension or a new build would reduce a number of existing issues around staff & patient experience that are directly attributable to the lack of space in the existing ED facility

4.5.10 Risk Adjusted NPC

A risk adjusted NPC and revised ranking for each option is presented in the table below following the quantification of risks.

Figure 55. Risk Adjusted Net Present Cost Analysis £'000

£'000	Option 1	Option 2	Option 3	Option 4	Option 5 (Option 7 in long list)
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NPC	7,225,276	7,238,829	7,239,502	7,263,495	7,311,566
Quantified Risk NPC	52,931	40,199	7,110	13,761	9,573
Risk Adjusted NPC	7,278,207	7,279,027	7,246,612	7,277,257	7,321,139
Rank	3	4	1	2	5
Distance from #1 Rank	+ 31,595	+ 32,415	-	+ 30,645	+ 74,527

Taking into account the risks to determine a risk adjusted NPC for each option, Option 3 emerges as the lowest NPC whilst Option 5 is the most expensive option over the appraisal period.

This risk adjusted NPC supports Option 3 as being the preferred option and the option that provides best value for money. However, in order to fully substantiate value for money and confirm that Option 3 should be the preferred option, it is necessary to consider the quantification of benefits which is considered in the next section.

4.5.11 Cash Releasing, Non-Cash Releasing and Societal Benefits

As part of the economic appraisal, the Trust have considered the benefits of delivering each option in comparison to the baseline Option 1. To do so, the Trust held a benefit identification workshop with key stakeholders. This workshop's objectives were to identify a wide-ranging set of benefits that could be delivered across the different options based on the planned investment and service delivery over the appraisal period.

The workshop identified a number of expected Cash Releasing Benefits (CRB) and Societal Benefits (SB) across the options – these are summarised in the table below.

Figure 56. Cash Releasing and Societal benefits

Benefit Identified	CRB / SB
Agency and Bank Staffing - Nursing	CRB
Agency and Bank Staffing - Medical	CRB
Reduction in sickness rates	CRB
Reduction in training costs	CRB
Reduced recruitment costs – Medical staff	CRB
Reduced recruitment costs – Nursing staff	CRB
Reduced supernumerary cover costs	CRB
Length of Stay reductions	CRB
Savings in legal fees	CRB
ED Drug stock & wastage reduction	CRB
A&E prescription charges	CRB
Reduced backlog maintenance and lifecycle costs	CRB
Workforce planning savings	CRB
Use of technology/digital health schemes	NCRB
Reduction in complaints	NCRB
Local regeneration through injection of capital, specifically to employment resulting from the development – Coffee pod	SB
Local regeneration through injection of capital, specifically to employment resulting from the development – Increased clinical staff	SB
Training space for external staff	SB
Ambulance handover	SB

CRBs identified are those which enable an actual reduction in budgetary costs incurred by the Trust, whilst NCRBs are those which result in efficiencies or productivity savings which are quantifiable in monetary terms

but do not create a budgetary release. SBs are quantifiable in monetary terms; however the benefit is realised by society outside DHSC/NHS.

An initial exercise was undertaken by the Trust to determine those benefits which were quantifiable in monetary terms. With the support of senior finance leads from the Trust, specific cost and income drivers were identified for each of the quantifiable benefits and a methodology was developed to determine an annual benefit value for each. The phasing of each benefit was considered to determine over what period the annual value could be realised, resulting in a present value of benefits for each option.

The detail of this process and the methodology for quantifying benefits is outlined within Appendix 4.9. The table below outlines the total quantified benefits over the 63-year appraisal period for each of the options.

Figure 57. Quantified Economic Benefits £'000

	Option 1	Option 2	Option 3	Option 4	Option 5 (Option 7 in long list)
Cash releasing benefits	-	10,287	124,149	84,179	122,674
Non-cash releasing benefits	-	10,566	12,595	-	12,595
Societal benefits	-	-	29,420	20,609	55,592
Total	-	20,853	166,164	104,788	190,861

Option 1 is not expected to deliver any benefits as a result of the redevelopment, primarily due to the limited scope of this option (backlog maintenance only). All other options go some way further to delivering quantifiable benefits through the new facilities, with a considerable increase in both CRBs and SBs realised through delivery of improved inpatient services that facilitate further length of stay reduction, patient facilities and enablement of greater capacity to meet future growth in specialist services.

Option 2 is expected to incur some benefit through the installation of a kiosk for prescription services, resulting in an estimated cash releasing benefit of £80k per year through charges to users, as well as a non-cash releasing benefit in the form staffing efficiencies realised through the installation and use of technology to improve patient and visitor streaming within the ED. No other benefits are expected for this option, as this option largely experiences similar issues and constraints around footprint as the BAU.

As expected, Options 3, 4, and 5 deliver a significantly higher level of quantified benefits over the appraisal period, most notably through improvements to staff & patient experiences, as well as the economic regeneration and wider societal impact of the development.

Options 3 and 5 are also assumed to result in several non-cash releasing benefits, specifically through efficiencies achieved through utilising e-kiosks for ED patients, resulting in improved streaming, as well as an overall reduction in the time spent by staff in managing and responding to complaints. Furthermore, both Options 3 and 5 are also assumed to result in an additional benefit to wider society through a reduction in the number of ambulance visits, achieved through increased ED deflection.

Option 5 achieves a marginally increased level of benefit compared to Option 3 through the value added to the local economy resulting from the increase in clinical and non-clinical staffing required to cover the significant increase in footprint under this option.

The societal benefit of enabling regeneration of existing NHS estate considers the value of benefits derived from the additional job creation and subsequent economic impact of the construction expenditure and has been determined based on 2016 UK Input-Output data tables.

Following submission of the OBC in January 2022, feedback from NHSEI & DHSC requested that the Trust quantify several non-cash releasing benefits (NCRBs), review whether any of the unmonetisable benefits could be monetised and include quality-adjusted life year (QALY) benefits, where applicable. QALY is a measure that combines the impact of total life years of a patient and the impact on quality of life of a development into a single measure, where one QALY equates to one year in perfect health for a patient, i.e., free from pain, disability, or mental distress.

The Trust has quantified two NCRBs for the FBC submission, those of which specifically relate to efficiencies achieved by staff through a reduction in time spent dealing with complaints (which was originally an unmonetisable benefit at OBC stage), as well as the use of technology and digital health initiatives to improve streaming of patients. The Trust has also quantified an additional societal benefit for the FBC, relating to a reduction in the number of local ambulance visits to the Trust due to improved ED deflection.

While the Trust acknowledges that the QALY approach allows for a sophisticated measurement of the health impact on users of the ED services following a given development, the Trust is unable to quantify the impact of QALYs, primarily due to the tight time frames allowed, as well as the cost to the Trust involved in ensuring these are quantified accurately, particularly given the relative size of the proposed scheme and the Trust's ability to fund detailed analysis there within.

In addition, the incremental benefits of Option 3 is anticipated to be sufficiently greater than Option 0, even when allowing for sensitivity analysis; therefore, some improvement in QALYs to service users is anticipated as a result of the development, and while this is not immediately quantified in this FBC, the impact of quantifying QALYs is expected to further improve the BCR ratio of each of the Options, with the exception of Option 0 and 1, which are assumed to contribute a similar level of ongoing health impact to service users.

4.5.12 Unmonetisable Benefits

In addition to the benefits quantified above, other benefits exist which could be monetised as part of a further benefits quantification exercise undertaken by the Trust. For example, the level of improved patient experience is expected to have a significant improvement in patient outcomes that could be demonstrated through quality-adjusted life-year (QALY) gains. If these benefits were to be monetised they would improve the benefit-cost ratio of the options against Option 1.

The Trust has also identified a number of unmonetisable benefits that apply to each of the refurb and new build options, including:

- Improved health & safety, as well as fire compliance;
- Improved business continuity and service resilience;
- Improvements to patient experience, particularly for specific groups (including paediatrics & mental health patients), supported by improved signage and use of technology;
- Improvements to CQC rating, as well as family and friends score
- Increase in capacity to provide services to a larger number of patients, mitigating existing inequality of access to services;
- Operational agility through working in zones, with implementation of additional ventilation in line with HBN requirements, to meet greater infection prevention standards; and
- Future proofing of the service provision, with any development remaining in situ and part of future developments on the Stepping Hill Hospital estate.

The cash releasing and societal benefits that have been monetised as outlined above have been considered against the incremental costs of delivering each option below.

4.5.13 Value for Money Analysis

In line with HMT and DHSC Guidance, the benefit-cost ratio of each option must be examined in order to determine the Absolute Value for Money (AVFM). The recognised threshold for health spending is currently a ratio of 4:1. That is, every £1 of marginal cost associated with an option must provide at least £4 of quantified benefits in order to demonstrate value for money from the required investment.

The AVFM has been examined by firstly taking into consideration the net quantified benefits outlined in the previous section and comparing these against the incremental NPC of each option to calculate the risk-adjusted Net Present Social Value (NPSV). The benefit-cost ratio has then been determined by comparing the incremental benefits to the incremental cost of options. For the purposes of this analysis, Option 1 is the baseline position against which all other direct investment costs, such as capital costs, are assumed to be marginal to the implementation of that option.

The benefit-cost ratio has been calculated on this basis and is outlined in the following table.

Figure 58. Benefit-Cost Ratio Analysis £'000

	Option 2	Option 3	Option 4	Option 5 (Option 7 in long list)
Incremental costs	13,553	16,008	40,001	88,072
Incremental benefits ¹⁰	20,302	113,145	82,254	109,825

¹⁰ Incremental benefits within the CIA model includes both the quantified Cash Releasing and Non-Cash Releasing and Societal Benefits, in addition to the incremental reduction in quantified risk compared to BAU.

Net Present Social Value	6,750	97,137	42,253	21,753
Benefit-cost ratio	1.50	7.07	2.06	1.25

The results of the benefit-cost ratio analysis demonstrate that Option 3 exceeds the 4:1 threshold set by DHSC guidance, and therefore initially represents value for money for the public sector, albeit subject to further sensitivity and switching analysis in the section below.

4.6. Sensitivity Analysis

In order to test the robustness of the appraisal's conclusions and consider the uncertainties around some of the key assumptions made, it has been necessary to perform sensitivity analysis to assess the impact, if any, on the relativities between options and the conclusions drawn regarding VfM.

A switching analysis has also been included, whereby scenarios are considered that could give rise to the preferred option either falling below the VfM threshold of 4:1 or being replaced by another option as the preferred way forward. We've also explored the tipping point at which the preferred option switches to the second-best option. Although not an exhaustive list of sensitivities, the analysis has focussed on the key areas of uncertainty as outlined below.

4.6.1 Capital Costs Increases

A key uncertainty surrounding any capital project is the level of planned capital expenditure. As such, another sensitivity to consider is the impact of capital costs increasing beyond what has been included within OB in Options 2, 3, 4, and 5. For the purpose of this analysis, an increase in capital costs of 10% beyond OB has been assumed.

Figure 59. Sensitivity Analysis: Capital Cost Increase £'000

	Option 2	Option 3	Option 4	Option 5 (Option 7 in long list)
Risk Adjusted NPC	7,279,776	7,246,612	7,277,257	7,321,139
Sensitised Risk Adjusted NPC	7,282,111	7,249,774	7,280,256	7,325,443
Variance	+ 2,335	+ 3,162	+ 2,999	+ 4,304
Sensitised benefit-cost ratio	1.22	5.90	1.91	1.19

The anticipated impact of a 10% increase in capital expenditure is that the benefit-cost ratio for Option 3 falls to 5.90. As this remains above the VfM threshold, and is the highest of the short-listed options, it remains the preferred option. As noted, this increase is in addition to the level of OB 15.0% already recognised within the CIA model. The Trust is seeking to mitigate capital cost risk uncertainty as far as possible through agreeing a Guaranteed Maximum Price (GMP) when procuring the asset. This is further examined within the Commercial Case.

Further switching analysis has been undertaken to understand when Option 4 has a more favourable BCR than Option 3, which determined that the gross capital costs for Option 3 would need to increase by c. £11.2m before Option 3 falls below the required VfM threshold, and by c. £35.7m before Option 4 becomes the preferred option.

4.6.2 Length of Stay Reduction

As outlined, the Trust has included a cash releasing benefit resulting from the creation of a dedicated SDEC area within the ED, which creates opportunities to change the patient pathways and subsequently release bed days and improve overall patient flow. This represents a significant benefit for a number of the options considered; therefore, a sensitivity has been modelled to consider the impact of this benefit not being realised following completion of any development, where applicable.

Figure 60. Sensitivity Analysis: Length of Stay Reduction £'000

	Option 2	Option 3	Option 4	Option 5 (Option 7 in long list)
Incremental Benefits	20,302	113,145	82,254	109,825
Sensitised Incremental Benefits	20,302	90,213	65,055	86,892
Variance	-	(22,932)	(17,199)	(22,933)
Sensitised benefit-cost ratio	1.50	5.64	1.63	0.99

As outlined in the figure above, the incremental benefits of the Options achieved over the 63-year appraisal period fall by between £17.2m and £22.9m respectively. However, the benefit-cost ratio for Option 3 remains the highest of the short-listed options, and therefore remains the preferred option. Only Option 3 remains above the AVFM threshold of 4:1 in this downside sensitivity, and therefore remains the preferred option. Option 2 does not assume any loss of benefit under this sensitivity, as this option is not expected to realise any savings or other related benefits as a result of reducing patient length of stay.

4.6.3 Total Downside Sensitivity

Following the sensitivity scenarios examined above, analysis was performed to consider a total downside sensitivity whereby all scenarios occur simultaneously. This results in the Option 3's benefit-cost ratio falling to 4.71, remaining above the threshold, while Options 4 and 5 fall to 1.51 and 0.94 respectively, both continuing to be below the AVFM threshold of 4:1.

Based on the very low likelihood of all scenarios occurring simultaneously, the selection of Option 3 as the preferred option is deemed to be robust. In addition, significant mitigations have been put in place by the Trust to manage downside risks, in particular around capital programme planning, contract and cost management and the ability to achieve the associated clinical operating efficiencies. These mitigations as further consider within the Management Case, are deemed sufficient to ensure that the option remains a value for money solution.

A summary of the impact of sensitivity analyses on each option is provided in Appendix 4.10. The CIA models demonstrating the impact of the sensitivity analyses are available on request.

The results of the sensitivity analysis therefore demonstrate that Option 3 is the option to be progressed as part of this business case.

4.7. Bid Evaluation

The bid evaluation process for the appointment of Interserve Construction Ltd (now Tilbury Douglas) (TD) as the PSCP was undertaken in line with the P22 process, managed by the Trust's internal project team and supported by Rider Hunt. The Trust followed the below process to review and select the preferred PCSP:

- The Trust agreed appropriate selection criteria, rank and weightings;
- The Trust issued a High-Level Information Pack, inviting all six PSCPs to submit a written Expression of Interest response;
- The Trust held a "virtual" open day via Microsoft Teams;
- The PSCPs submitted their expression of interest to the Trust for evaluation within a stipulated timescale addressing the criteria within the HLIP;
- The Trust assessed the Expressions of Interest;
- The PSCPs were invited to a moderation interview;
- The Trust reviewed, approved and confirmed the preferred PSCP;
- The Trust confirmed results to all PSCPs and the P22 Unit; and
- The Trust appointed the PSCP.

As per the P22 process, the PSCP submissions were evaluated based upon a 70% qualitative and 30% cost weighting.

The outcome of the P22 selection process for the Trust was documented by Rider Hunt and can be found in Appendix 5.2. Each PSCP bid was evaluated and scored based on quality and cost, following which a combined score for each was calculated.

Four of the six PSCPs submitted an Expression of Interest, after which the one with the lowest score based on the written submission chose not to attend the moderation interview. The preferred PSCP combined score was calculated at 71.34, in comparison to the other bidders at 69.76 and 65.73.

4.8. Conclusion

A robust process of economic modelling has been employed using the CIA model to support the development of a preferred option. The combined qualitative and quantitative economic appraisal demonstrates that Option 3 is the preferred option and has been selected based on its ability to achieve the Trust's investment objectives. This option provides a BCR of 7.07, with £16.0m of incremental costs

compared to £113.1m of incremental benefits, which demonstrates the investment meets the required absolute VfM threshold set by DHSC.

At OBC stage, the BCR for this option was 5.54, with £14.6m of incremental costs compared to £81.0m of incremental benefits. The main drivers for the change in BCR from OBC to FBC stage are derived from changes extending the appraisal period (and in turn the period for which incremental benefits for Option 3 are achieved) from 33 years to 63 years, as well as the additional quantification of a cash releasing benefit, two non-cash releasing benefits, and an additional societal benefit.

The figure below details the incremental changes in BCR for Option 3, specifically from the OBC to FBC stages:

Figure 61. Incremental Changes in BCR for Option 3 from OBC to FBC



Based on the above analysis and the results of this Economic Case, Option 3 has therefore been confirmed as the Preferred Option to be taken forward.

5. Commercial Case

5.1. Introduction

The purpose of the Commercial Case is to set out how the Trust is procuring the design and build works, enabling and temporary works, equipment, IM&T, and professional services; confirm the commercial and contractual arrangements; set out an appropriate transfer of risk; confirm the negotiated deal with the Trust's ProCure22 PSCP; and confirms that the proposed solution is commercially feasible and deliverable.

In addition, this section sets out the proposed solution in more detail, including all key design and compliance issues; statutory approvals; and the phasing and sequencing.

The project brief is to provide additional capacity, where urgent and emergency care services will be relocated to reduce congestion through the ED and to deliver co-located UTC and SDEC; both key elements for Urgent & Emergency Care in the NHS.

This section describes how the Trust is "Preparing for the Potential Deal", as set out in the HM Treasury "Green Book"; in order to demonstrate that the Trust will secure long-term public value during the operational phase of the project. This Commercial Case is based on the Trust implementing its current Preferred Option.

5.1.1 Procurement

In order to achieve the objectives of the new E&UCC, a number of goods and services need to be procured, which include:

- Professional services;
- Construction and associated works;
- Equipment; and
- IM&T.

All of these goods and services need to be procured in line with the Trust's standing financial instructions (SFIs); in accordance with national procurement legislation (Find a Tender); and provide best value.

5.1.2 Procurement of Professional Services

As set out in the Management Case, the Trust has an experienced and capable in-house capital project and estates team that will provide ownership, co-ordination, and continuity of the project at both a strategic and a management level.

The Trust will however require specialist advice in technical areas to support delivery; which will be procured by the Trust. The following professional services are required to deliver the project:

- Project Management;
- Cost Management;
- Health and Safety support/ CDM Principal Designer;
- NEC3 Supervisor/ Clerk of Works;
- Design and technical advisors (Architect, M&E Engineers, Structural and Civil Engineers, Surveys, BREEAM, Travel and Transport, and other related specialist technical support- e.g. fire, environmental, acoustics);
- Legal support - in relation to contracts, etc.;
- VAT advice;
- Business Case support; and
- Healthcare planning advice / peer review.

The following professional services have been commissioned to date to support the Trust in the delivery of the SOC, OBC and FBC:

- Rider Hunt (Project Manager/ Business Case Support);
- O'Neil & Partners (Cost Advisor);
- PwC (Business Case Support);

- Ryder (Architect); CAD21 (M&E Engineer); Sutcliffe (C&S Engineer); Spencer-Harrison (Healthcare Planner); Lichfields (Planning Consultant); Arcadis (Cost Consultant); OFR (Fire Engineer); Cundalls (Acoustic Consultant); Ridge (BREEAM Consultants) and Aecom (Travel and Transport Consultant) - all appointed through the Trust's P22 PSCP;
- Ryder (H&S/ CDM Principal Designer); and
- BDO (VAT advisor).

All of the above appointments were competitively tendered, awarded through the NHS Shared Business Services (SBS) Framework, appointed through the Trust's ProCure22 PSCP partner, or directly awarded due to their low value. These consultants are directly appointed by the Trust or PSCP.

Appointment of further professional services will be required for the construction stage. These appointments will be procured either through the ProCure22 Framework Partner; or if direct to the Trust - through the SBS Framework, mini-competition, or tender exercise in line with the Trust's SFIs.

5.1.3 Design Team Novation

The Trust has agreed with the ProCure22 PSCP that most of the incumbent design team have been taken on by the PSCP from commencement of RIBA Stage 3.

5.2. Commercial Feasibility

5.2.1 Summary

As noted in the OBC, the key conclusions relating to the procurement are as follows:

- **Procurement strategy:** The Trust has decided to pursue a Framework Arrangement, rather than undertake an OJEU procurement (now Find a Tender);
- **Contract type:** The Trust has determined that it will use the NEC contract, rather than the JCT;
- **Framework selection:** The P22 route has been selected;
- **Contracting approach:** The Trust has selected Single-Stage Design and Build contracting approach via P22 due to the high degree of cost certainty and the high level of risk transfer to the Contractor, rather than the two-stage Design and Build or traditional approach; and
- **Pricing mechanism:** The Trust will use a GMP pricing mechanism.

The process undertaken by the Trust to identify the procurement options is included within Appendix 5.1.

5.3. PSCP Appointment

The Trust undertook the selection of the P22 PSCP in parallel with developing the OBC; to allow the PSCP to be appointed in time to provide support to the Trust for the OBC and FBC.

5.3.1 Appointment of P22 Partner

The P22 Framework is a framework agreement with six organisations that have been selected via a previous OJEU tender process for capital investment construction schemes. A client may select a PSCP for a scheme they wish to undertake without having to go through a further OJEU procurement process. The six organisations on the Framework are:

- BAM Construction;
- Galliford Try;
- Graham Construction;
- Integrated Health Projects (JV between Vince and Sir Robert McAlpine);
- Interserve Construction (now Tilbury Douglas Construction) and
- Kier.

The Trust has used the evaluation methodology agreed as part of awarding the Framework position to the 6 organisations and appreciates the potential restrictions that imposes.

5.3.2 P22 Selection Process

This section outlines the process used with P22 from appointment through to completion of the unit, and each stage within the process is detailed below.

Stage 1: Selection of a PSCP

The following summarises the Trust's P22 PSCP selection process:

- Agree qualitative selection criteria, rank and weightings (70% qualitative);
- Identify which commercial criteria are to be used with evaluation undertaken by DHSC;
- Release a High-Level Information Pack with a well-developed design and survey information to all six PSCPs; and
- Hold an open day.

The interested PSCPs submit an expression of interest (EOI) to the Trust for evaluation and are invited to a moderation interview for a more detailed examination of their EOI. Following the evaluation, the Trust selects its preferred PSCP.

Stage 2: Project Start-Up

A Project Letter of Instruction is issued by the Trust to the PSCP requesting project proposals. On acceptance of the first proposal, there is a Project Agreement signed between the parties.

The client and PSCP will review the project and plan the start-up activities for the first six to eight weeks. The PSCP would review and adopt the design and survey information; contribute to the design process; introduce innovations; and advise on buildability, sequencing, and construction risk.

Stage 3: Scheme Development

The design development period covers the period from the PSCP's appointment through to agreement of the GMP and the start of construction. It can include finalisation of the brief; engagement of the supply-chain and other stakeholders; development of the preferred design with associated costs and programme; identification, allocation and management of risk; and development and agreement of the GMP and Stage 4 contract documents.

Stage 4: The Guaranteed Maximum Price (GMP)

The GMP, or 'target price' as defined in the NEC3 contract, is the maximum price payable (covering actual construction costs and fixed fees) by the Trust and agreed during this stage and the PSCP is bounded by the GMP when the contract is signed.

P22 is an incentivised process by the introduction of a pain/gain mechanism where:

- Any costs over the GMP is at the expense of the PSCP (i.e. the PSCP takes the pain);
- Any savings between 95% and 100% of the GMP is shared 50:50 between the Trust and the PSCP; and
- Any savings anything beneath 95% of the GMP all comes to the Trust.

Gain share should be the result of more efficient methods of construction or alternative materials or designs that do not affect the quality or functionality of the completed project. A gain share should not result from setting the GMP too high.

Stage 5: Construction

The final stage is the construction phase. The construction programme will include the schedule for the planned development of the E&UCC facility and will also include time for both the PSCP and the Trust to commission the building.

5.3.3 Selection of a PSCP for the E&UCC Project

The Trust selected its P22 PSCP Tilbury Douglas (formally Interserve Construction Ltd), who have been appointed. The P22 procurement process commenced in September 2020 and proceeded in line with the recommended timescales specified within the framework. The dates are set out in the table below:

Figure 62. ProCure22 Selection Timetable

P22 Procurement Milestone	Date
Register scheme with ProCure22	01.10.20
Develop and issue High Level Information Pack	06.10.20
Informal joint coffee/chat and site visit	12.10.20
PSCP Open day	19.10.20
PSCPs develop and submit EOI	06.11.20
Client to assess EOIs	09.11.20
Moderation Interviews	16.11.20
PSCP appointment	01.12.20

The procurement process was managed internally, supported by the Trust's technical advisors.

The Trust followed the approved P22 selection process as set out in the ProCure22 Guide, to maintain a robust and fair process which ensured the Trust selected the correct PSCP and mitigated the risk of any challenge to the outcome. Please refer to Rider Hunt P22 Selection Report in Appendix 5.2.

The selection process was run by the Trust's in-house Project Team, supported by Rider Hunt. Rider Hunt have extensive experience of using the P21/P21+/P22 framework and have supported Trusts with many selection processes under the framework.

The P22 Implementation Advisor provided advice and support throughout the selection process.

Further to a thorough and compliant selection process, the Trust selected Interserve Construction Ltd (now Tilbury Douglas) as its P22 PSCP. Certificate of Incorporation on Change of Name for information regarding change of name of the PSCP is included in Appendix 5.3.

The Trust has entered into a P22 Scheme Form of Agreement with TD and issued them with a Project Letter of Instruction for the Emergency and Urgent Care Campus project. The P22 "Stage 3" contract has been agreed and executed.

5.4. Other Procurement Items

5.4.1 Land Acquisition

No land is required to be acquired as part of the E&UCC development, and the proposed redline boundary sits wholly within the existing Stepping Hill Hospital site.

5.4.2 Buildings

No additional buildings will be purchased as part of the project.

5.4.3 Site

The proposed construction site is owned by Stockport NHS Foundation Trust.

5.4.4 Equipment

A significant amount of new furniture, fixtures, and equipment (FF&E) will need to be procured as part of delivering the E&UCC. The FF&E for the new building will be partly on an "all new" basis, with some FF&E transferred from the existing Stepping Hill Hospital estate, where appropriate, as part of a sustainable review.

A dedicated FF&E work stream has been established to manage and co-ordinate the specification, procurement, delivery, and installation of the required FF&E.

Equipment will be considered in accordance with the NHS standard equipment groups as follows:

- **Group 1** - items (including engineering terminal outlets) supplied and fixed within the terms of the building/works contract;

- **Group 2** - items which have space and/or other building construction and/or engineering service requirements and are fixed within the terms of the building contract but supplied under arrangements separate from the building contract;
- **Group 3** - items which have space and/or building construction and/or engineering service requirements, but which are supplied and fixed (or placed in position) under arrangements separate from the building/works contract; and
- **Group 4** - items supplied under arrangements separate from the building/works contract, possibly with storage implications but otherwise having no effect on space or engineering service requirements.

The Trust is procuring the new Group 2 and Group 3/4 equipment itself, utilising established NHS Frameworks and other suitable and compliant buying arrangements. Reviews are ongoing if alternative options offer better value (e.g., is it cheaper to procure certain items of equipment through the P22 PSCP), which will continue through the build stage. The Trust is also reviewing if any commercial deals could be done for any more expensive equipment.

With regards to the sourcing of the FF&E items, the Trust will seek to achieve best value for money in the procurement of all required FF&E to support the successful delivery of the project. The Trust's in-house Procurement Team are using available frameworks that can be utilised such as NHS Supply Chain, Crown Commercial Services, ESPO, YPO, and SBS Frameworks wherever possible, either on a direct award basis for those frameworks that allow, or by running mini competitions. Where these options are not available or the items that the Trust are looking to procure are not on any frameworks, then the Trust will run a Tender exercise in accordance with the Trust's SFIs. The Trust is also reviewing where existing suppliers could be utilised on the basis that these have been through a full procurement process.

The Trust's P22 PSCP (Tilbury Douglas) are also using the P22 Standard Components to generate the most effective pricing based on nationally negotiated agreements through the P22 framework for all equipment items, where this provides best value.

In preparing for the procurement of the new facility, the Trust has considered the development of the timing and process for the installation and commissioning of equipment and, in particular, those items that have a more integrated interface with the building in terms of weight, size, power, water, ventilation etc; which are being discussed as part of the user engagement and will continue through the remaining design and build stages.

Within the Project Team structure, dedicated resource has been committed for a lead Project Manager responsible for co-ordinating the delivery of all purchased Group 2 & Group 3/4 FF&E, installations and commissioning as required in accordance with the agreed schedules and programmes. All required purchase orders to manufacturers and contractors are being managed centrally within the Project Management Team, ensuring electronic systems are in place for formal receipting of all goods received, following the completion of all quality control checks.

The Trust has included a sum within the construction cost to cover all Group 2, 3 and 4 FFE, which has been refreshed at FBC stage, and is based on the latest room loaded layout plans.

Modern methods of design and construction have been used to develop repeated room structures as well as FF&E requirements.

The FBC stage equipment schedule is included in Appendix 5.4.

5.4.5 IM&T Strategy and Procurement

The Trust's Digital Strategy 2021-2026 is set out in Appendix 5.5. As part of the P22 construction works, the PSCP will provide a fully integrated, contained, and cabled IM&T network throughout all the new buildings with sufficient incoming ducts and cable ways for external fibre and communications cabling. A main IM&T Hub will be provided by the PSCP within the building, from here fibre cables will be distributed to each department and terminate in local IM&T cabinets, final positions to be determined. These will serve all the new IM&T hardware requirements and will future proof as much as is possible for new national and local digital strategies, operational and clinical needs, as described above. This will be provided by via structured data cabling to final outlet data point positions.

An IM&T Responsibility Matrix has been agreed which sets out the responsibilities of all parties, a copy of which is included within Section 2 of the Estates Annexe, in Appendix 5.8.

The Trust IM&T department in conjunction with the E&UCC Project Team, will purchase, supply and fit out all the necessary IM&T hardware required to service the new facility. This will include local IT cabinets, PCs,

monitors, tablets, remote devices, mobile telephony, and all associated equipment, including IT cabinets (located in the main IM&T Hub) and all their associated integral switches, panel, racks etc.

These items will be procured in the same way as the general FF&E (as set out above) via a procurement framework to comply with the Trust's Standing Financial Instructions; or where this is not possible via a tender exercise.

5.4.6 Procurement of Enabling Works and Temporary Facilities

The E&UCC project is required to be delivered on a phased basis whilst keeping the existing departments open and operational. Details of the proposed phasing, decanting, and temporary facilities are set out further in Section 5.19.

The vast majority of the required works to be undertaken are procured through the P22 agreement with the Trust's PSCP (Tilbury Douglas). However, the Trust is required to undertake a number of enabling, associated, and temporary works, including:

- Permanent relocation of Pacing to Block 41
- X-Ray A impact mitigation
- Temporary SDEC relocation
- Temporary Paeds ED relocation to Treehouse
- Healthier Together ED Resus
- Temporary ED staff welfare facilities
- Temporary ED office facilities

The scope and sequencing of these works is discussed further in Section 5.19.

All of the above will be undertaken as direct pieces of work and are being competitively tendered by the Trust as direct appointments outside of the P22 appointment, all of which is being undertaken in line with the Trust's procurement rules and SFIs.

Facilities Management (FM)

The majority of the existing facilities management is undertaken in-house by the Trust. This arrangement will be maintained for the newly refurbished building, and all existing SLAs will be extended as required at the end of each phase as it completes.

There are no major issues or commercial risks anticipated as a result of this.

5.5. Key Contractual Issues

5.5.1 ProCure22 Stage 4 Appointment (The Negotiated Deal)

In line with Actions 28 and 34 of the HM Treasury Blue Book, this section sets out the negotiated "Deal" and the contractual arrangements for the design and build elements of the project, including:

- Tilbury Douglas GMP and Trust review and acceptance;
- Value engineering and route to affordability;
- Proposed Stage 4 contract arrangements;
- Proposed payment basis; and
- Proposed gainshare and incentivisation agreements.

Once this FBC is approved, the Trust will enter into a formal P22 Stage 4 Agreement with Tilbury Douglas, authorising the completion of the final design and construction of all the works being completed under the P22 contract.

5.5.2 Guaranteed Maximum Price

The GMP or 'target price' in the NEC3 Contract is the agreed maximum outturn cost between the Trust and IHP for all Tilbury Douglas's costs, including Stage 4 construction works and all design work, based on the defined scope of work at the time the GMP is agreed.

Tilbury Douglas are due to issue their GMP submission on 21 June 2022, which is anticipated to be for a sum of approximately £23.75m. Full details of this will be provided to NHSE&I as an addendum to this FBC (to follow).

The Trust's Project Managers (Rider Hunt) and Cost Advisors (O'Neil & Partners) will review the Tilbury Douglas GMP submission and confirm they are satisfied the P22 process has been followed and sufficient market testing has been carried out.

The GMP will remain valid until the Stage 4 contract is executed, subject to any Trust risks coming to fruition.

5.5.3 Value for Money from the P22 Contract

The P22 contract will deliver value for money for the Trust's investment via the usual P22 mechanisms. The agreed contract price (GMP) is commensurate with a lump sum tender price if the scheme were tendered to the open market; and P22 will deliver a much closer final outturn cost, with far less risk to the Trust. Value for money is achieved through the P22 contract by:

- Competitive tendering of contract works packages or pre-tendered rates;
- Allocation of risk on a best value basis;
- One point of responsibility for design and construction;
- Reduced pre-contract timelines and the benefit of early contractor involvement;
- Fully open book and partnering approach, which reduces the risk of dispute and litigation;
- Agreement of a GMP prior to the Trust's committing to commencing construction; and
- An agreed post-contract process for change.

As the project will be delivered as a P22 National Framework Agreement, the Trust will follow an agreed approach for project management and the process for design and construction of the proposed works as set out in the standard P22 NEC3 Contract and P22 template and associated guidance. There is no intention to derogate from the standard contract documentation.

The level of specialist advisors is kept to a minimum with appointments to provide project management, cost consultancy and construction design and management support. Specialist legal or financial advisor support is provided from the Department of Health P22 team.

5.5.4 Value Engineering and Route to Affordability

Further to the submission of the OBC, and as the FBC stage design has developed, it became evident that increased construction costs would be incurred due to a number of contributing factors, including scope creep and other factors outside of the Trust's control (including the ongoing impacts of Brexit, COVID-19, market instability, material availability, and inflation).

Tilbury Douglas, working with Rider Hunt and O'Neil & Partners, have continued to produce interim stage cost plans. These cost plans produced in early 2022 based on the signed off design at this stage showed that the anticipated GMP would be over the Trust's affordability limit and would exceed the available capital budget, due to the above factors.

A detailed Value Engineering (VE) exercise was therefore undertaken to consider all potential efficiency opportunities whilst the project continued to progress, and the design continued to develop.

The VE process which was undertaken jointly and collaboratively between the Trust and Tilbury Douglas (supported by Rider Hunt and O'Neil & Partners) sought to reduce or eliminate unwanted project costs by considering the need for, and/or assessing alternative options in order to find the most cost-effective solution, whilst maintaining delivery of the E&UCC project's objectives.

The Trust has maintained a responsible approach to VE, only considering potential design alterations that would have minimal impact on the final building solution, its performance or key deliverables. Targeted focus has included:

- Alternative phasing approaches, which has resulted in a reduction in required works and a reduced timescale;
- Reductions in engineering solutions;
- Delivering electrical infrastructure works through an alternative procurement route, to deliver efficiencies by combining with other current work;

- Elimination of non-core space not essential to deliver the proposed solution, in order to safeguard clinical areas;
- Further review of room scope and sizes;
- Reduction and challenge to any “nice to haves”;
- Review and consolidation of first floor layout;
- General review and challenge on specification; and
- Review and challenge of Trust-side costs.

All scheduled VE opportunities were captured within a VE register, along with potential savings and potential impact; and were RAG rated, considering the likely consequences if instructed. Several VE sessions were held with key stakeholders, and all VE items considered reasonable were taken forward for further discussion and agreement.

The VE process has been managed and controlled by the Trust and Tilbury Douglas using the agreed P22 processes.

The VE process has achieved two things:

- A current anticipated GMP which is now within the Trust’s affordability envelope; and
- Assurance that the proposed design is cost-effective, offers VfM, meets the Trust’s brief, and delivers against its spending objectives.

5.5.5 Form of contract

The form of contract for all P22 projects is an amended version of the NEC3 Option C: Target Contract with Activity Schedule. The Trust has used this standard form of contract for the Stage 4 agreement with Tilbury Douglas, supported by project-specific information (Works Information, Site Information, Priced Activity Schedule, Programme, Risk Register etc.).

As with the Stage 3 contract, the Trust has not made any alterations to the standard NEC/P22 contract for Stage 4.

5.5.6 ProCure22 Actual Cost

The P22 Form of Agreement specifies that the Trust reimburses Tilbury Douglas on an actual cost basis for all of their works completed on the project. This cost is calculated based on actual cost incurred by Tilbury Douglas, work done against the pre-agreed Bid Return Document (BRD) rates (as provided when Tilbury Douglas tendered for the framework), and staff rates. These rates have been market tested by the Department of Health as part of Tilbury Douglas’s tender return for the P22 framework and reflect the competitive market conditions at the time of tender.

The GMP is based on market-tested packages, and tendered rates. During the remaining stages of the project, the PSCP continues to be paid on an actual cost basis but will never exceed the GMP. The GMP is adjusted during the project for any agreed changes to the PSCP’s work (either negatively or positively), using change control and the agreed NEC3 contract processes.

The final outturn cost (i.e., total actual cost paid by the Trust to Tilbury Douglas) cannot exceed the agreed Guaranteed Maximum Price (adjusted for any trust-led variations), or the agreed cap for Stage 3.

It is important to note that the Trust is currently only committed to Tilbury Douglas for the work undertaken to date up to the point when the Stage 4 (GMP) agreement will be signed.

5.5.7 ProCure22 Open Book Accounting

P22 requires the contract to be agreed and administered on an ‘open book’ basis. The Trust and its external advisors (Rider Hunt as Project Manager and O’Neil & Partners as Cost Advisor) and Tilbury Douglas have therefore agreed to adhere to this throughout the life of the project.

All PSCP and their supply chains have signed up with the DHSC to total disclosure of information, cost and processes.

5.5.8 Incentivisation and Gain Share

The P22 Framework incentivises the PSCP to make further savings once the GMP has been agreed, through a process of offering 50% of any post-GMP savings made through increased efficiency (but not

buying gain) back to the PSCP as a 'gain share'- up to a limit of 95%. The PSCP takes all the risk of exceeding the GMP.

This agreement is included within the Stage 4 contract documents between the Trust and Tilbury Douglas in full.

5.5.9 Delay Damages

Prior to agreement of the GMP, delay damages have been specified in line with the contract by the Trust. Delay damages will be claimed by the Trust should the PSCP be late in delivering the works, providing this is due to Tilbury Douglas.

5.5.10 Contract Terms

The Trust and Tilbury Douglas have agreed contract terms (subject to final agreement as part of the GMP submission in June 2022), which are included within the draft Stage 4 contract documents. The draft contract includes:

- Contract Data Part 1 and Part 2;
- A full set of Employer's Works Information- provided by the Trust, which is based on the standard P22 information populated with project-specific information;
- A full set of Contractor's Works Information- provided by Tilbury Douglas, which provides full details of Tilbury Douglas's offering and is supported by an extensive and detailed GMP information set (when issued); and
- Site Information.

The following key contractual items are included within the agreed contract (when the GMP is issued and agreed):

- Full set of financial information, including agreed GMP;
- Risks and risk allocation, including an agreed 'P22 Risk Register';
- Insurance provisions and requirements;
- Delay Damages;
- Agreed programme and key dates;
- Details of Employer's constraints;
- Details of all People and Things;
- Agreed scope of Tilbury Douglas work; and
- A Contract Terms Query Tracker is being used to agree the key contractual elements.

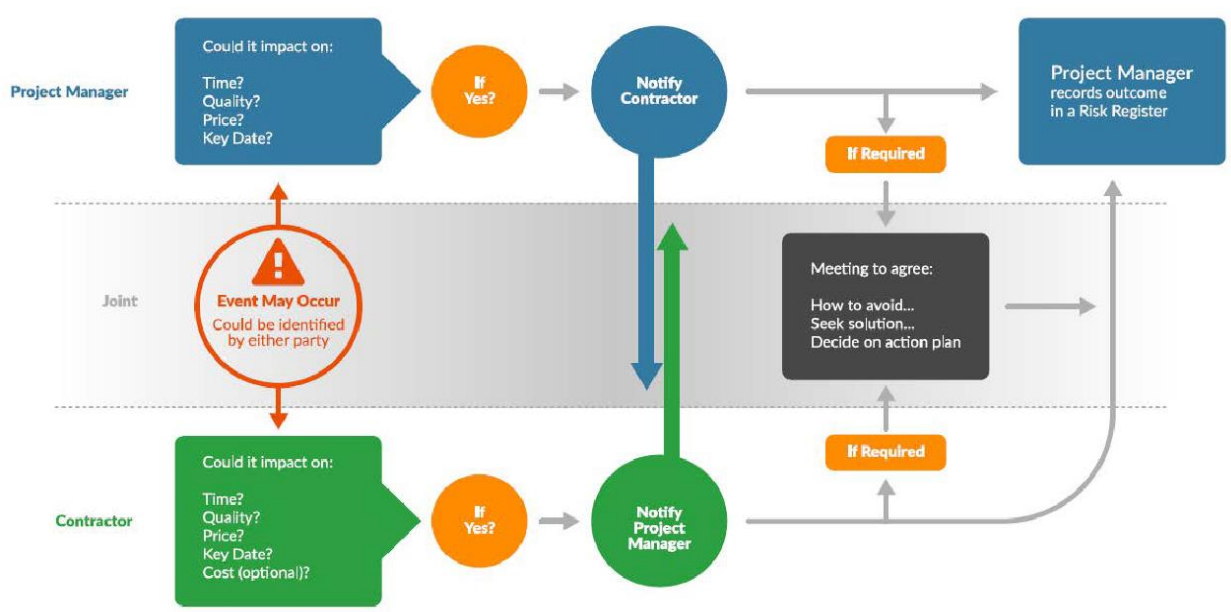
5.5.11 ProCure22/ NEC3 Project Management Processes

The Trust and Tilbury Douglas are using the full suite of P22/NEC3 contract protocols and processes for the management of all ongoing design and build issues, including:

- Risk management;
- Programme issue and acceptance;
- Cost reporting and assessments;
- Change control (Early Warning Notices (EWNs), PMIs, CEs); and
- Design acceptance (PF10s).

The agreed P22 change control process is shown in the figure below:

Figure 63. Agreed P22 Change Control Process



5.5.12 Solicitor Approval

The Trust's Solicitors have been involved in reviewing the contracts between the Trust and Tilbury Douglas prior to their execution and have provided expert advice and support. Details of Hempsons' review are set out in more detail in Section 5.7 and in Appendix 5.6.

5.5.13 Value for Money

Tilbury Douglas are in the process of undertaking a full programme of market testing in order to generate the GMP. There has been considerable interest from the market to date, and strong competition for packages.

The GMP submission will include the items of value engineering which have been agreed with the Trust, as set out in Section 5.5 above.

Prior to the GMP being issued, several meetings are scheduled to be held between Tilbury Douglas and the Trust's Project Managers (Rider Hunt) and Cost Advisors (O'Neil & Partners), to review the basis of the GMP and all of the work packages in turn. These sessions will evaluate the number of enquiries sent out and the number of tenders returned.

A full market testing exercise is being undertaken by Tilbury Douglas to compile the GMP, which is gaining significant interest, with a target of returning a minimum of 3 compliant tenders per package. Upon issue of each package for pricing the proposed tender list is being distributed by Tilbury Douglas to Rider Hunt / ONP for comment to ensure any requests from the Trust for specific suppliers or subcontractors are being included.

Some packages may have limited response and/or Tilbury Douglas may be unable to gain three quotations. In these instances, Rider Hunt/O'Neil & Partners will need to agree and ensure value for money is being delivered.

Whilst the tenders received will reflect current market rates, the other elements of the GMP are being reviewed and scrutinised, including inflation, risk allowance, fees and the like, to ensure they offer the Trust with value for money. The full costed breakdown forms part of the GMP submission.

Fortnightly commercial reviews are being held between Tilbury Douglas, Rider Hunt, and O'Neil & Partners to give transparency on the processes and progress.

5.5.14 Risk

The allocation of risk is a key area within the agreed P22 Stage 4 contract between the Trust and Tilbury Douglas. Risk workshops are ongoing, and a P22 Risk Register is being maintained. An in-depth risk review will be carried out immediately prior to the submission of the GMP, and the Risk Register updated, to ensure this is the most up to date for the GMP. The Risk Register is reviewed regularly and agreed between the Trust and Tilbury Douglas on an open book basis.

The general principle adopted by the Trust for the project is that risks are passed to the party best able to manage them, subject to VfM. All of the risks have been allocated to the most appropriate party, which has required rigorous review, mitigation and negotiation during Stage 3.

All design responsibility was passed to Tilbury Douglas at the point of their appointment. Tilbury Douglas and their supply chain are therefore fully responsible for carrying out all design requirements to meet the Trust's brief.

The Trust's management of risk and the overall Project Risk Register is covered within Section 7.6 of the Management Case.

The P22 contract is uniquely placed to allow the Trust to effectively manage the ongoing risk associated with Brexit, the COVID-19 pandemic, and the impact of the crisis in Ukraine.

5.5.15 Brexit

The UK's exit from the European Union (Brexit) may have an effect on the project, particularly in relation to items such as:

- Supply and availability of people, labour, and trades;
- Supply and availability of materials, products, components, equipment, and fittings; and
- Potential changes in the law.

The Trust and Tilbury Douglas have continued to review the actual and potential impact of Brexit on the E&UCC project, and both parties are working to the latest Cabinet Office Guidance and the P22 Guidance Note. The Trust and Tilbury Douglas are continuing to collaborate in a 'spirit of mutual trust and co-operation' in relation to managing the risk of Brexit. Any issues which arise are being dealt with through the agreed P22/NEC3 early warning and compensation event processes, particularly where these might have an impact on:

- Time (including completion and meeting key dates);
- Quality; and
- Cost.

Any changes to the law as a result of Brexit will be dealt with through the P22 processes, and NEC3 Option X2 is being used within the Trust's contract with Tilbury Douglas to manage this should it occur.

The Trust and Tilbury Douglas are identifying all risks and issues relating to Brexit during the project's regular risk reduction meetings; and these risks are captured on the agreed P22 Risk Register. Where action can be taken to address and mitigate these risks this may be mutually agreed between the Trust and Tilbury Douglas, which might include things such as:

- Forward purchasing of materials/components if it is evidenced that there may be long lead time or other supply problems;
- The use of off-site fabrication of assemblies helps reduce the need for site-based labour and may address skills shortages;
- The use of alternative materials or methods of construction (Modern Methods of Construction);
- The first line selection of UK based suppliers and UK sourced plant and materials/components; and
- Specific provisional allowances have been included within the agreed GMP to cover some of the specific risks.

Further detail on how the impact of Brexit on the project will be managed is covered within the contract.

5.5.16 Contractual Response to COVID-19

The ongoing COVID-19 pandemic has had a significant impact on the way the project has been managed to date; however to date the Trust has successfully mitigated this without any detriment to the project's progress.

For P22 Stage 3, the PSCP has included allowances for working on the project based on the COVID-19 restrictions in place at the point where work commenced within their Priced Activity Schedule. Any amendment to this is being dealt with as it occurs and is a Trust risk.

The Trust has agreed the way COVID-19 is dealt with in the P22 Stage 4 contract, which is based on the latest information at the time the GMP is agreed and is in line with industry best practice and the latest guidance from the P22 unit.

Tilbury Douglas and the Trust have agreed to follow the P22 Guidance published on the P22 Website.

Whilst the removal of COVID-19 restrictions in England has reduced the requirements for dealing with COVID-19, there does still remain a risk due to potential infections occurring (particularly to key people or a number of people within the same specialism and/or sub-contractor). There is also the possibility of potential future restrictions being imposed.

To this end COVID-19 continues to be an unknown factor that will be managed via the contract arrangements through both the P22 Joint Risk Register and the P22 Framework COVID Guidance.

Tilbury Douglas and the Trust will also continue to adopt good practice in relation to infection prevention and control to limit the risk of any infection outbreaks occurring.

Further information on the contractual and commercial arrangements within the Trust's P22 contract with Tilbury Douglas for COVID-19 are included in the contract.

5.5.17 Ability of P22 to Adapt to COVID-19 and Business Continuity

The use of the ProCure22 Framework has allowed the Trust to respond to the immediate issue of COVID-19 (and wider business continuity issues) through collaborative working and an open book and shared approach to risk. This has included identifying provisional amounts within the Stage 3 costs to cover potential issues and delays; identifying, mitigating, and allowing for risks associated with COVID-19 and other issues; and allowing a fully integrated approach to the design and how this might respond to the need for enhanced infection control measures.

It has also allowed a sensible, open-book, risk-based approach to COVID to be taken when agreeing the GMP.

5.5.18 Contractual Response to Crisis in Ukraine

The emerging crisis in Ukraine may have an impact on the project, including the capital costs. This impact is currently unknown, however has been identified as a risk and has been highlighted to both the Trust and Tilbury Douglas.

The potential impact could include:

- Difficulties in obtaining fixed price tender returns;
- General increase in capital costs- due to increases in fuel and energy costs; and
- Unavailability of labour, plant, and/ or materials which may have a link to the Ukraine region and/or impacted by sanctions against Russia.

There are currently no allowances within the project for any of the above, and the current situation is being monitored.

This will be included within the Stage 4 contract as a risk and should any of the above occur it will be dealt with using the usual P22 Trust procedures.

5.6. Commercial Risks and Risk Allocation and Transfer

The allocation of risk is a key area within the P22 contract. The project risks are being managed by the Trust and P22 PSCP (Tilbury Douglas) jointly and in an open and transparent way. Regular formal Risk Reviews are held between the Trust and PSCP, and the standard P22 risk register is being used as a basis for risk identification and management. The Risk Register and risk management process takes into account Trust risks as well as construction risks and are bound into the Trust's Stage 3 contract with the PSCP (and the draft Stage 4 contract). This risk managed approach is supported by the NEC3 'early warning' system which is being used to allow risks to be identified, formally reviewed and agreed actions implemented.

The general principle adopted for the E&UCC project is that risks are passed to the party best able to manage them, subject to value for money. The risk register has been reviewed regularly and the Trust has concluded that it will apportion risks in the design, build and operational phases as shown in the table below.

The apportionment of risks reflects that the assets underlying the works will remain in the Trust's ownership throughout, which is in line with works procured under a P22 contract. Regular review of the risk and allocation is undertaken collaboratively between the PSCP and the Trust. A number of in-depth risk reviews

have been carried out, and a fully up to date P22 Risk Register will be included within the Trust's 'Stage 4' contract with the PSCP.

Figure 64. Summary of Risk Apportionment

Risk Category	Allocation		
	Public	Private	Shared
Design (up to PSCP appointment)	✓		
Design (following PSCP appointment)		✓	
Construction and Development		✓	
Transition and Implementation			✓
Availability and Performance	✓		
Operating	✓		
Variability of revenue	✓		
Termination			✓
Technology and Obsolescence	✓		
Control	✓		
Residual value	✓		
Financing	✓		
Legislative			✓

5.6.1 Procurement Risks

The initial procurement risks to the project are:

- Procurement not undertaken in a timely manner, resulting in delays to the project;
- Procurement of design and construction not undertaken correctly under the ProCure22 framework processes (Risk now mitigated, as P22 selection completed);
- Procurement of design and construction not undertaken prior to expiry of the ProCure22 framework (Risk now mitigated, as P22 selection completed);
- Procurement of advisors is not in line with Trust's SFIs, procurement rules, and/or does not provide the Trust with value for money;
- Procurement of equipment is not in line with Trust's SFIs, procurement rules, and/or does not provide the Trust with value for money;
- Procurement of IT is not in line with Trust's SFIs, procurement rules, and/or does not provide the Trust with value for money;
- Potential commercial opportunities associated with the project not taken; and
- P22 Guaranteed Maximum Price unable to be agreed with the Trust's P22 PSCP.

The management of project risk is discussed in further detail in Section 7.6 of the Management Case.

5.7. Other Commercial Issues

5.7.1 Contractual milestones and delivery dates

The Trust has developed a programme to deliver the Preferred Option. The Programme and key dates are set out in detail in Section 7.2.7 of the Management Case.

5.7.2 Accounting Treatment

The accounting treatment of the Emergency Care Campus will be undertaken by applying the current accounting guidance as laid out in the HM Treasury Green Book (2018). The Trust recognises that the new asset will be recognised on the Trust's balance sheet along with the corresponding PDC funding.

The Trust suggests that this is a relatively "standard" assumption and that this does not need to be verified through the external auditors, although this can be obtained should this be required.

5.7.3 Commercial Opportunities and Charitable Funding

The Trust has considered available commercial opportunities which may arise as a result of delivering the new E&UCC. This may include commercial opportunities to reduce the overall capital cost of the project, and/or increased revenue opportunities.

The use of charitable funds is being explored for use on specific elements of the project that both warrant and meet the set criteria (eg potential for a fundraising drive to fit-out rooms).

If needed the Trust will explore the possibility of charitable funding to support the new E&UCC development with the Trust Charity. This is expected to focus predominantly on equipment, furniture and fittings that improve the patient and visitor experience.

The Trust will know whether it needs charity funding when GMP is finalised. A fully costed equipment schedule is currently being updated. It is still only expected that Charity funding will assist in the added patient experience improvements and will not replace core equipment requirements.

5.7.4 Market interest

There has been significant interest in the E&UCC project due to its size, profile, and South Manchester location; including significant interest from the supplier and sub-contract market.

The Trust has undertaken the ProCure22 selection process, which was keenly contested, and Interserve has been chosen as the P22 PSCP (now Tilbury Douglas). Tilbury Douglas have also selected their M&E PSCM.

The Trust and Tilbury Douglas have continued to receive a number of requests from suppliers and subcontractors to be involved in the project, and a good response is being experienced for the market testing.

5.7.5 Contractual Issues (including standard contract and variations)

The Trust has adopted the standard ProCure22 contract "NEC3 Engineering and Construction Contract (E&UCC)" for the project, complemented by the specific project details. There are not anticipated to be any variations from the standard contract.

Any direct works procured outside of P22 will use standard forms of contract, such as Joint Contract Tribunal (JCT), NEC3, or NHS Supply of Goods and Services.

5.7.6 Compliance with EU Procurement Law / Find a Tender

The Trust has fully complied with all required procurement legislation, including EU procurement law prior to Brexit, and Find a Tender afterwards, as well as the Trust's SFIs.

5.7.7 Legal Advice

The Trust has not experienced any significant procurement-related commercial or legal issues arising for the design and construction works to date, due to the Trust utilising the ProCure22 Framework which is the default option for NHS construction projects; and is not anticipating any significant issues arising in the future.

Hempsons Solicitors have reviewed the ProCure22 Stage 3 contract prior to this being executed by the Trust and Tilbury Douglas, and are supporting the development of the ProCure22 Stage 4 contract prior to this being agreed.

A letter from the Trust's Solicitors (Hempson) is included within Appendix 5.6.

5.7.8 Engagement with the Trust Procurement Team

The Trust Procurement Team has been involved in the project, and this FBC has been developed in conjunction with them. The Procurement Team are therefore fully on board with the items identified within this Commercial Case.

A letter from the Trust's Head of Procurement is included within Appendix 5.7.

5.8. Personnel Implications

The Trust does not expect there to be any redundancies arising from the preferred option.

TUPE regulations will not apply to this investment as no undertakings will transfer between employing entities.

For the preferred option no additional staffing is required and so none has been costed within the base revenue costs. A costed risk that extra staff is required has been included which is set out within the economic modelling.

Workforce implications due to the change in clinical services have been included within Section 7.7.4 of the Management Case.

5.9. Commercial Feasibility and Deliverability

The Trust considers that the E&UCC project is commercially feasible and deliverable; and comes with an acceptable level of risk.

5.10. Build Scheme and Compliance with Relevant Standards and Guidance

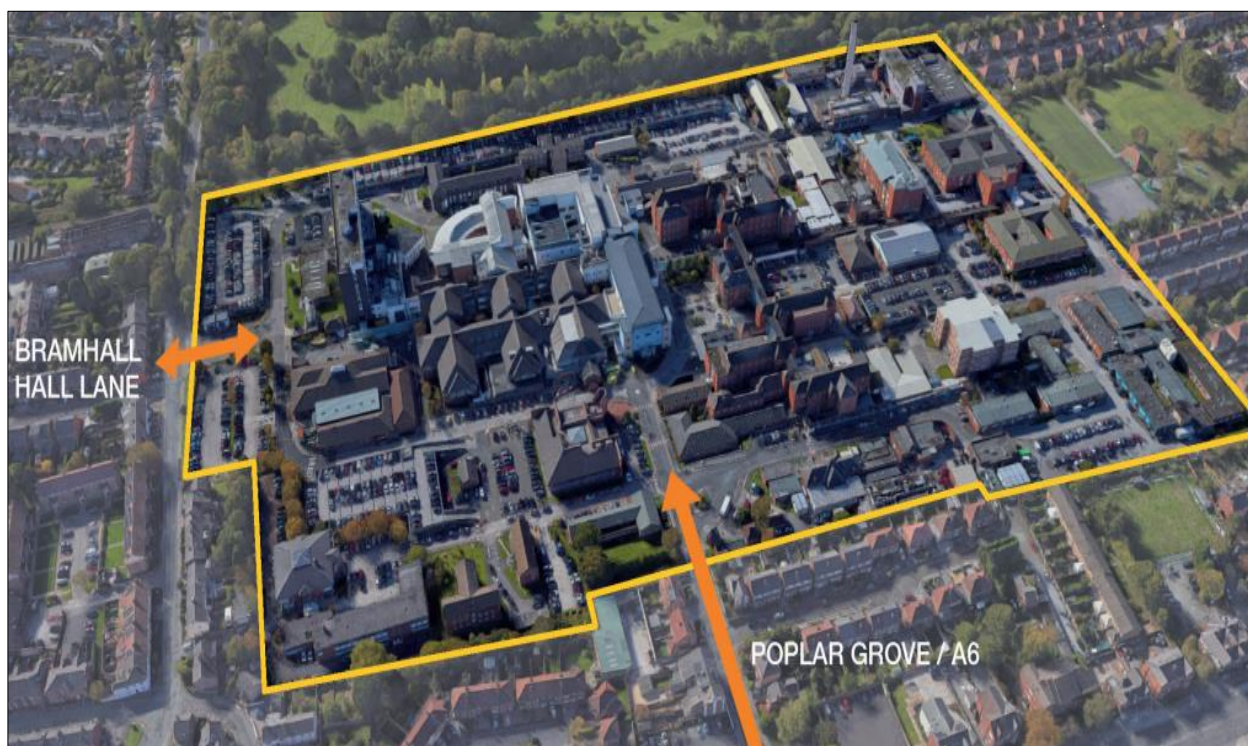
This section of the Commercial Case sets out the design and build and clinical quality elements of the proposed E&UCC project at the Stepping Hill Hospital site.

For further FBC stage details of all design and build elements please refer to the attached Estates Annexe in Appendix 5.8, as prepared by the Trust's P22 Partner, Tilbury Douglas.

5.10.1 Overview of the Site

The Stepping Hill Hospital complex is extensive and comprises an area of approximately 14.5 hectares bounded by the southern boundary of properties lining Aber Avenue in the north, Bramhall Moor Lane in the east, the railway line to the south and Great Moor Park to the west. The site contains a network of both detached and connected buildings of varying age, style and height developed over a period of circa. 119 years interspersed with vehicular and pedestrian routes and car parking.

Figure 65. Stepping Hill Hospital Site Overview



The proposed E&UCC will be located adjacent to the Poplar Grove main hospital entrance as detailed below:

Figure 66. Proposed Site Location of E&UCC



5.10.2 Core Design Principles

The design philosophy has been developed to remain cognisant of the ever-changing nature of the delivery of healthcare services, and the equally changing impact this has on the environment from which care is being delivered. The Trust has therefore developed a design where the structural grid of the first-floor element of the scheme caters for the blue light access and egress below depending upon current and future needs and using modern methods of design during the phasing and construction of the works. The existing stair cores have been retained include current points of escape for building users within the floors above whilst a general traffic lift has also been incorporated outside of the main ground floor clinical areas to provide staff access to the non-clinical and welfare accommodation within the new first floor extension.

The new proposed layout allows for changes brought about by digital or technological innovations whilst introducing a number of flexible spaces to allow for the changing needs of the Trust both at present and in the future.

The existing link corridor and hospital street to the rear of the ED is to remain unchanged and will be kept live throughout the course of the works in order to maintain connectivity across the hospital campus.

A designated first floor area has allowed for provision of clinical support office and welfare space required by the Trust for current and projected staffing numbers. Where possible, office, workspace and breakout space is designed as open plan avoiding individual cellular spaces, although some activities do require lone workspaces for concentration and to ensure that staff are not distracted from specific tasks. All non-essential space has been value engineered out.

The provision of storage spaces has been limited where possible to allow just in time stocking of consumables along with an effort to reduce waste and allow the Trust to work paperless, with the introduction of new digital technologies for patient and clinical spaces, and workspaces.

Externally, the existing blue light route has been re-directed to align with the new Ambulance Arrivals and RATS entrance whilst also providing a direct link through to the new HASU. The new design also incorporates a non-pedestrianised area outside of the HASU extension preventing direct thoroughfare for public and improving the privacy and dignity of patients from that of the current system. New ramped access has been introduced to both the Bereavement Suite and SDEC extensions to address the change in levels across the site. This also provides direct family access to Bereavement, a discreet external link from Bereavement to Mortuary and external point of escape from SDEC.

Although there is no provision for future expansion given the constraints of in and around the current ED; the requirements of the Trust around current and predicted patient numbers have been reflected within the signed off schedule of accommodation and the increased capacity throughout the department.

5.10.3 Summary of the Outline Design Solution

The proposed E&UCC is a 2-storey redevelopment and extension of the existing ED/ UTC.

The ground floor area is dedicated to the clinical departments with areas of the SOA being accommodated with the required adjacencies to provide the required efficiencies within a modern new ED Facility.

The rear of the facility connects back to the main hospital street giving the connectivity required to other departments. The front Entrance design as illustrated in the figure below provides cover for Blue Light arrivals and connects through to the existing road Network.

First floor accommodation provides office and administration space which supports the lower clinical levels. All plant provision is situated to the first floor, to allow new installations and connectivity to each department by roof level which facilitates the proposed phasing of the works.

1:200 drawings can be found in Section 2 of the Estates Annexe (Appendix 5.8). The Schedule of Accommodation is also included in the Estates Annexe - in Section 1.

The latest floor layout plans, elevations, and sections are set out in the figures below:

Figure 67. Ground Floor Plan



Figure 68. First Floor Plan

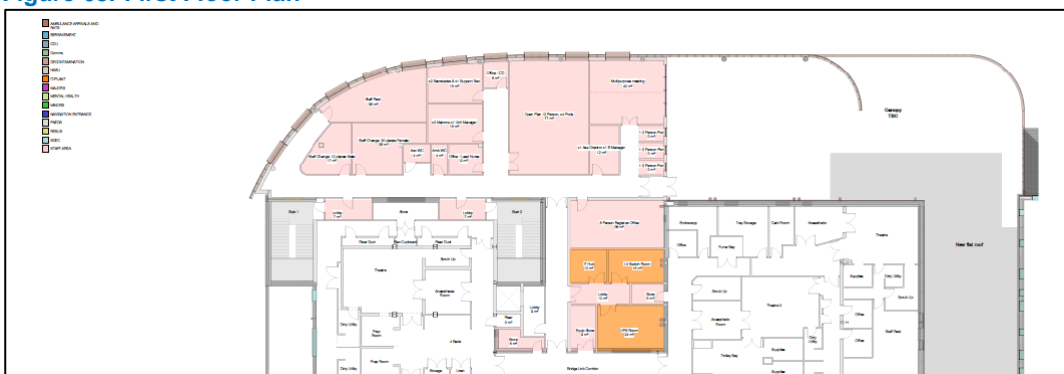


Figure 69. Building Elevations



Figure 70. Proposed Building CGI



5.10.4 Schedule of Accommodation (SOA)

A schedule of accommodation for the new E&UCC has been produced and agreed with the Trust. This has been updated during the RIBA Stage 3 design, and the latest FBC stage version is included within Section 1 of the Estates Annexe.

The SOA has been used as a basis of developing the 1:200 layout plans, the 1:50 layout plans, and the subsequent room loaded layouts.

The SOA has been based on extensive clinical discussions and engagement, benchmarking against other recently completed schemes of a similar size and nature, post-occupancy evaluation data from recent completed schemes, and other similar NHS projects and developments.

The SOA reflects latest best practice and is compliant with appropriate HBNS and HTMs relevant to the development.

A summary of the SOA is set out in the figure below:

Figure 71. Summary of the Schedule of Accommodation

Department	Area
Ambulance Arrivals and RATS	180 m ²
Bereavement	35 m ²
CDU	427 m ²
Circulation	376 m ²
Decontamination	12 m ²
HASU	205 m ²
IT/Plant	387 m ²
Majors	597 m ²
Mental Health	102 m ²
Minors	128 m ²
Navigation Entrance	249 m ²
Paediatrics	331 m ²
Resus	301 m ²
SDEC	447 m ²
Staff Area	496 m ²

5.10.5 1:200 scale layout plans

1:200 scale layout plans have been developed for the E&UCC building, which have undergone extensive user engagement and have been approved by all key clinical and non-clinical leads. These have been reviewed and updated as part of the RIBA Stage 3 design for FBC.

The latest version of the 1:200 layout plans are included within Section 2 of the Estates Annexe, in Appendix 5.8.

A summary of the latest design and plans are set out above within Section 5.10.

5.10.6 1:50 scale layout plans

1:50 scale layout plans have been developed for the E&UCC building based on the 1:200 layout plans, which were subject to extensive user engagement and approval by all key clinical and non-clinical leads. The 1:50 scale layout plans have been developed as part of the RIBA Stage 3 design for FBC.

The latest version of the 1:50 layout plans are included within Section 2 of the Estates Annexe, in Appendix 5.8.

A summary of the latest design and plans are set out above within Section 5.10.

5.10.7 C-sheets/ Room loaded layout plans

C-sheets and room loaded layout plans have been developed for the E&UCC building based on the 1:200 layout plans and the 1:50 scale layout plans, which were subject to extensive user engagement and approval by all key clinical and non-clinical leads. The C-sheets and room loaded plans have been revised and further developed as part of the RIBA Stage 3 design for FBC.

The C-sheets and room loaded layout plans are generally based on the P22 repeatable rooms layouts, with project and Trust specific elements incorporated.

The latest C-sheets and room loaded layout plans are included within Section 2 of the Estates Annexe (Appendix 5.8).

5.10.8 Elevations and Sections

Building elevations and sections have been developed for the E&UCC building based on the various layout plans, and have been subject to extensive user engagement and approval by all key parties at FBC stage, and have been developed as part of the RIBA Stage 3 design for FBC.

The building elevations have also formed part of the planning consultation work, along with CGI images of what the building is to look like when constructed.

The latest Building elevations and sections are included within Section 2 of the Estates Annexe (Appendix 5.8).

A summary of the latest elevations and the CGI are set out above within Section 5.10.

5.10.9 Compliance with relevant standards

The proposed E&UCC scheme forms part of the Trust's Development Control Plan.

The Trust has selected a collaborative procurement route in P22 that enables both early contractor and supply chain involvement with a whole-life approach to cost and carbon reduction across construction, operation and maintenance of public sector buildings and infrastructure.

The proposed development is compliant with the Common Minimum Standards for Construction to ensure cost effectiveness and productive engagement.

All current proposals are compliant with NHS estates design and costing requirements.

Spencer Harrison have acted as healthcare planners to date and supported the Trust in development of the OBC; and this appointment has continued (on an advisory basis- as required) through the development of the FBC.

The design team has worked closely with Trust clinicians to understand the clinical and non-clinical adjacencies, and the design will be further challenged and appraised as the scheme progresses.

The new building is compliant with all applicable standards and ED / acute hospital guidance, with only minor, considered, and approved derogations.

The new building is compliant with all applicable standards, including:

- ED guidance and latest best practice
- Applicable HBN and HTMs
- P22 repeatable rooms and standard components
- Post-occupancy evaluation data, including benefits realisation data and component testing

The design of the new building draws on the learnings and current deficiencies of the existing ED and UTC facility at Stepping Hill, including that gathered through extensive engagement with staff, and patients.

The building is compliant and consistent with the key guidance for Emergency Department and Urgent Treatment Centre facilities and is informed by engagement with the Trust and partner organisations, and an assessment of existing facilities and operational need. It has been benchmarked with similar schemes to ensure comparable in size and content. P22 repeatable rooms have been used to ensure correct space standards have been delivered.

5.10.10 Compliance with Health Building Note (HBN) Requirements

The design proposals have been developed to align with evidence-based guidelines adopted by the NHS including the relevant Health Technical Memoranda (HTM) and Health Building Notes (HBN). The current design has taken into consideration the following HBNs albeit this is not an exhaustive list:

- HBN 00-02: Sanitary spaces
- HBN 00-03: Clinical and Clinical Support Spaces
- HBN 00-04: Circulation and Communication Spaces
- HBN 00-07: Planning for Resilient Healthcare Estate
- HBN 01-01: Cardiac Care Facilities
- HBN 04-01: In-Patient Facilities
- HBN 07-01: Resilience Planning

- HBN 09-01: Infection Control in the Built Environment
- HBN 11-01: Primary and Community Care
- HBN 14-02: Medicines Storage
- HBN 12: Outpatients Department
- HBN 15-01 –Emergency Depts (no size guidance)
- HBN 22 – Accident and Emergency Depts (archived but with size recommendations)
- HBN 26: Surgical Procedures
- HBN 40-01: Common Activity Spaces – Public Areas
- HBN 40-02: Common Activity Spaces – Treatment Areas
- HBN 40-03: Common Activity Spaces – Staff Areas
- HBN 40-04: Common Activity Spaces – Circulation and Communication
- HBN 44: Ambulance Service Design Guide

5.10.11 Compliance with Health Technical Memorandum (HTM) Requirements

The design has been developed in line with HTM standards for materials, components and finishes such as; lab benching, sanitaryware, ceilings, floor finishes, doors and ironmongery, acoustics, firecode, control of infection in the built environment etc.

5.10.12 Derogations

Following development of the design the only current derogations applicable to the scheme are for room sizes where we have moved away in some cases from guidance, and a number of items relating to the M&E.

All deviations from standards have been fully communicated with the Trust (eg workshops where we have taped out room sizes and evidenced the space we have to make sure decisions made were correct). The latest schedule of accommodation provides details of the rooms where we have applied derogations.

The M&E systems are subject to some derogations, due to the project being a refurbishment and some existing areas are not fully compliant, however are retained on a value for money basis. In each instance these have been communicated with the Trust and agreed.

All derogations have been formally agreed via the Project Manager's Approval of Design (PF10) process.

The latest derogations schedules are included within Section 2 of the Estates Annexe.

5.11. Key Design Considerations

5.11.1 Fire Safety Compliance

The E&UCC design has been developed to meet with the requirements of HTM 05-02 Fire Code with all design works in relation to fire safety on hospital projects, and has been developed to provide additional flexibility of future use with the introduction of smoke lobbies as well as multiple access onto hospital streets.

The new building fire design is subject to agreement with:

- Building Control and Local Authority
- The local Fire and Rescue Service
- Trust's Fire Officer

Formal and informal engagement has been undertaken with the Trust's Fire Officer, who at the initial OBC stage helped develop the latest layouts and made a number of comments which have informed the design and the way the fire strategy works. This has developed further at FBC stage, and further engagement has taken place including obtaining agreement to the design at key stages. A Letter of Support from the Trust's Fire Officer is included within the Fire Section within Section 2 of the Estates Annexe.

OFR Fire Engineering (fire engineering consultants) have been appointed through the Trust's P22 PSCP (Tilbury Douglas) to provide specialist fire engineering advice and to lead on all aspects of the compartmentation and fire strategy of the proposed new E&UCC. OFR are able to provide not just specialist technical expertise but have brought a degree of independence to the design. OFR have authored an FBC stage Fire Strategy Report, which sets out how the fire engineering of the E&UCC project will be achieved, along with details of compliance with all applicable standards.

The fire strategy document serves three key purposes:

- To provide relevant design information through performance specifications for fire safety provisions / features within the building.
- To assist in future works/ fire risk assessments by documenting the fire strategy for the building. The report details how the building should operate from a fire safety perspective; and
- For initial review by the relevant stakeholders, i.e. Building Control, Trust Fire Advisor and the Fire & Rescue Service.

A copy of the OFR report is included within Section 2 of the Estates Annexe.

The fire strategy is included within the Building Regulations application. The new building satisfies the functional requirements of the Regulatory Reform (Fire Safety) Order 2005 and the Approved Document B (Fire Safety) of the Building Regulations 2010. To demonstrate Building Regulations compliance, the proposed building's fire safety design is primarily based on the relevant recommendations of HTM 05-02: Firecode Guidance in support of functional provisions (Fire safety in the design of healthcare premises) (2015).

The latest project-specific Building Regulations Tracker is included within Section 3 of the Estates Annexe.

The E&UCC project incorporates all relevant fire safety systems, including:

- Fire detection and alarm system
- Emergency lighting
- Fire signage
- Hold-open devices
- Smoke / fire dampers
- Emergency power

Full details of the fire safety systems included are set out within Section 2 of the Estates Annexe.

5.11.2 Infection Prevention and Control

There has been early engagement with Infection Prevention teams during the OBC to establish the project's IPC principles, and they have continued to support the team through the FBC design.

The FBC stage design has been reviewed with the IPC leads, and no significant issues have been raised.

Initial consideration of details on door styles, sanitaryware and standards of finishes has been undertaken. The IPC team have also contributed to resolving a number of detailed design queries, which have been subject to an ongoing change control process throughout the FBC.

The design complies with HTM standards, Trust policies and requirements, and national standards and best practice; including incorporating key lessons learnt from the ongoing COVID-19 pandemic.

A Letter of Support from the Trust's Infection Prevention & Control lead is included within Section 2 of the Estates Annexe (Appendix 5.8).

5.11.3 Design versatility to support future pandemics

Given the recent impact of COVID-19, the design been developed to provide the Trust with versatility to support the Trust's response to potential future pandemics.

One of the main benefits of the new care pathway is that emergency walk-in, emergency ambulance, urgent care and referral centre patients are all streamed to the individual areas from the central waiting area.

Paediatrics remains segregated from adult access.

The floor design has clear departments and improved circulation and has the ability to control the movement of patients and staff providing greater control in the event of a Pandemic.

5.11.4 Privacy and Dignity

Privacy and dignity have been taken into account within the design. Within all public, patient and staff areas, male, female and disabled WC facilities have been provided. A "changing places room" is being provided elsewhere within the Trust estate. Sex-segregated changing rooms and showers have also been provided.

As a part of the unplanned care pathway, sex segregation between patients' bays is not a requirement, although isolation rooms have been provided for patients on trolleys and those fit to sit. All cubicles are rooms with hard partitioning providing both privacy and dignity to all patients and reducing the need for sex segregation.

5.11.5 Pharmacy

Pharmacy have been fully involved in the development and design of the new E&UCC both at a macro level and a micro level to ensure safe, compliant medicines management throughout the department and for all patient pathways.

The design of the new E&UCC facility takes into account the requirements of the Trust Pharmacy Team, along with best practice and lessons learnt from elsewhere. Each sub department has its own fully equipped clean utility for drug prep and safe storage of drugs through the use of Omnicells, as well as localised drug storage. The pharmacy department also has its own office location within the department so that dedicated pharmacists can effectively manage to take away medications (TTAs) and support smooth timely discharge of patients from the department.

Engagement has been undertaken with the Trust's Pharmacy Team at OBC stage which helped to develop an initial pharmacy strategy. This engagement has continued with a number of structured meetings, sign-off of plans, and liaison around various elements of the design. The pharmacy design has developed further at FBC stage, including obtaining agreement to the related aspects of the design at key stages. Evidence of the team's liaison with the Trust's Pharmacy Team is included as part of the healthcare planner's initial engagement to develop the size of rooms and the SOA, which is included within Section 2 of the Estates Annexe (Appendix 5.8).

5.11.6 Resilience to Threats and Hazards

The project has been designed to be resilient to threats and hazards appropriate to its use and location.

The design team completed a pre-construction information CDM questionnaire, which was issued to the Trust and returned. Designer's risk assessments have been completed as part of RIBA stage 2 for inclusion within overall risk register; and a Pre-construction information pack (PCIP) has been completed.

A dedicated security office / staff retreat is provided within the main entrance.

Access control and security has been reviewed as part of RIBA stage 3.

Both the layout and integration of additional features and facilities to improve social distancing, segregation and sanitising are above the recommended guidance within HBN 00-07 in response to Covid-19.

5.11.7 Maintenance, Repair and Lifecycle Costs

The FBC stage design allows for the later stages to address lifecycle value in relation to robust materials in heavily used areas which are intended to be of high quality, low maintenance, and hard wearing.

A full cleaning and maintenance strategy has been developed and will be further developed during the construction phase.

The current design includes for enclosed plantrooms to the front of the new ED department with other areas of external plant located in the courtyard infills and close to the department they are serving. All access to either internal and external plant will be safe and designed to meet the requirements of robustness and safety.

The scheme provides new air handling units, however all other plant is re-used as part of the refurbishment. All systems installed are being discussed and agreed with the Estates department to ensure products and components meet with their requirements for availability and their maintenance programme.

Access to plant areas and roofs will be required and engagement in the detailed design will take place to ensure the design responds to safe systems of work that meet the Trust aspirations

The Trust/MEP have also reviewed the FM strategy and lifecycle costs.

A full lifecycle cost analysis has been undertaken for the FBC, a copy of which is included within Section 4 of the Estates Annexe (Appendix 5.8).

5.11.8 Security

Security has been considered within the design, and the Trust's security team has been involved.

A Crime Impact Survey (CIS) was not initially requested by the planning officer within the planning deliverables at OBC stage; however, a CIS has now been undertaken as part of the FBC and Planning Application.

Strategic placement of soft/hard landscaping, street furniture and stone features as protective barriers to the new E&UCC development from the main approach/ patient drop-off turning circle have all been adopted. Consideration has also been taken to provide good supervision of the main entrance and waiting areas and general observation of patients.

Existing Entrances have been maintained with minimal alterations due to available space and the current system working well. The main Poplar Grove entrance has been retained to avoid public traffic routes through E&UCC.

Places of easy concealment have been avoided; and CCTV and security lighting provision has been included within the MEP design, along with staff attack and patient/nurse call systems. Consideration of potential vandalism and theft has been taken into account with the external envelope material selection and specification of external street furniture and planting.

Approval from the Trust Security Lead has been achieved via a series of meetings and sign-off of the plans. Details of the latest Security Strategy are included as part of the M&E design information within Section 2 of the Estates Annexe (Appendix 5.8).

A copy of the Crime Impact Assessment is included as part of the M&E design information in Section 2 of the Estates Annexe (Appendix 5.8).

5.11.9 Access to the Facility for Patients, Staff and Visitors; and Flow & Logistics

Safety and flow through the unit has been intrinsic to the design.

The clinical flow of patient areas has been carefully developed to ensure privacy and dignity of patients as they pass through public areas into triage, assessment and observation zones, and into more private treatment areas.

Ambulance access into the unit is maintained to the front of the facility as previous with a one door policy. In addition, the long-term impact of Covid-19, and how this may affect the control of infection and patient flow throughout the unit has been discussed and the design of the facility allows for better management and control of patient flow should future outbreaks occur.

Facilities Management (FM), sample drop-off, consumables and waste flow has also informed the design to ensure the traffic remains separated as much as possible from patient flow and prevent logistical challenges and building damage.

5.11.10 Requirements of Patients, Staff, Carers, and Visitors

The service model and design has been developed to meet the requirements of service users, staff, carers and visitors both in personal and shared accommodation and facilities.

5.11.11 Patient Experience

The design has been specifically developed in consideration of the experience of patients and is patient-centric in its approach. The new E&UCC will significantly improve the patient experience- as set out elsewhere within this FBC.

5.11.12 Purpose and suitability

The design of the building is fit for purpose and has been designed to take into account the needs of patients, staff, and visitors; flow and workforce; and is in line with the agreed model of care.

5.11.13 Adaptability

The building is adaptable for the needs of the Trust now and in the future

5.11.14 Adjacencies

The layout of the proposed building has been carefully designed to achieve all clinical and non-clinical adjacencies.

5.11.15 DH consumerism requirements & privacy and dignity

The proposed E&UCC complies with DH's consumerism requirements, including relevant guidance on privacy and dignity, storage space, and single-sex accommodation.

5.11.16 Travel Plan Compliance

The E&UCC design is compliant with the Trust's latest travel plan and transport strategy. This is discussed further in Section 5.17.

5.11.17 P22 Repeatable Rooms and Standard Components

The proposed E&UCC development follows the P22 procurement route cost reduction programme, including the incorporation of the use of repeatable room designs and standardised components to improve cost efficiency, innovation, quality and risk. In doing so, this allows for future flexibility to accommodate the increasing demands placed upon the Trust.

The C-sheets and room loaded layout plans are generally based on the P22 repeatable rooms layouts, with project and Trust specific elements incorporated.

P22 standard components have been incorporated where they are able to be, based on value for money and project-specific needs. Even where standard components are not fully utilised, the design still ensures that the scheme is compliant with the requirements of standardisation within P22.

Standard components utilised for the E&UCC project include furniture fixings and equipment (FF&E), IPS panels, sanitaryware, flooring, ceilings, lights, and wall protection.

5.11.18 Development Control Plan

The E&UCC development is fully in line with the latest Trust Development Control Plan (DCP).

A copy of the current Development Control Plan is included within Appendix 5.9.

5.11.19 Estates Strategy

The E&UCC development is fully in line with the latest Trust Estates Strategy.

A copy of the current Estates Strategy is included within Appendix 5.10.

5.11.20 Space Utilisation (Carter / Model Hospital)

The E&UCC project is fully compliant with Carter and Model Hospital efficiency recommendations regarding space utilisation; and the project has been designed to maximise space utilisation through the provision of numerous flexible and bookable spaces.

The proposed accommodation being provided as a result of the E&UCC project is all fundamental to the operation of the Emergency and Urgent Care department and as such is all classed as clinical accommodation.

By choosing to undertake the E&UCC scheme as a refurbishment/ new build extension within the existing ED/UTC location the Trust is deliberately maintaining a "hot core" of key acute hospital activity at the heart of the Stepping Hill Hospital site, which supports the ongoing estates strategy and emerging redevelopment proposals.

The ratio of proposed clinical to non-clinical accommodation is therefore 100%, which maintains (or even slightly improves) the existing clinical to non-clinical ratio.

Based on anticipated demand, the new development will be fully utilised.

5.11.21 Reduction in Backlog Maintenance

The E&UCC project results in a reduction in the Trust's Backlog Maintenance position.

The latest six-facet summary indicates a backlog of £46.2m and a budget backlog of £21.6m giving a total figure of £67.8, which when coupled with relevant on-costs gives a gross backlog figure of £106.5m.

The E&UCC project will deliver a reduction in the Trust's backlog position by addressing the issues within the areas being refurbished, as well as consequential reductions in other areas.

The reductions comprise:

- £808k for Block 94;
- £833k for the Emergency Department; and
- £448k for Block 41 (as a result of the Pacing enabling works project).

All of the above are included in the CIA model within Appendix 4.3.

5.11.22 NHS Premises Assurance Model (PAM)

NHS PAM is a management tool that provides NHS organisations with a way of assessing how safely and efficiently they run their estate and facilities services. It is a basis for:

- Allowing NHS healthcare providers to assure boards, patients, commissioners and regulators on the safety and suitability of estates and facilities where NHS healthcare is provided;
- Providing a nationally consistent approach to evaluating NHS estates and facilities performance against a common set of questions and metrics; and
- Prioritising investment decisions to raise standards in the most advantageous way.

The NHS PAM supports boards, clinical leaders and directors of finance and estates to make more informed decisions on the development of their estates and facilities services. It also provides important information to commissioners for use during the commissioning process and regulators in identifying risks.

The Trust's PAM has been developed, and has been reviewed in the context of the new E&UCC.

5.12. Modern Methods of Construction

The new Emergency and Urgent Care Development (E&UCC) incorporates Modern Methods of Construction (MMC) as an intrinsic part of the design.

In line with the Government 2019 statement "Presumption in Favour of MMC", the project has started out as being delivered by MMC from inception, which has continued through the OBC, the FBC stage design, and then into the pre-construction and construction stages of the project.

The previous OBC set out details regarding the choice of modern methods of construction / smart construction which the Trust and P22 PSCP had considered and chosen for the project. This section of the FBC updates this for the latest design and confirms how we have arrived at the preferred MMC method for the FBC stage design, as well as the current calculated percentage use of MMC for the E&UCC project.

5.12.1 Initial MMC Strategy

The initial strategy for MMC was set out at OBC stage, which has been reviewed and developed following the engagement and FBC stage design; and includes the following items applicable to this project:

- Implementation of P22 repeatable rooms;
- Structural main frame to be offsite manufactured;
- Main plant to be offsite modular;
- Cladding systems to be offsite modular;
- IPS panels to be offsite modular;
- Doors, frames and ironmongery to be offsite fully certified doorsets; and
- Reception desks and staff bases to be offsite Trespa and Corian.

The design team and PSCP have reviewed both an off-site precast solution; and a complete volumetric solution- however both of these have been discounted as this project is a refurbishment utilising an existing steel frame and drainage positions, and in addition it would not be possible to construct this in the extremely constrained site location with insufficient site access through the hospital to facilitate large deliveries.

Offsite construction has also been reviewed as a potential for repeatable rooms and sanitaryware pods.

5.12.2 Design Team MMC Development

The E&UCC Design Team are incorporating MMC into the design, which has been reviewed in the context of the DHSC drive to make best use of Modern Methods of Construction (MMC) by dividing into three main categories that use standardisation and offsite techniques, combined with digital design and engineering to optimise the construction process; particularly with this highly complex 24/7/365 live hospital sites such as Stepping Hill. These three categories set traditional construction as benchmark and are as follows:

- Manufactured – High levels of standardisation of both process and components;
- Volumetric – Fully fitted modules; and
- Components – Standardised design elements.

The purpose of testing the potential to use MMC is for one of four main reasons:

- Health and Safety (reduction of site activity);
- Time (Reduction in overall programme);
- Quality (Factory production methods); and
- Workforce/Labour (Reduction in site labour and specialist skills).

All of these can also positively impact on cost.

Like most new build major hospital developments, during the design and construction of the E&UCC Project we can test the opportunity of introducing MMC across four key disciplines:

5.12.3 Structural Systems

The New Build elements will be constructed by steel frame system with metal decking all recut and sized off-site due to site constraints, and to achieve speed of construction which is essential to the project delivery.

The external wall will be constructed from Structural Metsec Panels pre-fabricated and assembled off-site and craned into each façade area.

The following options were considered within the FBC stage design, although were not viable due to the complex nature of the project and the size and location of each phase: Flat Slab Concrete Variants; Hybrid Precast Concrete Variants; DfMA Concrete Variants; and Precast; Panelised Modular; and Volumatic Modular.

5.12.4 Facade

A range of façade systems can be utilised for the E&UCC project. These include unitised facades; curtain walling; and structural framing systems (SFS). All systems will be pre-assembled and sized offsite to reduce waste and promote speed of construction.

5.12.5 Building Services

The building services team have developed the design, and the following MMC M&E components have been incorporated/ are to be incorporated into the E&UCC project:

- All plant and plantroom equipment will be factory assembled and delivered as complete units, including switchgear, generators and oil stores, free standing flues, pump rigs, medical gas equipment, air handling units, thermal plant, and extract fans.

Other MEP assemblies and components include:

- Distribution spines in corridors;
- External buried concrete ducts;
- Roof mounted racks; and
- Risers, where these are complex multiservice assemblies.

Components, such as:

- Pre-plumbed bed head trunking;
- Pre-plumbed IPS units;
- Valve arrays to air handling units;
- Manifolds for medical gasses;
- Pre-assembled distribution boards;
- Valve arrays to terminal units;
- Control sections to mechanical equipment assemblies;
- Packaged plantrooms; and
- Modular wiring.

5.12.6 Architectural Finishes

The following MMC architectural components have been incorporated/ are to be incorporated into the E&UCC project:

- Doorsets;

- Glazed screens;
- IPS panels (see building services also);
- Reception designs; and
- Specialist fitted furniture and joinery.

5.12.7 P22 PSCP Development of MMC

The P22 PSCP has reviewed MMC as part of their design work. This has built on the initial design work undertaken, and then the OBC stage design; and this has been incorporated into a single MMC strategy and plan.

The MMC construction strategy includes the following items:

- Corridor service modules – 6m long service modules containing all the primary services in the corridor ceilings
- Modular wiring – ‘plug and play’ technology
- Pre-packaged and commissioned service risers – full MEP risers made offsite and lifted in place as the building frame is installed
- Pre-fabricated clinical service panels – in a similar method to the IPS panels, wall mounted clinical panels are fully fitted offsite and installed in one operation.
- Lightweight steel framing in lieu of hot rolled steel for AHU enclosures
- Collaborative digital onsite control for quality and safety inspections
- Drone surveys of existing buildings for informing early design, without the need for scaffold
- Use of AR and VR for Client visualisation
- Off-site manufactured plant skids
- Incorporate repeatable, standardised systems and components across all buildings on site to ease maintenance and spares stocks
- The use of standardised components and repeatable rooms also allows streamlined decision-making, saving hours of consultation time
- BIM - Digital engineering. Focus on making sure the models are fully integrated across the entire supply chain, and instilling a philosophy of ‘build once in the virtual environment, once on-site’
- Collaborative partnerships such as that between Tilbury Douglas Construction and Tilbury Douglas Engineering Services
- Next generation Building Management Systems - Efficiencies are gained through real-time optimisation of the building systems, using connected devices to monitor and maintain services
- Early engagement and open collaboration with specialist chain allow for a more open process that drive out unnecessary risk allowances and promotes innovation, giving suppliers the opportunity to work together at a time when their input can have the greatest impact.
- Use of the BIM model to carry out ground works and accurate setting out of the building
- Use of BIM Model for communication including user engagements and on-site management toolbox talks and understanding
- Potential for prefabricated / premade reinforcement for piles and pile caps
- Reinforcement matt for slab rather than mesh and hand delivery simple roll out and install
- Plastic drainage longer lengths more cost effective and less breakages
- Pre-cut metal framing improving speed of install and health and safety
- Windows pre-glazed complete with brackets improves speed and quality
- High insulated walls within a narrow lean construction improving U values and driving down energy requirements
- Steel floor beams using slim beam construction to match into existing floor levels
- Pre-wired distribution boards

- Use of wireless technology where possible
- Ensuring the building supports integration with smart systems (Smart Building technology)
- Pre-cut components such as plasterboard, the largest contributor of waste
- Pre-assembled FFE complete within MEP system installed ready for one connection point
- Pre-glazed screens
- Standardise details of the external envelope

5.12.8 Estimated Percentage of MMC within New Building

At FBC stage the Trust estimates 57% of total project footprint will be applicable to off-site construction methods due to the high-level percentage of repeatable rooms. This is subject to further review, and due consideration of the site constraints. A MMC calculator is being populated at each RIBA Stage showing the core rating achieved.

An MMC calculator has been populated at FBC stage showing the core rating achieved. This is included within the project specific MMC Strategy and Plan, which is included within Section 2 of the Estates Annexe (Appendix 5.8).

A summary of the MMC for the E&UCC project is set out in the figure below:

Figure 72. Modern Methods of Construction

P22 MMC UTILISATION ASSESSMENT TOOL - PERCENTAGE													PROCUR					
Project: Stockport ED		Stage: FBC		The ultimate aim is to maximise the utilisation of MMC with low carbon intensity														
PSCP: Tilbury Douglas		Date: 09/03/2022																
Trust/Client: Stepping Hill Hospital		Version: i.e. V1																
BCIS PROJECT ELEMENT Complete Element rows relevant to the Project. Rows/Elements can be merged/grouped together to reflect the way the Project is being delivered.		PERCENTAGE OF BCIS BUILD COST (excl design & prelims/site accommodation and facilities) Replaced these example figures with actual, where available from elemental cost analysis.		CIRIA/P22 MMC CAT# TO BE UTILISED From MMC Categories tab. Multiple categories can be included for each element. Insert "Y" in drop down where applicable.							MMC DESCRIPTION High level details of MMC options to be utilised for the element. Covering all MMC Categories to be utilised including off-site manufacturing (PMV)		% MMC OF ELEMENT Project team inserts estimate based on MMC Categories & description	% MMC OF PROJECT Resultant MMC % estimate for element & Project	CARBON INTENSITY INDICATOR relative to NHS Net Zero Carbon Building Standard			
				(Tier 1 elements highlighted)		High intensity		Medium intensity		Low intensity								
													Use the drop down list to indicate the design's carbon intensity compared to Net Zero standard					
1		SUBSTRUCTURE													EMBODIED CARBON	OPERATIONAL		
1.1		Substructure		7.7%									Pre-fabricated Shutters Pre-made Reinforced Pile Cages Pre-made reinforced Pile Caps		30.0%	2.3%	Medium	Low
2		SUPERSTRUCTURE																
2.1		Frame		3.1%									Steel Frame Off Site Painted Off Site fire protection Safety Systems handrails bolt ons incorporated Handrail to stairs lifted in With Stairs Metal Decking Pre-cut		60.0%	1.9%		
2.2		Upper floors		7.1%									Pre-Made reinforcement matts Shear Studs pre welded Precast planks		58.0%	4.1%		
2.3		Roof		3.9%									Kalzip Roof Construction Pre-made Gutters Longspan to reduce pulirs requirements		58.0%	2.3%		
2.4		Stairs and Ramps		0.6%									Precast Stairs with integral landings and Handrails		40.0%	0.2%	Medium	Low
2.5		External Walls		3.5%									Metsec Walls premade Offsite with Outside weather board Precut Insulation systems Precut click and install Cladding systems Optimised Internal Drying boards cut to sizxe to reduce waste		58.0%	2.0%		
2.6		Windows and External Doors		5.1%									Windows Pre glazed with brackets added Windows already installed within Metsec wall system		58.0%	3.0%		
2.7		Internal Walls and Partitions		6.5%									All Studs Measured and cut to reduce waste Optimised wall Baords to building Height Corridor Modules fitted with Top down wall construction to reduce fire stopping requirement Pre fabricated IPS Panels Repeatable room P22		45.0%	2.9%		
2.8		Internal Doors		4.0%									Door sets to all areas Pre finished Ironmongrey factory installed Pre made and completed Sliding Doors Pre Made Nurse Corner bases		58.0%	2.3%		
3		INTERNAL FINISHES																
3.1		Wall Finishes		3.7%									Wall Protection and Trovex Wall finishes cut and off site measured and installed Artwork requirements		60.0%	2.2%	Low	Low
3.2		Floor Finishes		2.4%									Standard P22 components used		70.0%	1.7%	Medium	Low
3.3		Ceiling Finishes		2.0%									Standard P22 components used		70.0%	1.4%	Low	Low
4		BUILDING FITTINGS &																
4.1		Fixed Fittings and Equipment		4.0%									Pre-made Units everything made off site Offsite manufactured reception desks Use of Repetable Rooms P22 Components and Suppliers		40.0%	1.6%		
5		SERVICES																
5.1		Sanitary Installations		1.0%									Pre-plumbed IPS and Saitaryware Units P22 Components Pre-fabricated Pods		63.0%	0.6%	Low	Medium
5.2		Services Equipment		0.0%									primary services in the corridor ceilings		63.0%	0.0%	Medium	Medium
5.3		Disposal Installations		1.0%									Modular wiring - 'plug and play' technology		63.0%	0.6%	Medium	Medium
5.4		Water Installations		8.7%									Pre-packaged and commissioned service risers - full MEP risers made offsite		63.0%	5.5%	Medium	Medium
5.5		Heat Source		3.5%									and lifted in place as the building frame is installed		63.0%	2.2%	High	Medium
5.6		Space Heating and Air Con		4.2%									Prefabricated clinical service panels - in a similar method to the IPS panels,		63.0%	2.6%	Medium	Medium
5.7		Ventilation Systems		4.2%									wall mounted clinical panels are fully fitted offsite and installed in one operation		63.0%	2.6%	High	Medium
5.8		Electrical Installations		9.9%									Pre-wired distribution boards		63.0%	6.2%	Medium	Low
5.9		Fuel Installations		0.0%									Use of wireless technology where possible		63.0%	0.8%	Low	Low
5.10		Lift and Conveyor Installations		4.4%									Ensuring the building supports integration with smart systems (Smart Building technology)		63.0%	2.8%	High	Low
5.11		Fire and Lightning Protection		0.0%									Other MEP assemblies and components include:		63.0%	0.0%	Low	High
5.12		Comm, Security & Control Systems		5.8%									Distribution spines in corridors; External buried concrete ducts; Roof mounted racks; and Risers, where these are complex multiservice assemblies. Components, such as:		63.0%	3.7%	Medium	Medium
5.13		Specialist Installations (Med Gas/Eq BWIC with Services		3.2%									Pre-plumbed bed head trunking; Pre-plumbed IPS units; Valve arrays to air handling units; Manifolds for medical gasses; Pre-assembled distribution boards; Valve arrays to terminal units;		63.0%	2.0%	Medium	Medium
5.14				0.5%											20.0%	0.1%	Medium	Medium
6		EXTERNAL WORKS																
6.1		Site works		0.0%									TBC		10.0%	0.0%	Medium	High
6.2		Drainage		0.0%									Use of Plastic Drainage Systems Re-use Demo Material for pipe bedding and surrounding		40.0%	0.0%	Low	Low
6.3		External services		0.0%									Adam Gilbertston		30.0%	0.0%	Medium	Medium
Total				100.0%												56.9%	Medium	Low

5.13. Sustainability, Energy and Carbon

The new E&UCC development meets the requirements of DH energy and sustainability targets. The project achieves significant improvements in estates provision, including environmental, energy consumption, maintenance, and backlog; as well as maintaining space utilisation and an efficient use of the Trust's estate, including:

- Energy usage;
- Carbon footprint; and
- BREEAM Very Good rating.

The refurbished building has been designed to meet all current standards for environment, energy, and carbon where possible within the existing hospital and project constraints.

5.13.1 Trust's Green Plan

In 2015 the United Nations Paris Agreement was adopted by 191 countries with the aim of reducing greenhouse gas emissions and keeping the rise in average global temperatures to less than 2°C (3.6 °F) above pre-industrial levels, with an ultimate ambition of 1.5 °C (2.7 °F).

In 2020 the NHS published its strategy *"Delivering a 'Net Zero' National Health Service"*, highlighting that one of most significant challenges to the health care system is the climate emergency.

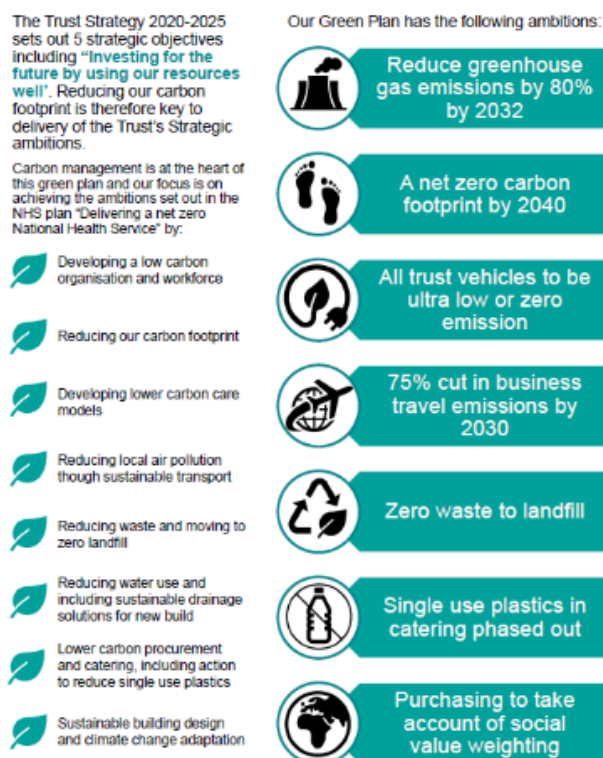
The Trust has therefore set out a comprehensive "Green Plan", in line with the Trust's Objective to *"support the health and wellbeing of our communities and utilise our resources in an efficient and effective manner"*.

The Green Plan *"sets out the progress and future actions required to reduce our impact on the environment and help address the climate emergency. It is the Trust's ambition for the emissions we control directly - our carbon footprint - to reach net zero by 2040, with an initial 80% reduction on our 2012/13 baseline by 2032. For all other emissions that we can influence - our Carbon Footprint Plus - we aim to reach net zero by 2045, with an 80% reduction by 2039. We will keep these targets under annual review and, where possible, we will move further and faster with our ambitions, subject to available resources. In addition, we will undertake a full review of progress and action plans every three years."*

A summary of the Trust's Green Plan is set out below.

Figure 73. Summary of Green Plan- Feb 2022

2. Our Green Plan on a Page



5.13.2 Building Research Environmental Assessment Method (BREEAM)

The new facility has been designed to achieve a Building Research Establishment Environmental Assessment Method (BREEAM) “Very Good” rating as it is predominantly a refurbishment project.

BREEAM outlines the standards, in line with best practice, in sustainable building design, construction and operation and is recognised as the most effective measure of the environmental performance of a building.

The Trust has appointed Ridge as specialist BREEAM advisors through Tilbury Douglas; who have been involved during the OBC and FBC stages, and have undertaken full reviews of targeted credits, and are working with the Trust to ensure these credits are achieved at the relevant stages.

A BREEAM pre-assessment has been completed including:

- Review of current design team documentation prior to the pre-assessment review;
- A pre assessment review workshop with the design team and client to establish a formal target and assign responsibility; and
- Registration with the BRE under BREEAM New Construction 2018.

An initial BREEAM design stage assessment has been undertaken; and should all of the targeted and potential criteria be pursued the building we would achieve a score of 58.7%; which is captured within a BREEAM credits tracker. All critical actions for Stage 2 BREEAM compliance have been completed.

The BREEAM credits tracker has been updated to reflect the FBC stage design and includes details of all of the credits discharged to date.

A copy of the BREEAM Pre-Assessment Report and the latest BREEAM Tracker are included within Section 2 of the Estates Annexe.

5.13.3 Energy Usage

The new E&UCC development meets the requirements of DH energy targets. The project achieves significant improvements in energy consumption and maintains an efficient use of the Trust's estate.

The new building has been designed to meet all current standards for energy, and will minimise energy consumption in use, where possible.

Passive design initiatives focus on the new build elements of the scheme and include:

- Solar shading on northeast to control solar gain
- Locate new office accommodation on external façade to facilitate natural ventilation
- New build element fabric and air tightness properties that exceed Approved Document Part L minimums

The Trust is targeting BREEAM Very Good, including required energy standards.

The following active energy saving initiatives are also considered:

- Where natural ventilation is not feasible, new AHUs for majority of both new and refurbished areas incorporating electronically commutated fans (fans represent an enormous potential for energy savings to reduce carbon emissions, as they are among the largest single users of energy in healthcare estates)
- New LED lighting throughout per ‘Delivering a Net Zero National Health Service’ Guidance and complete with presence/absence detection to minimise energy use.
- High efficacy levels specified for all lighting systems throughout the scheme
- High efficiency HRUs (Heat Recovery Units) for ventilation provision wherever practicable
- Heating, Ventilation and Air Conditioning (HVAC) and lighting systems to operate ‘on-demand’ wherever practical, or with system ‘set back’ control
- Automatic control routines to ensure HVAC systems are enabled/disabled at optimum times (i.e. latest possible start-up time and earliest shut-down time)
- PV array installation

A copy of the latest project-specific Sustainability and Embedded Carbon Report is included within Section 2 of the Estates Annexe.

5.13.4 Carbon Reduction / Net Zero Carbon

The project's carbon reduction strategy was developed as part of the OBC and has been progressed further at FBC stage. The Trust is doing all it can to achieve carbon reduction, and the Trust is actively considering carbon reduction as part of the design and how this can be improved by the E&UCC project. The Trust would welcome developing a net zero carbon solution; however, acknowledges that the nature of the project as a refurbishment, and then previous capital allocation does not currently allow for this.

No final decisions have been made on materials (for embodied carbon), transport and plant, nor life-cycling. All of this will be developed further as part of the construction stage design.

A copy of the latest project-specific Sustainability and Embedded Carbon Report is included within Section 2 of the Estates Annexe.

5.13.5 NHSE&I Sustainable Development Unit

The Trust will engage with the NHSE&I Sustainable Development Unit during the next stage of the project, should this be required.

5.14. Alignment of Chosen Procurement with HM Government Policy Objectives

The Trust's chosen procurement strategy of the DHSC P22 Framework aligns with HM Government's policy objectives; and allows the Trust to meet these objectives throughout the contract period.

5.14.1 SMEs

The Trust is working with the P22 PSCP to ensure SMEs are encouraged throughout the supply chain. In order to achieve this, the Trust has, in conjunction with the PSCP:

- Engaging with local labour and supply chains;
- Holding a number of "meet the buyer" events with the PSCP and Trust;
- Developed a procurement strategy which embraces local suppliers and sub-contractors (a copy of the FBC stage procurement strategy is included within Section 4 of the Estates Annexe;
- Obtaining a commitment from the PSCP for a minimum % of local spend (currently set at 80%+ of the spend to be spent locally);
- "Building in" spending local within the PSCP's operating plan;
- Encouraging wider engagement with community and local businesses (eg catering);
- Recording where local spending has been achieved;
- The P22 PSCP engaging with their Tier 1 supply chain to understand their own supply chains and identifying opportunities to improve local investment with local SMEs and organisations; and
- Developing local social value charters which place emphasis on, and require significant commitments around social value and the engagement of locally based SMEs.

5.14.2 Prompt Payment

The Trust is committed to paying all external consultants and all contractors promptly, and in line with the agreed payment terms, in order to maintain cashflow through the supply chain. This is also built into the Trust's P22 Stage 4 contract documentation with the P22 PSCP.

5.14.3 Social Value

The Trust remains fully committed to social value. The Trust will work with the selected PSCP to deliver community and social benefits as part of the beneficial project outcomes. In order to achieve this, the Trust will:

- Provide a project-specific community liaison/ corporate social responsibility manager;
- Establish regional relationships with local training, employment, and education providers; and
- Work within the existing communication and engagement plan.

As part of the E&UCC project, the Trust's P22 PSCP Partner (Tilbury Douglas) have developed a project-specific Social Value Plan. The E&UCC Social Value Plan has been developed as a vehicle to deliver employment opportunities, develop skills, and improve environmental sustainability. Our key priorities are to:

- Give Back to our communities;

- Deliver opportunities for all;
- Improve health, wellbeing and safety; and
- Improve the environment.

The E&UCC project is currently anticipated to deliver a 39% (£7.68m) Social Value Return on Investment achieved through the deliverables below. This figure will be updated as the project progresses, and the national TOMs calculator will be used to provide monthly reports on progress against our targets.

Project-specific deliverables include:

- 80% orders placed with SMEs (£16m);
- 50% spend within 30 miles (£10m);
- 1 Meet the Buyer event;
- 28 hours supporting SMEs;
- 7 new employment opportunities;
- 168 apprentice weeks (1 X commercial and 1 X technical for the 84-week programme);
- 12 weeks work placement (2 x 6 weeks);
- 8 events supporting education (Inc Site Tours) – Stockport Grammar School 3-18 yrs & Stockport College, Construction and Building Services Course;
- 80 hours 'Give a day of your time' Volunteering – site team to select activity:
<https://stockportvolunteerhub.org.uk/volunteer-roles/#:-:text=Making%20Space%201%20To%20volunteer%20at%20Stockport%20Open,signpost%20people%20to%20other%20service%20when%20appropriate.%20>
- £2,000 raised – Stockport NHS Charity;
- £2,000 donation in kind - Trussell Trust Food Bank / Easter Eggs/ Selection Boxes;
- Resident Mental Health First Aider;
- 40+ Considerate Constructors Score; and
- Armed Forces Covenant Commitment, Women in Construction & Black Professionals in construction.

The plan focusses on early market engagement involving all tiers of the supply chain including product manufacturers, SMEs and VCSEs. This allows us to embed social value in what we buy and identify opportunities for innovation and modern methods of construction.

We are using consistent tools, frameworks and practices to communicate value drivers to the market. We are conducting robust evaluation processes to ensure compliance with public procurement rules and best practice set out in PPN 06/20 by central government.

Collaboratively we are setting critical success factors encompassing social value to influence the project scoreboard. The scoreboard will be managed by senior responsible owners both contractor and client side. A shared focus on outcomes, rather than scope, will unlock innovation and drive continuous improvement and commercial advantage.

We will ensure that solutions put forward by potential suppliers are accompanied by a whole life carbon assessment. This will be conducted in collaboration with the wider supply chain, reflecting ways of minimising the GHG emissions across the life of the asset in order to meet Tilbury Douglas's target to be carbon neutral by 2023.

The latest project-specific Social Value Plan is included within Section 5 of the Estates Annexe.

5.14.4 Sustainability

The Trust is committed to meeting all applicable sustainability targets via the chosen procurement route. This is described in more detail in Section 5.13.

5.14.5 KPIs

The P22 Framework incorporates a specific Performance Management Plan (PMP), which sets out the processes to be used by DH to measure, monitor and, where necessary, manage the performance of the PSCPs in delivering their obligations under the Framework Agreement. The PSCP remains directly responsible to the Trust for the delivery of the project.

Performance management focusses on compliance and performance under both the Framework Agreement and Trust-specific Scheme Agreement, comprising one or more individual project level contracts between the chosen PSCP and the Trust. The PMP also extends to the PSCP's subcontractors where performance obligations contained within the PMP are undertaken by or impacted by the PSCP's supply chain.

The PSCP is obliged to comply with the requirements of the PMP and fully participate in the processes within the prescribed timescales.

The PMP comprises both performance tracking (data collection and reporting) and review. The performance tracking comprises:

- Project Monitoring (Monthly Monitoring System);
- Project Key Performance Indicators and Project End Reviews;
- Project End Reviews;
- Health Checks; and
- Framework Monitoring.

The reviews comprise:

- Yearly performance review meetings between DH and PSCP and PSCP Chief Executive;
- Twice yearly performance review meetings between DH Implementation Advisors and PSCP; and
- Unscheduled review meetings as required by DH at its sole discretion.

All of the above is being undertaken by the P22 PSCP (Tilbury Douglas) and is being overseen by the Trust.

5.15. Government Construction Strategy

The Government Construction Strategy published in May 2011 emphasises the need for designers and constructors to work together to develop an integrated solution that best meets the required outcome and for contractors to engage key members of their supply chain in the design process where their contribution creates value. The strategy validates the approach for frameworks whilst assessing the effectiveness of existing arrangements. Additional elements of the strategy outline the need to incentivising cost and programme efficiency via pain /gainshare, encouraging off site fabrication and genuine integration of tier 1 supply chain partners. These are most effectively delivered via a well-structured framework environment.

The elements of the strategy have been considered fully during the procurement review. The procurement route was chosen as the Trust considered this the best route to obtain the best possible value for money and which is compliant with an agreed and signed off design.

The proposed solution is compliant with HM Government construction strategy, including:

- Cost reduction;
- Procurement reform;
- Building information modelling (BIM);
- Government 'soft landings'; and
- Benchmarking.

5.15.1 Cost Reduction

The proposed new development achieves a substantial revenue benefit, as set out within the Financial Case, and supports the Trust's Cost Improvement Plans (CIPs). This is achieved through:

- Implementing Phase one of the Trust's Development Control Plan;
- A reduction in backlog; and
- A reduction in reactive maintenance and running costs.

5.15.2 Procurement Reform

The design and construction works for the new E&UCC are procured through the DH's ProCure22 framework. The technical consultants are appointed through the NHS SBS Construction Consultancy Services Framework. All procurement complies with Trust SFIs and best practice. This is set out in more detail in Sections 5.1 and 5.2.

5.15.3 Building Information Modelling (BIM)

The proposed development is designed to Building Information Modelling Level 2 standards to increase productivity and collaboration through technology

A BIM Execution Plan (BEP) was developed during the OB, which has been refined and updated for the FBC. The FBC Stage BIM Execution Plan is included within Section 1 of the Estates Annexe.

5.15.4 Government 'Soft Landings'

The Trust is committed to a "soft landings" approach to completion, which has been "built in" to the Trust's ProCure22 contract with the PSCP; and fully integrates with the Trust's transition planning.

5.15.5 Benchmarking

Key aspects of the FBC have been benchmarked, including:

- A review of the clinical model against other Trusts and national best practice has been undertaken at OBC stage through the Healthcare Planner;
- Staffing costs have been peer reviewed against other projects and against national data;
- The capital works costs have been built up using rates from other similar projects; and have been reviewed and benchmarked by the PSCP; and
- Key elements of the Schedule of Accommodation have been benchmarked against other similar schemes and room standards.

5.15.6 Trust Policies

The design takes into account relevant Trust policies and procedures.

5.16. Statutory Considerations

5.16.1 Planning

The new E&UCC development requires full planning approval from Stockport MBC as the Local Authority. As this is a refurbishment of an existing footprint the planning process is a simple process, and we expect to have swift approval in line with our programme of works.

The Trust has employed Lichfields as its Planning Consultant to manage the process and engagement with planners, to ensure the submission is accurate, and approval is given in line with the agreed timescales.

The Trust has engaged with the Local Authority throughout the development to date, and the planners are supportive of the new development. An initial Letter of Support was received at OBC stage, and the Trust and Lichfields have continued to engage with the Local Authority through the FBC stage, including with the Full Planning Application, any additional information required, and emerging conditions.

The planning application is minor in nature, and we are anticipating this will be approved prior to the Joint Investment Committee.

The Trust consider the nature of the risks relating to parking, transport, and impact on residents to be relatively low; and no more significant than other major developments undertaken at the Stepping Hill site.

The planning application was made on 5 April 2022, and full and final planning approval is anticipated to be received at the very latest by 7 July 2022, which is based on the very conservative assumptions of allowing for a planning approval period of 13 weeks, the requirements to work around purdah, and taking on board the fact that there is no planning committee meeting in May.

The Trust's Project Delivery Team, planning consultants, and LPA Case Officer have all worked closely throughout the process to resolve the various ongoing queries, which were promptly resolved by all involved. There has been local positivity and lack of objection towards the development to date, all of which will support a swift approval process by the LPA team.

The planning application formally applies for the physical construction of the E&UCC development new building areas and the demolition and refurbishment zones- all identified within the submitted documents.

As appropriate to a development of this size and nature, the consent will be subject to a series of planning conditions which include pre-commencement and pre-occupation conditions, none of which are anticipated to be unreasonable or unexpected.

A planning condition tracker document has been produced and will be used to actively monitor and manage the process of discharging all planning conditions at the earliest opportunity, and prior to pre-commencement/ pre-occupation as appropriate.

Planning Application Strategy

The Trust and project Design Team agreed early on in the project to adopt a pre-application and full planning permission strategy, considering programme, effectiveness, delivery confidence and value for money.

The alternative and more traditional process of submitting an outline planning application (13-week target determination period) followed by reserved matters planning application (also 13-week target determination period) provided a much longer programme to obtain an outcome decision. The level of information required for an outline application has also become increasingly similar to a full application in recent years, therefore, after careful consideration a pre-application/full application strategy was adopted.

Planning Pre-Application Process

The Trust adopted a formal town planning pre-application process with the LPA to secure support for the principle of development, feedback on the planning application strategy and programme (based on a full planning application post pre-application engagement), and feedback on the emerging detailed design in terms of size, scale, and access arrangements based on at least 1:200 level of detail.

Pre-Application Planning Meeting

Lichfields have been appointed as the Trust's planning consultant for the project and they are the single point of contact for the LPA. They have been in constant contact with the planning officer and carried out a pre-application meeting on the 5 January 2022. Following this the LPA formally responded to the Pre-Planning Application submission on 9th February 2022 and provided no objections in principle to the current proposals in terms of size, scale, layout and principal use; along with some minor comments. These comments have been addressed as part of the final submission.

Planning Application Response and Approval

Now the full Planning Application has been submitted, it is being followed up Lichfields to ensure we keep in touch with the LPA and allow us to react to any further information or comments they may have. The Trust has also requested early sight of the conditions so we can commence work on the information for discharge particularly on those that may be pre-commencement conditions.

As the project isn't increasing vehicle or traffic movements that are notifiable in the planning submission and a large percentage of the project falls under refurbishment, we expect that any conditions applied will be low in number and will be completed within our programme timeline.

5.16.2 Building Regulations

The project is fully compliant with Building Regulations.

The project has been registered with Building Control, and ongoing dialogue is being held as part of the design process on a monthly basis.

A Building Control Authorised Inspector has been appointed, and a rolling project-specific Building Regulations Tracker is being updated on a regular basis.

Further information, including the latest project-specific Building Regulations Tracker is included within Section 3 of the Estates Annexe.

5.16.3 PLACE

The Trust has a PLACE assessment, which will be improved as a result of the new development.

The new E&UCC will provide a purpose-built facility which ensures that the environment and buildings are providing a clear message of Stockport's intention to be compliant in all aspect of these audits. The building design and environmental planning, alongside the inclusion of innovative practices and advances in

technological equipment and resources, ensures the service will also have appropriate levels of sustainability, and future proofing, for many years to come.

The process for designing the new facility has been inclusive of patients and both clinical and non-clinical staff input, and reflects the experiences of both groups in its final iteration and delivery.

Throughout the design process environmental efficiency around energy use and Co2 emissions have been taken into account.

5.17. Travel and Transport

Highways, and specifically parking, was raised as a potential challenge at the early pre-application discussions with the Council, which included Highway's representatives.

It was subsequently demonstrated that as part of the justification for the planning application that the new E&UCC does not increase activity for either patients or staff across the site, but merely streams them in a different way, with a view to reducing blockage and ultimately putting less pressure on parking within the campus. This has been accepted by the Council, and is being incorporated within the Planning Application, which makes efforts to provide additional parking across the campus in a series of unused or newly vacated locations.

No car parking spaces will be lost as part of the scheme. Phase 3 of the latest Development Control Plan also shows a multi storey car park.

Public transport is unchanged.

The E&UCC design is compliant with the Trust's latest travel plan and transport strategy, which have been developed by Stockport MBC and AECOM in conjunction with the proposed E&UCC scheme.

Further details, including the latest AECOM Transport Assessment and Travel Plan are included within Section 3 and Section 6 of the Estates Annexe.

Externally, the existing blue light route has been re-directed to align with the new Ambulance Arrivals and RATS entrance whilst also providing a direct link through to the new HASU. The new design also incorporates a non-pedestrianised area outside of the HASU extension preventing direct thoroughfare for public and improving the privacy and dignity of patients from that of the current system. New ramped access has been introduced to both the Bereavement Suite and SDEC extensions to address the change in levels across the site. This also provides direct family access to Bereavement, a discreet external link from Bereavement to Mortuary and external point of escape from SDEC.

5.18. Engagement and Assurance

5.18.1 Engagement

The Trust has undertaken extensive engagement with developing the OBC and FBC. The engagement sessions held to date are included in Appendix 7.10.

5.18.2 Senior Oversight

The design has been subject to review, approval, and oversight from senior clinical colleagues and also from the Trust's Executive Team; and all approvals have gone through the appropriate levels of governance.

5.18.3 Visits to Similar Sites

The Trust has undertaken some site visits to other similar recently completed facilities; however extensive visits have not been possible due to the ongoing COVID-19 pandemic.

A visit to Manchester University NHS FT's new UTC and new ED build at Wythenshawe hospital was undertaken in February 2022, with further visits planned for later in 2022 and beyond.

In addition, the Trust is working closely with Tameside and Glossop Integrated Care NHS FT on their parallel ED and UTC project to share learning.

5.18.4 Design Assurance

Internal peer reviews have taken place as part of developing the concept design.

Key elements of the Schedule of Accommodation have been benchmarked against other similar schemes and room standards.

5.18.5 Healthcare Planner Review

Spencer Harrison have acted as healthcare planners to date and to inform development of the OBC and FBC; this appointment has continued (as required) through the development of the FBC. The design team has worked closely with Trust clinicians to understand the clinical and non-clinical adjacencies, and the design is being further challenged and appraised as the scheme progresses.

5.18.6 P22 Design Assessment Tool (DAT)

The P22 Design Assessment Tool (DAT) toolkit is used to evaluate how the design meets the investment objectives. A DAT workshop has been undertaken in March 2022, with the results included within Section 2 of the Estates Annexe (Appendix 5.8).

5.18.7 P22 Repeatable Rooms and Standard Components

The proposed E&UCC development under the P22 procurement route cost reduction programme has incorporated the use of repeatable room designs and standardised components to improve cost efficiency, innovation, quality and risk. By doing so, this has allowed future flexibility to accommodate the increasing demands placed upon the Trust.

The design also adopts a number of the P22 standard components.

The use of P22 repeatable rooms and standard components within the E&UCC project is set out in further detail in Section 5.10 above.

5.19. Construction and Deliverability

5.19.1 Construction methodology

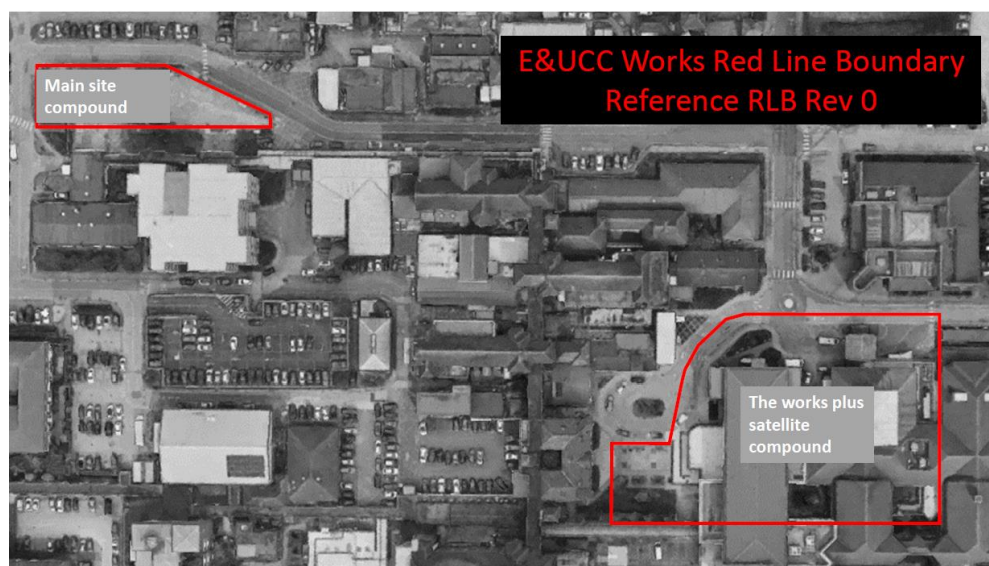
The new E&UCC development will be wholly constructed by the Trust's P22 PSCP partner (Tilbury Douglas), with the Trust directly managing, supplying, and undertaking the installation of equipment, installation of IM&T, commissioning, fitting out, training, and occupation.

The new E&UCC facility will be a combination of both new real estate extensions and courtyard infills tied into the existing building(s).

The construction works are being undertaken on a phased basis whilst keeping the existing departments fully operational. Completion of the project will therefore be on a phased basis, with the service transferring into each phase as it completes and is commissioned. Full details of the construction methodology and phasing are included within Section 5 of the Estates Annexe (Appendix 5.8).

The proposed construction red line is set out in the figure below:

Figure 74. Proposed Construction Redline Boundary



5.19.2 Phasing

The E&UCC project is being constructed across five main phases, all of which are being undertaken whilst keeping the existing departments open and operational.

Significant work has been undertaken on the phasing and sequencing, including detailed review sessions with all key parties and a number of iterations. The phasing has also been subject to value engineering, as discussed further in Section 5.5. The latest phasing plan is included within Appendix 5.11, and is summarised below:

- Phase 1a involves the decanting of Paediatrics, Pacing (into Block 41), Medical SDEC, and the staff rest area; whilst commencing works to the bereavement suite shell; making minor amendments to create a temporary wait and triage; and minor amendment to the UTC (to accommodate Minors); followed by decanting of Minors into the temporary UTC
- Phase 1b involves converting Minors into a temporary Majors, decanting X-ray main wait, and relocating drop-off/ public access; and commencing main works to new SDEC, Resus, and Paediatrics, plus the first floor. The bereavement suite shell is also completed.
- Phase 2 involves commencing the new CDU, commencing a new HASU/ ambulance arrival; and the completion of Medical SDEC, Paediatrics, (which will be fit out as temporary majors) and CDU. The new RATS is completed and handed over part way through this phase
- Phase 3 involves creating Resus and completing HASU, remodelling the bereavement suite, and decanting Reception, Triage, and Majors. First floor accommodation will be live at the end of this phase
- Phase 4 involves completion of the first floor, and creating the new entrance, Majors, Minors, and Mental Health areas
- Phase 5 involves the conversion to form the Medical SDEC and Paediatrics

5.19.3 Enabling, Associated, and Temporary Works

The vast majority of the required works to be undertaken are procured through the P22 agreement with the Trust's PSCP (Tilbury Douglas).

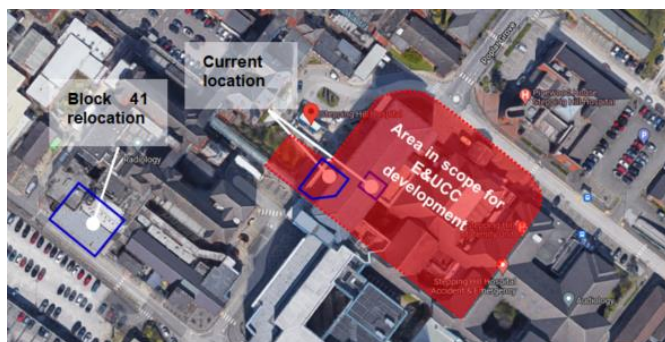
The Trust is however required to undertake a number of enabling, associated, and temporary works, including:

- Permanent relocation of Pacing to Block 41;
- X-Ray A impact mitigation;
- Temporary SDEC relocation;
- Temporary Paeds ED relocation to Treehouse;
- Healthier Together ED Resus;
- Temporary ED staff welfare facilities; and
- Temporary ED office facilities.

The main scheme within this is the relocation of the existing cardiology pacing suite and recovery area (Pacing), sometimes referred to as the “Cath Lab”, as it currently sits within the footprint of the proposed E&UCC, to a vacant location within the current estate. The space vacated will be developed for the future SDEC area of the E&UCC.

Due to poor adjacencies the Trust had planned to carry out this element of work regardless of the E&UCC. Works will be completed before the main construction works for the E&UCC commence.

Figure 75. Relocation of Pacing Suite



The proposed works comprise internal refurbishment and alterations within Block 41 to deliver the new pacing room, recovery space and associated office / clinical accommodation.

Block 41 is currently a redundant space and an existing scheme within the Trusts backlog maintenance programme. Backlog maintenance for Block 41 is estimated to be approximately £470k + VAT.

The intention is to develop and deliver this scheme by means of design and build procurement, selecting a tender via a two stage tender process. The enabling works will be funded internally as part of the Trust's capital programme.

5.19.4 Deliverability

The Trust's proposed Preferred Option is achievable and deliverable from a technical, design, and build point of view, and will be fully compliant with the Trust requirements and all applicable regulations and guidance.

6. Financial Case

6.1. Introduction

The purpose of this section is to set out the forecast financial implications of the preferred way forward (as set out in the Economic Case) and the proposed solution and its procurement route (as set out in the Commercial Case). It describes the impact on the main financial statements of the Trust – the Statement of Comprehensive Income (SoCI), the Statement of Financial Position (SoFP) and the Statement of Cashflow (SoCF) – and forms a conclusion on the overall affordability and accounting treatment of the options.

The financial models and assumptions used within the Financial Case are derived from the Trust's current financial trajectories which are integrated within the Trust's operational plans.

The financial modelling demonstrates that the Preferred Option as identified in the Economic Case is recurrently affordable subject to the achievement of the Trust's operational plans.

6.2. Trust Financial Overview

Since 2014, NHS funding has grown more slowly than historic long-term trends. NHS providers are facing significant financial challenges, and very little central investment in transformation and capital has been available. Local authority budgets are also under significant pressure, affecting social care and public health provision. The Trust continues to experience a high proportion of patients in hospital beds who are medically fit for discharge and awaiting social care packages or placements, which results in a delay to their discharge from hospital.

In line with the publication of the NHS LTP, the Government announced an increase in NHS funding to support the development of a new 10-year long-term plan for the NHS. Whilst this funding is welcomed, it is widely acknowledged that this funding alone will not match the levels of increased demand the NHS is expecting to see. Providers will therefore be increasingly required to redouble efforts to ensure funding is used as efficiently and effectively as possible to increase productivity, reduce waste and face the challenges ahead. The ageing population and increasing demand for health and social care services places a significant financial strain upon acute and community services at the Trust.

The underlying financial deficit is currently £43m, and the Trust's Long Term Financial Plan therefore indicates that the Trust will require continued support through the Financial Recovery Funding (FRF) or equivalent system support, and efficiency savings at levels in excess of the national requirement. Having delivered £47m in efficiency savings over the previous 5 years, the Trust is finding the continued delivery of savings in excess of the national requirement extremely challenging.

Each year, the Trust invests around £11 - 13 million on internally funded capital improvements to the Stepping Hill site and community locations - this includes upgrades to Estate and IT infrastructure and new and replacement medical equipment.

Stockport CCG accounts for around 70% of total Trust income, with Derbyshire CCG being the second largest commissioner (10%). Cheshire CCG accounts for around 6%, Specialist Services 5% and Tameside & Glossop 4%. Prior to the Covid finance regime the Trust held contracts with 19 commissioners in total, and a number of other commissioners from many areas not under a contract providing the Trust with its income.

Approximately 72% of total expenditure is spent on staffing. Ensuring the most effective spending and use of resources on staffing is crucially important, and the Trust is committed to reducing the amount incurred on agency and bank staff each year – this remains a major priority.

Despite having a strong track record of operational and financial control, the historical financial performance shows that the Trust has been in underlying deficit for the last three financial years. Some of these difficulties were addressed during 2019/20 through central Provider Sustainability Funding (PSF), Financial Recovery Funding (FRF), and Marginal Rate Emergency Tariff (MRET). However, the Trust has not been able to achieve balance without this external funding due to key drivers of the Trust financial position identified later in this section. In 2020/21 and 2021/22 national planning regime was stood down and a new pandemic financial regime established. Against this background the Trust delivered a deficit of £6.7 million in 2020/21 (adjusted financial performance deficit of £5.3 million).

The Trust faced continuing pressures in 2021/22 both from the pandemic and restoration of elective activity. It is forecasting to deliver a balanced plan but is reliant on significant system support. National Planning for 2022/23 is still underway and the FBC has been developed with the underlying deficit of the Trust carried

forward from the OBC forecasting at £42.9 million. The recent financial performance of the Trust is highlighted below.

Figure 76. Statement of Comprehensive Income 2019/20 to 2021/22

	Actual 2019/20 £'000	Actual 2020/21 £'000	FOT 2021/22 £'000
Operating income from patient care activities	277,373	311,990	364,563
Other operating income	63,300	72,320	37,653
Operating expenses	(334,481)	(387,464)	(397,608)
Operating surplus/(deficit) from continuing operations	6,192	(3,154)	4,608
Net finance costs	(3,554)	(3,338)	(4,604)
Other gains/(losses)	(42)	391	424
Reported Surplus/(Deficit) for the year	2,596	(6,101)	428
Less: Impairment Reversal	(2,658)	-	-
Less: PSF, FRF, MRET	(27,633)	-	-
Less: Non-Recurrent CIP & Operational Performance	(15,195)	-	-
Underlying Surplus/(Deficit) for the year	(42,890)	(6,101)	428

Note that the 2019/20 figures above reflect the pre-COVID-19 underlying financial outlook and that the 2020/21 and 2021/22 reflects actuals including COVID-19 system support.

The underlying financial performance from 2021/22 excluding Covid system support funding is as follows:

Figure 77. Underlying SoCI 2021/22 Excluding Covid System Support Funding

	Underlying 2021/22 £'000
Operating income from patient care activities	267,976
Other operating income	31,375
Operating expenses	(337,631)
Operating surplus/(deficit) from continuing operations	(38,280)
Net finance costs	(4,590)
Underlying Surplus/(Deficit) for the year	(42,870)

Figure 78. Cash Balances 2019/20 to 2021/22

	2019/20 £'000	2020/21 £'000	FOT 2021/22 £'000
Cash Position as at 31 March 2022	17,631	32,534	50,453

The above table illustrates that the Trust has maintained a healthy cash balance through system support over the past three financial years. In line with the 2021/22 cash financial regime the Trust will need to request PDC revenue support to maintain its liquidity at the current level of underlying deficit in future years. The Trust has strong cashflow management processes which it uses to model the necessary 13-week cash flows required for cash support.

6.3. Key Drivers of the Trust's Financial Position

In the context of a financially strained NHS, where many providers are in underlying deficit, as a Trust which has historically benchmarked favourably against the national Reference Cost Index (<100 RCI), an

underlying deficit of c£43m is disproportionately high when compared to total income of c£300m (excluding central funding).

There are five key drivers of the Trust's financial position:

- **Local demographics** - Stockport has the oldest age profile in Greater Manchester and the population continues to age. Currently 19.8% of people are aged 65+ and this is likely to rise to 21% by 2024, with an additional 5,800 people aged 65 or over;
- **Premium rate staffing costs** - Local competition with neighbouring Trusts across GM, smaller specialties, transport links to the Stepping Hill site, and unavoidable cost pressures linked to investment in quality & safety, supported by CQC recommendations;
- **Structural drivers** – GM-wide loss-making services borne by the Trust, Tariff shortfalls & dis-economies of scale, CNST premium increases only partly offset by tariff, and historic strategic service transfers;
- **Delays to local health economy initiatives** – the Trust continues to actively work with partners across the local health economy in the delivery of strategic programmes of work; and
- **Legacy of Historic Financial Deficits** - Prior to Central Funding support received during 2019/20, the Trust had accumulated losses totalling £72m between 2015/16 – 2018/19, thereby exhausting all historically generated cash resources available for re-investment, and a requirement to take on external borrowing. The Trust has received System Support in 2020/21 and 2021/22.

The E&UCC development is a key step for the Trust in addressing the drivers of the financial position, by modernising services and facilities within the ED estate for patients and staff, including provision for same day emergency care (SDEC).

This forms part of a longer-term estate and clinical strategy for which the Trust is currently developing plans to attract further external capital funding. The Trust has already secured external capital funding of £8.9 million associated with being designated a Specialist Site for urgent and acute general surgery as part of the GM Healthier Together programme. It has also expressed a formal interest in the New Hospitals Programme for a whole new acute hospital facility in Stockport Town Centre alongside redevelopment on the existing Stepping Hill site at an initial estimated cost of £610,800,000.

6.4. Long Term Financial Model (LTFM)

The Trust's LTFM outlines the underlying position for 2021/22 and financial plan to 2030/31. The key assumptions underpinning this modelling are as follows:

Figure 79. LTFM Assumptions

Economic Modelling Assumptions	2021/22 Onwards
Tariff (net)	1.2%
Pay Inflation	3.0%
Drugs	0.6%
Non Pay Inflation	3.1%
CIP	1.1%

- **Tariff** uplifts of 1.167% per annum (net of national efficiency requirement) from 2021/22 onwards;
- **Inflation** assumptions across pay and non-pay consistent with national tariff consultation guidance;
- **CIP** savings of 1.1% per annum – consistent with the 2020/21 Financial Improvement Trajectory national requirement and 21/22 H2 Planning guidance – consistent across all options
- **Central FRF and MRET** funding currently excluded from modelling pending confirmation of financial arrangements post 2021/22;
- **Capital** additions modelled in accordance with Governmental Capital Departmental Expenditure Limit (CDEL) rules. Under these rules, where an organisation operates in deficit, over time capital availability will reduce. The financial modelling assumes that where capital availability becomes minimal, capital additions are assumed to be held at 'Business as Usual' levels. However, in this event, additional external funding would be required in order to support the capital programme; and
- **Cash** balances have been maintained at the 2020/21 level over the financial appraisal period. Financial modelling assumes that cash support will be made available as PDC when required.

6.5. Affordability Analysis

This section sets out the forecast affordability of the estate options that have been considered, specifically:

- Option 1 - BAU
- Option 3 – Preferred Option: Reconfiguration and extension of the existing UEC footprint
- The financial forecast for Option 1 (BAU) has been used in the Economic Case as part of the VfM analysis to baseline against the various options modelled. For the purposes of the financial appraisal and affordability analysis, a comparison of the key differences between the economic and financial appraisals is summarised per the table below.

Figure 80. Differences between the Economic and Financial Appraisals

Area	Economic Appraisal	Financial Appraisal
Cost	Net cost in relation to the baseline “BAU”	Full costs of each option
Prices	Constant base year prices – discount rate 3.5% applied	Current nominal prices – no discount rate applied
Inflation	Excludes general inflation	Includes inflation
Depreciation & capital charges	Excludes depreciation and capital charges	Includes depreciation and capital charges

Financial modelling assumptions have been applied in the LTFM in order to model the estate options referenced above, including the capital investment implications of each option, and the recurrent costs of each option.

6.5.1 Capital Funding Considerations

The total capital expenditure of the scheme is set out below. The original PDC funding allocation to the Trust was £30.6m. Since the development of the OBC the Trust has worked with its Project Manager, Cost Advisors and PCSP Partner towards RIBA Stage 3. The latest cost plan reflects an increase in costs for the E&UCC development of £905,000 to a total cost of £31.5 million.

It has also been acknowledged that the early design fees and Trust costs in 2020/21 were costs incurred for the original Emergency Care Campus design and are not related to the current E&UCC development. The Trust Board of Directors approved a write off of these early costs of £945,000 asset under construction in the financial year 2021/22. The Board agreed that the Trust internal capital programme will fund the increase in costs of £905,000. Work will continue with partners to review costs of the scheme through ongoing value engineering.

The Trust Charity Committee has been approached to consider funding additional expenditure for staff welfare facilities and it was agreed in principle that an application can be progressed.

Figure 81. Capital Cost & Source of Funding (including write off) – Preferred Option

Capital Cost	20/21	21/22	22/23	23/24	Total
Source	£000	£000	£000	£000	£000
PDC funding	-	1,273	15,904	13,418	30,595
Cash (Internal Capital Programme)	945	-	-	905	1,850
Total Funding	945	1,273	15,904	14,323	32,445

Figure 82. Capital Cost and Source of Funding (after removal of early fees)

	Do Nothing		Preferred Option				
Capital Costs			Capital Costs	Net	V.A.T.	Total Cost	Net
				£000	£000	£000	%
Works costs	-		Works costs	19,982	3,452	23,434	63%
PCSP Risk	-		PCSP Risk	1,130	226	1,356	4%
Fees	-		Fees	4,125	-	4,125	13%
Non-Works Costs	-		Non-Works Costs	250	50	300	1%
Equipment Cost	-		Equipment Cost	704	141	845	2%
Trust Risk	-		Trust Risk	1,200	240	1,440	4%
Sub Total	-		Sub Total	27,391	4,109	31,500	87%
VAT	-		VAT inc Recovery	4,109			13%
Total Cost			Total Cost	31,500		31,500	100%

Capital costs for the purposes of the economic appraisal have been provided at PUBSEC 263 reporting index and exclude VAT and any anticipated outturn inflation between the base date and commencement of the capital programme.

In assessing the financial impact of the scheme on the affordability to the Trust, for the purposes of the Financial Case, both VAT and outturn inflation have been included to determine the financial impact within the LTFM modelling. The figure below provides a reconciliation of the Preferred Option's initial capital costs in the Economic Case and Financial Cases respectively.

Figure 83. Reconciliation of the Preferred Option Capital Costs

Item	£
Capital costs (Economic Case) at PUBSEC 263	£26.0m
Add: VAT	£4.1m
Add: Inflation to mid-point of construction (August 2022)	£1.4m
Capital costs (Financial Case) inclusive of VAT @ PUBSEC 279	£31.5m

During 2020/21 and 2021/22 the Trust was able to accelerate future year capital projects by utilising ICS capital slippage. For 2021/22 the Trust is prioritising Critical Infrastructure and Backlog Maintenance estates schemes with a view to addressing the highest risk areas identified in the Trusts 6 facet survey. Additionally, it received PDC for the delivery of Healthier Together capital schemes and COVID-19 elective recovery programmes. Significant IT and replacement equipment schemes were brought forward into the capital plan for 2021/2022 to provide further CDEL coverage into the next two financial years.

The above is with a view to ensuring internal resources for 2022/23 can be managed to cover the enabling works necessary to facilitate the phasing plan for the refurbishment of the Emergency Department under the preferred option. These works include £1.6 million for the relocation of the Pacing Suite, and a further £1.6 million for configuration of the Treehouse to accommodate the paediatric emergency department, minor works to the X-Ray A area and the relocation of Medical Same Day Emergency Care (MSDEC).

The following table sets out the Capital Programme forecast outturn for 2021/22 and the draft Capital Plan for 2022/23.

Figure 84. Breakdown of Capital Costs Updated to FBC

Capital Plan	2021/22	2022/23
Estates EUCC Enabling Schemes*	-	3,193
EUCC Fees**	1,273	-
Estates Projects Critical Infrastructure & Backlog Maintenance	2,517	6,450
IMT	4,220	2,437
Equipment	5,890	1,604
GM CDEL	13,900	13,684
Elective Recovery Fund/TIF Monies	3,740	11,524
Healthier Together	4,600	4,300
Digital	6,026	700
Diagnostic	394	-
UTF Infrastructure	275	-
PDC Funding	15,035	16,524
MR Scanner IFRS 16	-	1,204
Bllood Science Equipment IFRS 16	-	541
Children and Young Peoples Respite Centre IFRS16	-	477
Vehicles IFRS 16	-	40
IFRS 16 Additions	-	2,262
Total Capital Programme	28,935	32,470

* EUCC Pacing Suite £1.6 million, Paediatric Treehouse relocation, Temporary MSDEC

** EUCC Costs for 22/23 to be funded from PDC excluded from table. 21/22 costs met from internal programme (PDC Drawdown in 20/21 of £1.3 million)

6.5.2 Affordability Update from OBC

Alongside the submission of the OBC, the Trust has continued with its PCSP partner and cost advisors with the design and cost plan. This has involved so far three sessions led by the PCSP partner to consider value engineering options. As part of this review the design consultants conducted a detailed review of early design and Trust fees and these were highlighted as abortive costs related to the previous ECPC project. As the costs of the ECPC design were unrelated to this business case the E&UCC Project Board and Executive Team agreed to write off the sum of £945,135 in the 2021/2022 financial year from the asset under construction value.

Even allowing for the removal of abortive early costs the overall cost plan is still showing an over-commitment to the PDC funding envelope of £30.6 million. The current cost plan reflects an increase of £905,000 to £31.5 million. There have been cost increases to construction prices and other market factors such as supply/pricing issues from Brexit, the Covid pandemic and the Ukraine crisis have put pressure on the overall financial envelope. The cost plan includes headroom to take account of these factors with both a Trust Contingency and Construction and Design contingency.

The increase in costs from the OBC to FBC is shown in the table below:

Figure 85. Breakdown of Capital Costs Updated to FBC

Preferred Option				
Capital Costs	OBC	FBC	Variance	%
	£000	£000	£000	£000
Works costs	17,421	19,982	- 2,561	15%
Fees	3,578	4,125	- 547	15%
Non-Works Costs	100	250	- 150	250%
Equipment Cost	1,257	704	553	-56%
Optimism Bias/PCSP/Trust Risk	4,347	2,330	2,017	-54%
Sub Total	26,703	27,391	- 688	3%
VAT	5,380	5,298	82	-2%
VAT Recovery	- 1,488	- 1,189	- 299	-20%
Total Cost	30,595	31,500	- 905	3%
PDC Funding	30,595	30,595		
Shortfall	-	905		

6.5.3 Revenue Funding Considerations

The Preferred Way Forward is expected to deliver a range of benefits as is evidenced by the opportunities highlighted by the most recent Model Hospital data. The Trust flags as the highest quartile for cost per attendance in Emergency Medicine and indicators on staff retention, sickness and length of stay for patients admitted through A&E all indicate areas for improvements to productivity. More information on the basis of assumptions can be found at Appendix 6.7. The following assumptions have been made in the LTFM for revenue:

- **Clinical Income** – no additional commissioner income is assumed against both options. The LTFM assumes inflation and growth in line with the latest national assumptions issued for H2 2021/22;
- **Non-Clinical Income** – Two smaller income generation opportunities arise from the Preferred Option for a Coffee Retail pod and Prescription Charges kiosk for out of hours' recovery of charges; and
- **Expenditure** – the Preferred Option demonstrates the increase in capital charges offset by quantifiable cost reductions and mitigation as follows:
 - Depreciation charges will be applied on a straight-line basis over a 30-year life. As the new build extensions are intrinsically linked to the refurb elements and could not remain in isolation this element will also be depreciated over 30 years. This will be partially offset by current depreciation and PDC charges for the ground floor ED building prior to the demolition and remodelling works. Equipment will be depreciated over 10 years.
 - Impairment will be applied when the asset is brought into use. This was assessed at the value of professional fees for the OBC with a professional opinion obtained from the District Valuer for the FBC.
 - It is assumed that PDC Dividend will become payable as the scheme progresses from 2021/22.
 - The Preferred Option is expected to drive improved workforce recruitment, retention, training and sickness resulting in a reduction in bank and agency spend. Costs have been modelled to improve vacancy rates and reduce bank and agency spend by approximately 14 nursing WTE. Savings have been offset by recruitment to substantive posts. This is realistic and still leaves an agency and bank budgeted cost of 12% and 20% of total ED nursing spend.
 - Reduction in the nursing vacancy rate will also assume improved sickness levels to 4.18% being the Trust's Peer Median on Model Hospital.
 - Similar improvements to the Medical Staffing locum budget are expected with an assumption of a reduction in locum of 3 middle grade doctors.
 - Improved adjacencies and the provision of modern facilities with Same Day Emergency Care (SDEC) will provide significant opportunities to improve productivity. Specifically, the dedicated SDEC area will allow for improved waiting times and patient flow and ultimately bed days. Reducing length of stay and forward admission drives opportunities to reduce the overall bed base and temporary staffing. The Trust staffs two escalation wards within run rate with temporary staffing. Model Hospital shows the Trust is in the highest quartile for length of stay for patients admitted through A&E. Benefits have been calculated to reduce the escalation beds by 8 still leaving 20 beds for escalation.

Figure 86. Increased Annual Capital Charges

	Gross	Including Impairment	Releasable Charges	Net
	£000	£000	£000	£000
Depreciation	1138	968	-224	744
PDC Dividend	1136	957	-213	744
Total Capital Charges	2,274	1,925	-437	1,488

6.5.4 Workforce Modelling

As set out in the Strategic Case this project is primarily an estate re-development and re-organisation. Alongside the design plans of the reconfigured Emergency Department engagement activities have taken place to review the future workforce model to support improvements to the ED service provision. The current workforce model reflects the challenges within emergency departments of recruitment, turnover, sickness and vacancy rates. However, the particular restraints of the Stockport ED have also exacerbated these

national issues, and this is reflected in Model Hospital statistics. For example, expenditure/cost per WAU for nursing expenditure is 10.9% higher than peer median. It is believed that the redevelopment of the ED and associated working environment will lead to improved staff morale which will in turn have an impact on staffing permanent establishment and sickness and turnover rates.

The Trust must also consider the required skills and capabilities required of the new layout in an assessment of any movement in whole time equivalent (WTE). The updated workforce whole time equivalents reflect a skill mix review of unregistered nursing to allow for greater delegation of tasks not required to be taken by a registered nurse.

The following table summarises the movement in the WTE by staffing group and budget. It addresses the workforce challenge of managing the larger footprint with increased number of assessment spaces and still within funded establishment.

Figure 87. Whole Time Equivalent Movement to FBC

Staffing Type	2021/22 Baseline Budget WTE	Workforce Review	New Budget for EUC (WTE)	Movement in Budget £000
Consultant	14	-	14	-
Junior Doctors (incl ACP/PA)	56.78	-	56.78	-
Registered Nurses	135.14	-5.55	129.59	-181,300
Unregistered Nursing	63.02	5.57	68.59	181,900
A&C	24.38	-0.73	23.65	-16,200
Total	293.32	-0.71	292.61	-15,600

6.6. Statement of Comprehensive Income

In addition to the capital costs, an understanding of the revenue costs for each option is required in order to fully comprehend whether the option is financially sustainable in the long term.

An overview of the recurrent cost of each of the options is provided below and detailed breakdown of workings are provided in the appendices to this business case.

6.6.1 Option 1 - BAU

The figure below demonstrates the summary SoCI impact of Option 1 (BAU) over the period 2020/21 to 2030/31. A detailed breakdown of the SoCI for Option 1 is provided in Appendix 6.1.

Figure 88. Option 1 SoCI

Option 1: Business As Usual	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
Clinical Income	267,976	271,103	274,267	277,468	280,706	283,981	287,296	290,648	294,040	297,472	300,943
Other Income	31,375	31,375	31,375	31,375	31,375	31,375	31,375	31,375	31,375	31,375	31,375
Total Income	299,351	302,479	305,642	308,843	312,081	315,357	318,671	322,024	325,416	328,847	332,318
Pay	(226,074)	(230,569)	(234,950)	(239,414)	(243,962)	(248,598)	(253,321)	(258,134)	(263,039)	(268,036)	(273,129)
Non pay	(100,670)	(100,417)	(101,902)	(103,419)	(104,969)	(106,553)	(108,171)	(109,824)	(111,513)	(113,238)	(115,000)
Depreciation	(10,887)	(12,900)	(12,900)	(12,900)	(12,900)	(12,900)	(12,900)	(12,900)	(12,900)	(12,900)	(12,900)
PDC	(3,914)	(3,914)	(5,618)	(7,479)	(9,505)	(11,705)	(14,174)	(16,752)	(19,533)	(22,527)	(25,744)
Interest	(675)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)
Total Expenditure	(342,221)	(348,460)	(356,029)	(363,872)	(371,997)	(380,416)	(389,227)	(398,271)	(407,645)	(417,362)	(427,433)
Surplus/(Deficit)	(42,870)	(45,981)	(50,387)	(55,029)	(59,916)	(65,059)	(70,556)	(76,247)	(82,229)	(88,515)	(95,114)

Whilst the funding regime post 2021/22 remains uncertain, the above makes no provision for central funding previously received as Financial Recovery Funding (FRF), leading to financial deterioration as a result of escalating costs of revenue support. It also assumes additional expenditure resulting from worsening CNST premiums, additional staffing costs from increased sickness and recruitment costs and capital charges costs of additional backlog maintenance costs necessary if BAU continued.

The above is consistent with the Trust financial trajectory considered in the context of the pre-COVID-19 Control Total offer received ahead of the 2020/21 financial year. The COVID-19 financial regime is assumed to be non-recurrent and is not modelled in the financial years beyond 2020/21. This illustrates, that Trust will require continued external funding (FRF or equivalent revenue support from DHSC) in order to avoid escalating costs of financing (included in PDC Dividend), and cash support for the foreseeable future.

In this event, over time capital availability and PDC charges would reduce. The financial modelling assumes that where capital availability becomes minimal, capital additions and PDC repayments are assumed to be

held at BAU levels, whilst resulting PDC dividend changes for additional cash support are modelled across all scenarios.

6.6.2 Option 3 – Reconfiguration and Extension to Existing UEC Footprint (Preferred Option)

The figure below demonstrates the summary SoCI impact of the Preferred Option over the period 2024/25 to 2030/31. A detailed breakdown of Option 3 SoCI is provided in Appendix 6.2.

Figure 89. Option 3 SoCI

Option 3: Preferred Option	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
Clinical Income	267,976	271,103	274,267	277,468	280,706	283,981	287,296	290,648	294,040	297,472	300,943
Other Income	31,375	31,375	31,375	31,375	31,530	31,530	31,530	31,530	31,530	31,530	31,530
Total Income	299,351	302,479	305,642	308,843	312,236	315,512	318,826	322,179	325,571	329,002	332,474
Pay	(226,074)	(230,370)	(234,747)	(239,207)	(242,272)	(246,383)	(251,064)	(255,834)	(260,695)	(265,649)	(270,696)
Non pay	(100,670)	(100,160)	(101,640)	(103,152)	(104,778)	(106,358)	(107,972)	(109,621)	(111,306)	(113,027)	(114,784)
Depreciation	(10,887)	(12,900)	(12,900)	(12,900)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)
PDC	(3,914)	(3,958)	(6,236)	(8,245)	(10,227)	(12,533)	(14,880)	(17,416)	(20,151)	(23,096)	(26,260)
Interest	(675)	(1,605)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)
Impairment	0	0	0	0	(4,135)	0	0	0	0	0	0
Total Expenditure	(342,221)	(348,993)	(356,183)	(364,164)	(375,716)	(379,579)	(388,221)	(397,176)	(406,457)	(416,075)	(426,045)
Surplus/(Deficit)	(42,870)	(46,514)	(50,541)	(55,321)	(63,480)	(64,067)	(69,395)	(74,997)	(80,886)	(87,073)	(93,571)

All economic modelling assumptions in Option 3 remain consistent with those applied to the BAU option.

The incremental improvement in the Trust financial deficit is set out in the following figure as summarised in Appendix 6.3 with the detailed incremental SoCI included in Appendix 6.4. Excluding impairment, the Trust financial trajectory following build completion improves and indicates a net improvement of £0.5 million rising to £1.5 million by 2030/31.

Figure 90. Preferred Option v BAU

Option 3: Incremental SoCI BAU v Preferred Option	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
Clinical Income	0	0	0	0	0	0	0	0	0	0	0
Other Income	0	0	0	0	155	155	155	155	155	155	155
Total Income	0	0	0	0	155	155	155	155	155	155	155
Pay	0	199	203	207	1,691	2,215	2,257	2,300	2,343	2,388	2,433
Non pay	0	257	262	267	191	195	199	203	207	211	215
Depreciation	0	0	0	0	(744)	(744)	(744)	(744)	(744)	(744)	(744)
PDC	0	(44)	(618)	(766)	(722)	(828)	(706)	(664)	(618)	(568)	(516)
Interest	0	0	0	0	0	0	0	0	0	0	0
Impairment	0	(945)	0	0	(4,135)	0	0	0	0	0	0
Total Expenditure	0	412	(154)	(293)	416	838	1,006	1,095	1,188	1,287	1,388
Surplus/(Deficit)	0	(533)	(154)	(293)	(3,564)	993	1,161	1,250	1,343	1,442	1,543

Figure 91. Preferred Option Incremental Bridge

Option 3 Preferred Option v BAU £000	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
PRIOR YEAR SURPLUS / (DEFICIT)	0	0	(533)	(154)	(293)	(3,564)	993	1,161	1,250	1,343	1,441
Inflation	0	0	14	14	14	57	72	74	76	77	79
CIP	0	0	(5)	(5)	(5)	(21)	(27)	(27)	(28)	(28)	(29)
Agency and Bank staffing	0	0	0	0	738	0	0	0	0	0	0
Sickness Rates	0	89	0	0	67	0	0	0	0	0	0
Reduction in training costs	0	29	0	0	47	0	0	0	0	0	0
Recruitment Cost (including international recruitment)	0	39	0	0	51	0	0	0	0	0	0
Superannuation cover costs	0	43	0	0	70	0	0	0	0	0	0
Workforce EUCC Review - RN	0	0	0	0	181	0	0	0	0	0	0
Workforce EUCC Review - UN	0	0	0	0	(182)	0	0	0	0	0	0
Workforce EUCC Review - A&C	0	0	0	0	16	0	0	0	0	0	0
LoS Reduction in escalation beds	0	0	0	0	492	492	0	0	0	0	0
Insurance Premiums	0	257	0	0	0	0	0	0	0	0	0
Prescription Charges Income	0	0	0	0	80	0	0	0	0	0	0
Retail Income	0	0	0	0	75	0	0	0	0	0	0
Reduction in Legal Fees	0	0	0	0	19	0	0	0	0	0	0
ED Medicine Drug Inventory holding	0	0	0	0	7	0	0	0	0	0	0
Additional Estates, Facilities and Utilities costs	0	0	0	0	(107)	0	0	0	0	0	0
PDC	0	(44)	(574)	(148)	44	(106)	122	42	45	49	52
Depreciation	0	0	0	0	(744)	0	0	0	0	0	0
Impairment	0	(945)	945	0	(4,135)	4,135	0	0	0	0	0
SURPLUS / (DEFICIT)	0	(533)	(154)	(293)	(3,564)	993	1,161	1,250	1,344	1,441	1,543

6.7. Statement of Financial Position & Cash Flow

The figure below demonstrates the SoFP under the Preferred Option 3 over the period 2020/21 to 2030/31. A detailed breakdown of Option 3 SoFP and SoCF is provided in Appendix 6.2.

Figure 92. Forecast SoFP

STATEMENT OF FINANCIAL POSITION £'000	2020/21 Actual	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan	2025/26 Plan	2026/27 Plan	2027/28 Plan	2028/29 Plan	2029/30 Plan	2030/31 Plan
Opening	159,391	169,709	184,799	200,703	214,121	209,986	209,986	209,986	209,986	209,986	209,986
Additions - Business as Usual	18,455	27,662	12,900	11,995	13,644	13,644	13,644	13,644	13,644	13,644	13,644
Additions ECC - Trust	0	945	0	905	0	0	0	0	0	0	0
Additions ECC - PDC	945	328	15,904	13,418	0	0	0	0	0	0	0
Depreciation	(10,887)	(12,900)	(12,900)	(12,900)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)
Other	1,557	0	0	0	0	0	0	0	0	0	0
Impairment	0	(945)	0	0	(4,135)	0	0	0	0	0	0
Trade & Other Receivables	248	0	0	0	0	0	0	0	0	0	0
Non Current Assets	169,709	184,799	200,703	214,121	209,986	209,986	209,986	209,986	209,986	209,986	209,986
Current Assets											
Cash	34,991	50,453	35,418	35,418	35,418	35,418	35,418	35,418	35,418	35,418	35,418
Debtors	16,499	16,324	16,324	16,324	16,324	16,324	16,324	16,324	16,324	16,324	16,324
Inventories	1,552	1,552	1,552	1,552	1,552	1,552	1,552	1,552	1,552	1,552	1,552
Total Current Assets	53,042	68,329	53,294	53,294	53,294	53,294	53,294	53,294	53,294	53,294	53,294
Liabilities											
Creditors due < 1 year	62,282	78,142	63,107	63,107	63,107	63,107	63,107	63,107	63,107	63,107	63,107
Creditors due > 1 year	19,005	19,005	19,005	19,005	19,005	19,005	19,005	19,005	19,005	19,005	19,005
Provisions	2,935	2,935	2,935	2,935	2,935	2,935	2,935	2,935	2,935	2,935	2,935
Total Liabilities	84,222	100,082	85,047	85,047	85,047	85,047	85,047	85,047	85,047	85,047	85,047
TOTAL ASSETS EMPLOYED	138,529	153,046	168,950	182,368	178,233	178,233	178,233	178,233	178,233	178,233	178,233
Taxpayers Equity											
PDC	145,881	160,960	227,405	296,144	355,489	419,556	488,951	563,948	644,834	731,907	825,478
Revaluation Reserve	46,788	46,788	46,788	46,788	46,788	46,788	46,788	46,788	46,788	46,788	46,788
Retained Earnings	(56,798)	(57,360)	(107,901)	(163,222)	(226,702)	(290,769)	(360,164)	(435,161)	(516,047)	(603,120)	(696,691)
Charitable Fund Reserves	2,658	2,658	2,658	2,658	2,658	2,658	2,658	2,658	2,658	2,658	2,658
TOTAL TAXPAYERS EQUITY	138,529	153,046	168,950	182,368	178,233	178,233	178,233	178,233	178,233	178,233	178,233

The incremental improvement in the Trust SoFP and SoCF is set out in the following figure, as summarised in Appendix 6.5.

Figure 93. Incremental Impact Preferred Option SoFP v BAU

BALANCE SHEET £'000	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
Opening	0	0	(945)	14,959	28,377	24,242	24,242	24,242	24,242	24,242	24,242
Additions - Business as Usual	354	(1,273)	0	(905)	744	744	744	744	744	744	744
Additions ECC - Trust	0	945	0	905	0	0	0	0	0	0	0
Additions ECC - PDC	945	328	15,904	13,418	0	0	0	0	0	0	0
Depreciation	0	0	0	0	(744)	(744)	(744)	(744)	(744)	(744)	(744)
Impairment	0	(945)	0	0	(4,135)	0	0	0	0	0	0
Non Current Assets	1,299	(945)	14,959	28,377	24,242	24,242	24,242	24,242	24,242	24,242	24,242
Total Current Assets	0	0	0	0	0	0	0	0	0	0	0
Total Liabilities	0	0	0	0	0	0	0	0	0	0	0
TOTAL ASSETS EMPLOYED	0	(945)	14,959	28,377	24,242	24,242	24,242	24,242	24,242	24,242	24,242
Taxpayers Equity											
PDC	1,299	44	16,102	29,812	29,241	28,249	27,088	25,838	24,495	23,053	21,510
Retained Earnings	0	(989)	(1,143)	(1,435)	(4,999)	(4,007)	(2,846)	(1,596)	(253)	1,189	2,732
TOTAL TAXPAYERS EQUITY	0	(945)	14,959	28,377	24,242	24,242	24,242	24,242	24,242	24,242	24,242

An underpinning assumption to the financial modelling that has been undertaken is that cash balances are maintained at 2020/21 outturn levels, with requisite deficit funding being made available to the Trust.

Figure 94. Preferred Option Forecast SoCF

CASH FLOW £'000	2020/21 Actual	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan	2025/26 Plan	2026/27 Plan	2027/28 Plan	2028/29 Plan	2029/30 Plan	2030/31 Plan
Cash flows from operating activities											
Operating surplus/(deficit)	(3,147)	(40,951)	(43,645)	(46,416)	(52,583)	(50,874)	(53,855)	(56,921)	(60,075)	(63,317)	(66,651)
Non-cash income and expense:											
Depreciation and amortisation/Impairments	10,887	12,900	12,900	12,900	13,644	13,644	13,644	13,644	13,644	13,644	13,644
Fixed Asset Impairments	2,543	0	0	0	4,135	0	0	0	0	0	0
(Increase)/decrease in debtors	4,788	175	0	0	0	0	0	0	0	0	0
(Increase)/decrease in inventories	285	0	0	0	0	0	0	0	0	0	0
Increase/(decrease) in Creditors due < 1 year	8,493	(175)	0	0	0	0	0	0	0	0	0
Increase/(decrease) in Creditors due > 1 year	(32)	0	0	0	0	0	0	0	0	0	0
Increase/(decrease) in provisions	556	0	0	0	0	0	0	0	0	0	0
Other movements in operating cash flows - remove underlying forecast deficit 21/22	(1,358)	45,526	0	0	0	0	0	0	0	0	0
Net cash generated from/(used in) operating activities	23,915	17,475	(30,744)	(33,515)	(34,814)	(37,229)	(40,211)	(43,277)	(46,430)	(49,673)	(53,007)
Cash flows from investing activities:											
Interest received	7	0	0	0	0	0	0	0	0	0	0
Purchase of intangible assets	(2,156)	0	0	0	0	0	0	0	0	0	0
Purchase of property, plant, equipment and investment property	(13,024)	(12,900)	(43,839)	(26,318)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)
Purchase of property, plant, equipment - EUCC Development	63	426	0	0	0	0	0	0	0	0	0
Sales of property, plant, equipment and investment property	90	0	0	0	0	0	0	0	0	0	0
Cash from (disposals) of business units and subsidiaries (not absorption transfers)/Charity	90	0	0	0	0	0	0	0	0	0	0
Net cash generated from/(used in) investing activities	(15,020)	(12,474)	(43,839)	(26,318)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)	(13,644)
Cash flows from financing activities:											
Public dividend capital received - revenue	46,055	44	50,541	55,347	58,345	64,067	69,395	74,997	80,886	87,073	93,571
Public dividend capital received - capital EUCC	1,299	0	15,904	13,392	0	0	0	0	0	0	0
Public dividend capital received - capital	11,710	15,035	0	0	0	0	0	0	0	0	0
Loans repaid/received from the Department of Health/Capital element of Finance Leases	(47,721)	0	0	0	0	0	0	0	0	0	0
Other interest paid	(940)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)
PDC dividend paid	(3,192)	(3,958)	(6,236)	(8,245)	(10,227)	(12,533)	(14,890)	(17,416)	(20,151)	(23,096)	(26,260)
Net cash generated from/(used in) financing activities	7,211	10,461	59,549	59,834	48,458	50,874	53,855	56,921	60,075	63,317	66,651
Increase/(decrease) in cash and cash equivalents	15,206	15,462	(15,035)	0	0	0	0	0	0	0	0
Cash and cash equivalents at 1 April	19,785	34,991	50,453	35,418	35,418	35,418	35,418	35,418	35,418	35,418	35,418
Cash and cash equivalents at 31 March	34,991	50,453	35,418	35,418	35,418	35,418	35,418	35,418	35,418	35,418	35,418

Figure 95. Incremental Impact Preferred Option Forecast SoCF v BAU

CASH FLOW £'000	2020/21 Actual	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan	2025/26 Plan	2026/27 Plan	2027/28 Plan	2028/29 Plan	2029/30 Plan	2030/31 Plan
Cash flows from operating activities											
Operating surplus/(deficit)	0	456	464	474	(2,842)	1,820	1,867	1,914	1,961	2,010	2,059
Non-cash income and expense:											
Depreciation and amortisation/Impairments	0	0	0	0	744	744	744	744	744	744	744
Fixed Asset Impairments	0	0	0	0	4,135	0	0	0	0	0	0
(Increase)/decrease in debtors	0	350	0	0	0	0	0	0	0	0	0
Increase/(decrease) in Creditors due < 1 year	0	(175)	0	0	0	0	0	0	0	0	0
Increase/(decrease) in Creditors due > 1 year	0	(175)	0	0	0	0	0	0	0	0	0
Other movements in operating cash flows	0	(455)	0	0	0	0	0	0	0	0	0
Net cash generated from/(used in) operating activities	0	456	464	474	2,037	2,564	2,611	2,658	2,705	2,754	2,803
Cash flows from investing activities:											
Purchase of property, plant, equipment and investment property	0	0	(15,904)	(13,418)	(744)	(744)	(744)	(744)	(744)	(744)	(744)
Net cash generated from/(used in) investing activities	0	0	(15,904)	(13,418)	(744)	(744)	(744)	(744)	(744)	(744)	(744)
Cash flows from financing activities:											
Public dividend capital received - revenue	44	154	318	(571)	(992)	(1,161)	(1,250)	(1,343)	(1,442)	(1,543)	
Public dividend capital received - capital EUCC	1,299	0	15,904	13,392	0	0	0	0	0	0	0
Public dividend capital received - capital	11,710	0	0	0	0	0	0	0	0	0	0
PDC dividend paid	0	(44)	(618)	(766)	(722)	(828)	(706)	(664)	(618)	(568)	(516)
Net cash generated from/(used in) financing activities	13,009	0	15,440	12,944	(1,293)	(1,820)	(1,867)	(1,914)	(1,961)	(2,010)	(2,059)
Increase/(decrease) in cash and cash equivalents	15,206	15,462	(15,035)	0	0	0	0	0	(0)	(0)	0
Cash and cash equivalents at 1 April	19,785	34,991	50,453	35,418	35,418	35,418	35,418	35,418	35,418	35,418	35,418
Cash and cash equivalents at 31 March	34,991	50,453	35,418	35,418	35,418	35,418	35,418	35,418	35,418	35,418	35,418

6.7.1 Affordability Summary

The Trust LTFM illustrates that the investment as set out by the Preferred Option 3 is deliverable. Excluding impairment, it improves the Trust financial trajectory by £0.5 million in 2024/25 rising to £1.5 million in 2030/31. Under both options, the Trust would require external funding in the form of revenue support from DHSC over the life of the investment, which emphasises that even though both options are financially viable, the continued availability of central system support funding is vital to long term financial sustainability, whilst the Trust develops further schemes linked to the E&UCC which will further improve the financial return on investment.

6.8. Tax and Accounting Considerations

In developing the OBC and FBC, the Trust has assumed the treatment of capital and revenue expenditure in line with the Trust's accounting policies. As such, the refurbished estate and new build extension would be recognised as an asset in the Trust's Statement of Financial Position and depreciated over its useful economic life and the Trust would recognise an increase in PDC, representing DH's equity interest. As a result, the net book value of net relevant assets held by the Trust will increase, which, in turn will increase the capital charges that would need to be met by the Trust, provided the Trust has surplus cash.

The Trust has engaged with the design team with regards to determining recoverability of VAT on the scheme and assumes VAT will be reclaimed for areas of the estate being refurbished, along with associated fees of the development. The Trust has engaged BDO, Procure22 VAT advisors, to undertake a VAT review of the E&UCC development which will be updated into the financial modelling with updated capital cost plans as GMP is finalised.

Based on the extent of the design and remodelling of the refurbishment and new build, the Trust assesses that the site valuation post-build will reflect an impairment that has been assessed as the value of professional fees. Financial modelling therefore assumes a £4.1 million impairment arising upon completion. The District Valuer has been engaged to undertake an initial impairment assessment based on the latest

cost plan and design. This will be updated in the financial modelling when available. The asset will be professionally valued again on completion to accurately reflect this impairment in the Trust financial statements.

The Trust has assumed all costs associated with the procurement, internal costs of the project team and the costs of advisers and technical support are capitalised as part of the resulting capital asset. As highlighted above the initial costs of the ECPC capital scheme (an earlier discontinued design) have been written off in 2021/22. A schedule of costs associated with bringing the E&UCC Business Case to OBC and FBC stage is set out below. To date the Trust has drawn £1.299 million PDC funding in 2020/21.

Figure 96. E&UCC Business Case Development: 6% Early Drawdown of Fees

E&UCC Development	Description	Cost (£)
Programme Manager	8b	20,492
Estates Project Manager	8a	59,185
Programme Support	7	21,028
Project Management / Business Case Development		100,705
Business Case Author	External Consultants Bid Writers	86,698
Construction Project Management Consultants	External Consultants	79,872
Technical Design Consultants	External Consultants	921,600
Cost Management	External Consultants	64,655
BREEAM	External Consultants	-
Incidental Fees (Planning/Regs, etc.)	External Consultants	1,200
Site Surveys	External Consultants	18,722
PSCP Partner, Architect, Design & Cost Consultants		1,172,747
TOTAL		1,273,452

The Commercial Case sets out how the Trust plans to utilise the P22 Procurement Framework, in order to secure the protections offered as part of the tender process for compliance purposes, and those further offered through the GMP guarantee incentive.

6.9. Contingency Plans

The Trust has included an allowance for contingency (in addition to the PCSP design risk) within the capital cost plan. This will continue to be reviewed as GMP is progressed. Additionally, the internal capital programme has been managed in 2021/22 to fund enabling schemes for the phasing plan for construction of the E&UCC development. The Trust Charity Committee has agreed in principle for a bid to progress to support staff welfare facilities within the Emergency Department.

The Trust intends to work closely with Procure 22 specialists in ensuring the approach to risk management is in line with the framework guidance. The Trust has performed an internal due diligence exercise as part of the procurement process in order to form a view on the risks associated with supplier failure prior to award of contract.

6.10. Sensitivity Analysis

The affordability and impact to financial statements give assurance that the Preferred Option is affordable to the Trust. In preparing the FBC and the underpinning assumptions, the Project Board has been clear on the level of risks and mitigating actions.

In order to test the robustness of the appraisal's conclusions and consider the uncertainties around some of the key assumptions made, it has been necessary to perform sensitivity analysis to assess the impact, if any, on the relativities between options and the conclusions drawn regarding affordability. The analysis has focussed on the two key areas of uncertainty as outlined below.

6.10.1 Capital cost increases

A key uncertainty surrounding any capital project is the level of planned capital expenditure. As such, another sensitivity to consider is the impact of capital costs increasing beyond what has been included within contingency in the Preferred Option. For the purpose of this analysis, an increase in capital costs of 10% has been assumed.

6.10.2 Non-Delivery of Financial Benefits

Further analysis has been modelled in order to illustrate the sensitivity of assumed financial benefits on workforce recruitment expected benefits that are included under the Preferred Option, lower than expected levels of income generation and an additional risk of the new facilities increasing demand. The possible impact of these risks is detailed below.

Figure 97. Impact of Risks and Sensitivities

No	Risk	Sensitivity	Mitigation	Impact
1	Capital costs are higher than planned.	Capital costs increase by 10% higher than planned.	The Trust has consulted closely with its stakeholders and technical professional advisors and design plans are signed off and costed. Cost plans include an allowance for contingency and optimism bias.	Capital £3.1m I&E £0.2m
2	Risk that workforce benefits are less than expected.	Workforce recruitment costs increase for medical and nursing fees, nursing training costs including supernumerary cover.	Workforce benefits assumed are largely from a reduction in temporary staffing costs. A level of bank and agency spend is still retained in ED medical (14%) and nursing budgets (32%).	I&E £0.14m
3	Changes in demand due to increased numbers attracted by new facilities.	Additional escalation bays required for Oct - Mar staffed by temporary staffing.	This will be included in the annual assessment of winter pressures with associated workforce modelling.	I&E £0.2m
4	Risk that income generation will not meet levels expected.	Income generated is 50% less than expected.	Income assumed is set at conservative estimates initially.	I&E £0.1m
5	Reduction in savings in length of stay in first year post construction does not materialise by 50%.	Benefit added back in 24/25 to sensitivity model	This will be a key indicator to be monitored in the Benefits Management Plan.	I&E £0.3m
6	Bank and agency savings take longer to materialise	Benefit profiled over two years.	This will be included in the ongoing HR and Workforce modelling and assessment of improvements to staff morale and working environment and its impact on turnover.	I&E £0.4m in year 1 only

Post build the Trust LTFM reflects a financial trajectory for the Risk adjusted Preferred Option that still reflects an improvement to BAU from 25/26 of £0.05 million, after all benefits are modelled to impact the income and expenditure position, rising to £0.4 million by 2030/31. The figure below demonstrates the summary SoCI impact of the Preferred Option over the period 2024/25 to 2030/31. A detailed breakdown of Option 3 SoCI Sensitivity Adjusted is provided in Appendix 6.6.

The risk adjusted SoCI is as follows:

Figure 98. Risk Adjusted SoCI of Preferred Option

Option 3: Preferred Option Sensitivity Adjusted	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
Clinical Income	267,976	271,103	274,267	277,468	280,706	283,981	287,296	290,648	294,040	297,472	300,943
Other Income	31,375	31,375	31,375	31,375	31,450	31,450	31,450	31,450	31,450	31,450	31,450
Total Income	299,351	302,479	305,642	308,843	312,156	315,432	318,746	322,099	325,491	328,922	332,394
Pay	(226,074)	(230,370)	(234,747)	(239,207)	(243,206)	(246,966)	(251,658)	(256,440)	(261,312)	(266,277)	(271,336)
Non pay	(100,670)	(100,160)	(101,640)	(103,152)	(104,778)	(106,358)	(107,972)	(109,621)	(111,306)	(113,027)	(114,784)
Depreciation	(10,887)	(12,900)	(12,900)	(12,900)	(13,749)	(13,749)	(13,749)	(13,749)	(13,749)	(13,749)	(13,749)
PDC	(3,914)	(3,958)	(6,236)	(8,245)	(10,372)	(12,711)	(15,091)	(17,662)	(20,434)	(23,417)	(26,621)
Interest	(675)	(1,605)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)	(660)
Impairment		(945)	0	0	(4,135)	0	0	0	0	0	0
Total Expenditure	(342,221)	(348,993)	(356,183)	(364,164)	(376,901)	(380,444)	(389,130)	(398,132)	(407,461)	(417,130)	(427,151)
Surplus/(Deficit)	(42,870)	(46,514)	(50,541)	(55,321)	(64,744)	(65,012)	(70,384)	(76,033)	(81,970)	(88,208)	(94,757)

Figure 99. Risk Adjusted Preferred Option Incremental v BAU

Option 3 Preferred Option Sensitivity v BAU £000	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
PRIOR YEAR SURPLUS / (DEFICIT)	0	0	(533)	(154)	(293)	(4,829)	47	171	214	259	306
Tariff	0	0	0	0	0	0	0	0	0	0	0
Inflation	0	0	14	14	14	29	55	56	57	58	59
CIP	0	0	(5)	(5)	(5)	(10)	(20)	(20)	(21)	(21)	(22)
Unavoidable Cost Pressures	0	0	0	0	0	0	0	0	0	0	0
FRF & MRET Retracted	0	0	0	0	0	0	0	0	0	0	0
Agency and Bank staffing	0	0	0	0	369	369	0	0	0	0	0
Sickness Rates	0	89	0	0	67	0	0	0	0	0	0
Reduction in training costs	0	29	0	0	14	0	0	0	0	0	0
Additional staff requirement	0	0	0	0	0	0	0	0	0	0	0
Recruitment Cost (including international recruitment)	0	39	0	0	(11)	0	0	0	0	0	0
Supernumerary cover costs	0	43	0	0	20	0	0	0	0	0	0
Workforce EUCC Review - RN	0	0	0	0	181	0	0	0	0	0	0
Workforce EUCC Review - UN	0	0	0	0	(182)	0	0	0	0	0	0
Workforce EUCC Review - A&C	0	0	0	0	16	0	0	0	0	0	0
LoS Reduction in escalation beds	0	0	0	0	246	492	0	0	0	0	0
Insurance Premiums	0	257	0	0	0	0	0	0	0	0	0
Prescription Charges Income	0	0	0	0	40	0	0	0	0	0	0
Retail Income	0	0	0	0	35	0	0	0	0	0	0
Reduction in Legal Fees	0	0	0	0	19	0	0	0	0	0	0
ED Medicine Drug Inventory holding	0	0	0	0	7	0	0	0	0	0	0
Additional Estates, Facilities and Utilities costs	0	0	0	0	(107)	0	0	0	0	0	0
Poor performance of services	0	0	0	0	(174)	0	0	0	0	0	0
PDC Dividend	0	(44)	(574)	(148)	(101)	(138)	89	7	9	10	12
Depreciation	0	0	0	0	(849)	0	0	0	0	0	0
Impairment	0	(945)	945	0	(4,135)	4,135	0	0	0	0	0
SURPLUS / (DEFICIT)	0	(533)	(154)	(293)	(4,829)	47	171	214	259	306	356

6.11. Conclusion

The Trust LTFM illustrates that the investment as set out by the Preferred Option (Option 3) is deliverable and improves the Trust financial trajectory post build and impairment from £0.5 million to £1.5 million to 2030/31.

Under each option, the Trust would require external funding over the life of the investment, which emphasises that even though both options are financially viable, the continued availability of central FRF funding/System support is vital to long term financial sustainability, whilst the Trust develops further schemes linked to the E&UCC which will further improve the financial return on investment.

7. Management Case

7.1. Introduction

This section of the FBC explains the governance and management arrangements for delivering the preferred option. It provides details of the actions that will be required to ensure the successful delivery of the project in accordance with best practice. The Management Case provides information about the controls developed and implemented to support delivery of the project. It provides assurance that the scheme is being managed in a controlled, effective and efficient manner within the constraints defined in this FBC and the Trust's wider governance arrangements. This section also demonstrates that the Trust has the required resource capacity and relevant experience to deliver the project.

7.2. Project Management

The Trust has experience of developing business cases for large capital schemes and a successful record of accomplishment in the planning, management and implementation of key projects from business case inception through to operational delivery. The most recent of which has been the tangible and successful delivery of the Trust's transformation programme.

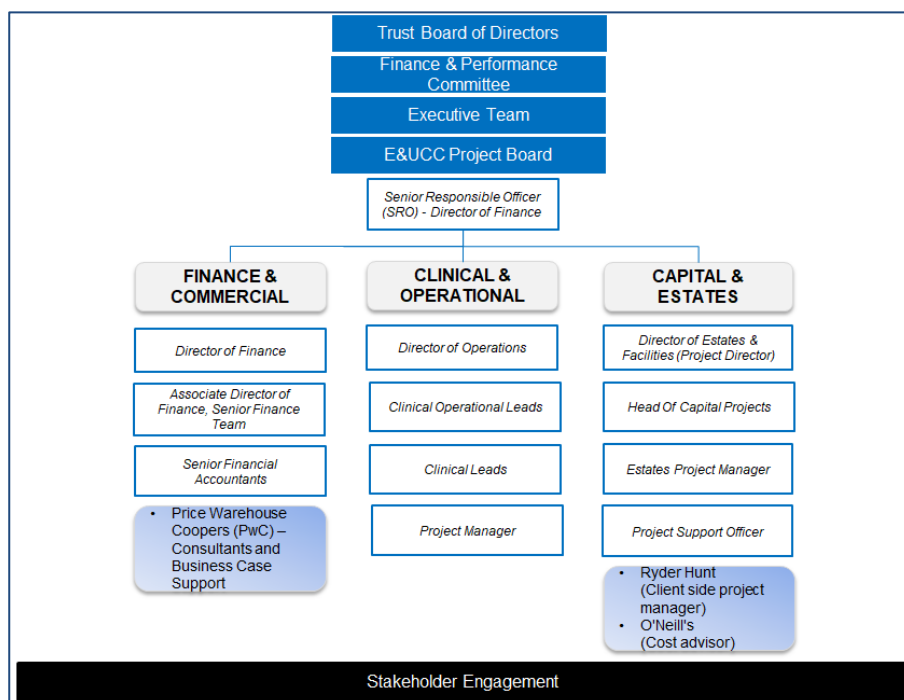
The project arrangements have been designed to ensure the project is delivered:

- With compliance to the HMT Green Book and NHS Capital Investment Manual guidance;
- On time and aligned with the agreed budget;
- In a transparent and accountable manner;
- Using Prince 2 methodology;
- With an appropriate level of engagement from clinical teams and other stakeholders;
- With an appropriate level of engagement, review and oversight from Trust executives and partner organisations; and
- With processes in place to ensure that the objectives are achieved.

7.2.1 Governance Arrangements & Structure

The following diagram demonstrates the governance arrangements.

Figure 100. Project Governance Structure



The governance arrangements ensure that clinical, operational, financial and transformation expertise is used effectively so that the project is delivered effectively.

The project is structured with clearly defined roles for individuals, and the establishment of a series of meetings, which are appropriate for the project.

7.2.2 Trust Board

The Trust Board consists of Executive Directors, appointed to specific roles within the organisation, and Non-Executive Directors who do not work for the Trust, but bring a range of external expertise with them.

The Board of Directors has overall responsibility for the approval of the FBC, to be assured that it is implemented in line with NHSE/I guidance and delivers its agreed investment objectives and benefits.

The Board of Directors will receive and consider the FBC prior to submission to NHSE/I.

7.2.3 Committees of the Board

The Board of Directors is supported by established Committees that scrutinise and provide assurance on internal controls, plans and key decisions. The committees of the Board include:

- Finance and Performance Committee;
- Quality Committee;
- People Performance Committee;
- Audit Committee;
- Charitable Funds Committee; and
- Remuneration Committee.

The Stockport NHS Foundation Trust Constitution 2019 is set out in Appendix 7.1. Of particular note relating to this project is the Finance & Performance Committee. This is a formal committee of the Trust Board and receives updates and recommendations from the Project Board.

In addition to updates on the financial performance of the project and on the delivery of benefit realisation in line with the agreed plans, the Finance & Performance Committee will also receive recommendations of the post project evaluation to be assured of the value for money of the project.

7.2.4 Executive Team

The Executive Team (ET) will receive updates and assurances from the Project Board on the progress of the project, cost management and on the mitigation of risks. ET will take key strategic decisions regarding the project and work to unblock issues arising as the scheme progresses. ET will report through and make recommendations to the formal committees of the Trust Board.

7.2.5 Project Board

The Project Board is the forum at which all elements of the scheme will be monitored, and assurance sought on progress, effectiveness and planning arrangements. This group will maintain the project action plan, risk register and will make key decisions on the implementation of the scheme. The Project Board meets fortnightly and provides updates to the Executive Team and the Finance & Performance Committee.

The membership is structured to ensure that the right core skill mix is in place and that the Senior Responsible Officer is able to draw on the wider expertise of the Trust and that of the wider health economy at the appropriate time.

Terms of reference for the Project Board have been ratified by the Executive Team and are contained within Appendix 7.2. Meeting minutes and actions are captured and approved at the subsequent Project Board meeting.

In summary the key roles and responsibilities of the Project Board include:

- Ensure the timely completion of the business case process;
- Delivering of the project within the parameters set within the business case;
- Providing high level direction on stakeholder involvement and monitoring project level management of stakeholders;

- Providing the strategic direction for the project;
- Ensure continuing commitment of stakeholder support;
- Key stage decisions; and
- Progress monitoring.

The Project Board has developed a rigorous process in order to provide assurance and ensure ownership. Regular progress reports are submitted through the SRO (the Director of Finance) to the Executive Team, Finance & Performance Committee and to the Board of Directors.

From the outset, sub-groups of the Project Board were established with responsibility for:

- Developing the project;
- Operational and clinical factors;
- Decision on matters for escalation for direction/ information;
- Management of risks and issues and escalation of appropriate matters for executive direction/ approval;
- Drawing together the outputs of Working / Task & Finish Groups and coordination of cross cutting issues.

Working / Task & Finish Groups such as a Design Team, and a Clinical & Operational Planning Group, were convened as required to provide advice and direction to the detailed design process and dependent on the emergence of risk, opportunities or threats to the project.

Specific individuals are responsible for coordinating the activities to progress the project and to develop the business cases, ensuring that interdependencies between the work streams are identified and addressed.

As illustrated in the governance structure above, all members of the Project Board are accountable through the Executive Team, to Board Committees and ultimately the Board of Directors for the delivery of the project.

7.2.6 Project Management Budget

The programme management structure to Executive level has been outlined above and demonstrates the high level of executive support across strategic and financial priorities with clinical leadership at the heart of the project inception and design.

The project management budget is provided within the table below.

Figure 101. Project Management Budget

E&UCC Development	Description	Cost (£)
Programme Manager	8b	20,492
Estates Project Manager	8a	59,185
Programme Support	7	21,028
Project Management / Business Case Development		100,705
Business Case Author	External Consultants Bid Writers	86,698
Construction Project Management Consultants	External Consultants	79,872
Technical Design Consultants	External Consultants	921,600
Cost Management	External Consultants	64,655
BREEAM	External Consultants	-
Incidental Fees (Planning/Regs, etc.)	External Consultants	1,200
Site Surveys	External Consultants	18,722
PSCP Partner, Architect, Design & Cost Consultants		1,172,747
TOTAL		1,273,452

The initial draw down to commence business case development was made in March 2020.

The contract management section below outlines the additional resource required to manage the project through to and post FBC approval.

7.2.7 Project Management Plan

The following documents are key to the project delivery plan, reporting and monitoring of the E&UCC Programme, and are attached in the following appendices:

- Project Initiation Document (PID) – Appendix 7.3;
- Milestone Tracker – Appendix 7.4;
- Project Delivery Tool – Appendix 7.5;
- Risk Register – Appendix 7.6; and
- Equality Impact Assessment – Appendix 7.7.

The project is intended to deliver the proposed development by April 2024. However, this timeline is founded on meeting key submission and approval dates outlined below.

The key milestones for this project are set out below. These proposed dates provide the fastest possible route to delivering the required project benefits, balanced with the need to ensure adequate planning, engagement, approvals, and due diligence are undertaken; as well as allowing sufficient periods for the Trust to obtain the necessary approvals from NHSE/I, the DHSC, and HM Treasury as appropriate.

Figure 102. Key Milestones

Milestone		Date
E&UCC Project Board review and approve FBC		07/04/22
ET review and approve FBC		11/04/22
FBC submitted to NHSEI (without GMP)		12/04/22
F&P review and approve FBC		21/04/22
Trust Board review and approve FBC		05/05/22
Refreshed FBC submitted to NHSEI (without GMP)		06/05/22
FBC queries:	First queries to Trust from cash & capital/DHSC/regional team	20/05/22
	Trust responses to queries	27/05/22
	Ongoing review and closing down of queries	27/05/22 – 14/06/22/2
GMP issued to Trust		21/06/22
GMP approved by Trust		06/07/22
Refreshed FBC submitted to NHSEI (with addendums for GMP, Planning and Letters of Support).		06/07/22
JISC review and approve FBC		18/07/22
Build phase:	Site Preparation	September 22
	Enabling Schemes	October 22
	Phase 1	December 22
	Phase 2	June 23
	Phase 3	October 23
	Phase 4	March 24
	Phase 5	April 24
Commissioning & Opening		April 24
Post Project Evaluation commences		April 24

The construction phasing plan was co-developed and agreed with the construction partner and has been approved by the Project Board. The phasing plan, found in Appendix 5.11, details the key dates of enabling works, decant, temporary arrangements, commencement and completion of key zones over the course of the construction period.

As part of the business case development, an Equality Impact Assessment and Risk Potential Assessment have both been completed and approved by the Project Board. Copies of these assessments are found in Appendix 7.7 and Appendix 7.8 respectively.

The project governance arrangements include robust management, reporting and escalation procedures ensuring overall confidence in the delivery of the investment objectives and that the project is being effectively managed. Prince 2 methodology has been implemented throughout the development of the scheme.

7.2.8 Project Management Team

The governance arrangements ensure all team members understand their role and responsibilities and provide a clear and auditable route for decision making and the escalation of risks and issues.

The project team provides a balance of in-house resource, complemented by external resource where this is required due to the need for additional specialist expertise (e.g. P22 Project Manager, P22 Cost Advisor). This achieves the best value for money for the Trust.

The team is responsible for coordinating the activities to progress the project and to develop the business cases, ensuring that interdependencies between the work streams are identified and addressed.

A dedicated and experienced P22 Project Manager has been appointed by the Trust. The Cost Adviser from OBC stage has been retained by the Trust with the remainder of the design team novated over to the appointed P22 PSCP.

As the scheme has progressed to FBC stage, broader expertise and input has been drawn upon from within the Trust and from partner organisations.

The roles, responsibilities and experience of the team is summarised in the table below.

Figure 103. Roles, Responsibilities & Experience of the Team

Role	Responsibilities	Experience
Deputy Chief Executive & Director of Finance, Stockport NHS Foundation Trust		
Senior Responsible Officer	<ul style="list-style-type: none"> Overall responsibility for the delivery of the scheme Authority to resolve issues Responsible for realisation of benefits Ensures the long-term affordability of the project in relation to the trusts long term financial model Responsible for identifying and securing the funding for the project 	<p>The SRO is an experienced Director of Finance who has worked for a range of organisations including, a Health Authority, the North West Regional Office, the Directorate of Health and Social Care North, the Department of Health, a Strategic Health Authority, a Mental Health Foundation Trust and a leading University Teaching Hospital.</p> <p>Before joining Stockport NHS Foundation Trust, the SRO was Executive Director of Finance and Deputy Chief Executive of the Royal Liverpool & Broadgreen University Hospitals NHS Trust. Prior to this, he was Director of Finance & IMT at Greater Manchester West Mental Health Foundation Trust.</p>
Executive Director of Operations, Stockport NHS Foundation Trust		
Operational Lead	<ul style="list-style-type: none"> Accountable for the project governance arrangements Responsible for production of an approvable business case Key liaison to external stakeholders Management of key strategic risks 	<p>The Operational Lead joined Stockport NHS Foundation Trust in December 2020 as Director of Operations, having previously held the same post at Tameside & Glossop Integrated Care NHS Foundation Trust. She has over 12 years senior management experience in acute sector NHS roles across a number of North West trusts.</p> <p>Prior to joining the NHS, she worked within the private sector in the logistics sector.</p>

Executive Director of Estates & Facilities, Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust		
Estates Lead	<ul style="list-style-type: none"> Accountable for the quality of build products Ensure technical proposals or designs are realistic and practical and deliver the design brief Ensures control is maintained under the trust's SFIs and that procurement regulations are maintained 	<p>In 2021, the Estates Lead was appointed as Executive Director of Estates & Facilities over both Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust.</p> <p>Prior to joining Tameside and Glossop IC NHS Foundation Trust in 2019, he was Director of Estates and Facilities at Bradford Teaching Hospitals NHS Foundation Trust.</p> <p>The Estates Lead qualified as a chartered surveyor in 1994 and holds first class honours and master's degrees. He has spent his entire career working for a variety of NHS organisations. He is enthusiastic about how the built environment and facilities services provided to it can make a significant difference to the patient experience and has led the delivery of a number of large-scale redevelopment and transformation projects.</p>
Divisional Director for Medicine, Urgent Care & Clinical Support Services, Stockport NHS Foundation Trust		
Operational Service Lead	<ul style="list-style-type: none"> Provides operational leadership Ensures multidisciplinary views are considered Leads the operational planning for both the transitional period of construction and for the new models of care Responsible for ensuring the design will enable the model of care to be delivered and performance standards maintained 	<p>The Operational Service Lead joined Stockport NHS Foundation Trust in January 2018, having been a Divisional Director and former Head of Partnerships at Wirral University Teaching Hospital NHS Foundation Trust. Prior to this, she worked at Salford Royal NHS Foundation Trust for almost 5 years leading on transformation and urgent care redesign projects.</p> <p>The Operational Lead has been instrumental in the improvement journey for emergency and urgent care at Stepping Hill Hospital.</p>
Clinical Director for Strategy and Assurance in Emergency Medicine, Stockport NHS Foundation Trust		
Clinical Lead	<ul style="list-style-type: none"> Provides clinical leadership Represents the views of clinicians and ensures multidisciplinary views are considered Leads the clinical/model of care work stream Responsible for ensuring the design will enable the model of care to be delivered Responsible for developing the workforce plan Production of staff training and development plans for the new department Production of workforce transitional plans to meet the needs of the phasing programme Identification of workforce risks Support the operational delivery of the programme 	<p>The Clinical Lead has been employed by Stockport NHS Foundation Trust since July 2009. As well as his CD responsibilities, and an active physician in emergency medicine, he is also the Trusts Paediatric Emergency Medicine Lead.</p> <p>The Clinical Lead is an exceptional leader, able to set a vision engage his peers and take people with him on an improvement journey.</p>
Capital Projects Lead, Stockport NHS Foundation Trust		
Capital Projects Lead	<ul style="list-style-type: none"> Support the production of the commercial/estates cases of the OBC and FBC 	<p>The Capital Projects Lead joined Stockport NHS Foundation Trust in July 2019, having worked in capital projects management roles for 10 years previously. Before this, he worked as a Building Surveyor for over</p>

	<ul style="list-style-type: none"> • Ensure the project is delivered to the required quality, within the timescale and budget • Ensure that the end product can deliver the expected benefits • Development of the programme of activities • Reporting progress to the Project Board • Ensuring risks and issues are identified, recorded and regularly reviewed • Report on progress to Project Director • Liaison with contractors • Responsible for ensuring the construction plans link with transition plans • Responsible for commissioning of the new facility 	<p>5 years.</p> <p>In addition to Building Surveying and Project Management, he is experienced in Architectural Design, Contract Administration and Estates Management.</p> <p>The Capital Projects Lead has experience within a variety of professional practice environments. Recent projects include extension and refurbishment of the Trusts endoscopy unit, installation of a High Acuity Care Unit for Covid-19, schemes linked to Healthier Together, various ward refurbishments and an imminent pacing suite development.</p> <p>In addition to this project, he is presently working up the Trust's bid for a new hospital site in Stockport.</p>
Capital Project Support Officer, Stockport NHS Foundation Trust		
Project Support	<ul style="list-style-type: none"> • Maintaining & updating project documentation • Arranging and minuting meetings • Report writing 	<p>The Capital Project Support Officer has recently graduated to becoming a Capital Projects Manager having been a trainee and supporting the delivery of projects all across the Trust.</p> <p>She is organised, efficient, articulate and has great presentation skills.</p>
Associate Director of Finance, Stockport NHS Foundation Trust		
Finance Lead	<ul style="list-style-type: none"> • Support the production of the Financial Cases of the OBC and FBC • Management of the budget 	<p>The Finance Lead has been employed by Stockport NHS Foundation Trust since July 1992, culminating in being Chief Financial Accountant before being appointed Associate Director of Finance.</p> <p>She has been involved in the Trust's successful achievement and delivery of the Greater Manchester Healthier Together programme in Stockport.</p>
Programme Manager, Stockport NHS Foundation Trust		
Project Manager	<ul style="list-style-type: none"> • Support the production of the Strategic and Management Cases of the OBC and FBC • Responsible for delivering the business case in line with the agreed milestones • Provide a clear project plan and timeline within the business case • Review the resource requirements associated with the project • Support stakeholder engagement • Co-develop the communication & engagement plan 	<p>The Project Manager has been employed by Stockport NHS Foundation Trust for almost 7 years. He was appointed as full-time Programme Manager for this proposal and started in post in January 2022.</p> <p>He is a qualified physiotherapist and specialised in respiratory care before undertaking a post graduate qualification in veterinary physiotherapy.</p> <p>In the last 12 years, the Project Manager has been successful in various NHS management roles gaining experience and expertise in operational management and project developments. Recent transformation projects include the planning and delivery of an Acute Frailty Unit as well as Medical Same Day Emergency Care.</p>

The Trust has recently applied for members of the project team to undertake foundation and/or practitioner level courses from the NHS National Business Case Training Programme. Presently 3 members of the team have completed the foundation course. By November 2022, seven staff are expected to have completed both foundation and practitioner level courses.

7.2.9 Use of Specialist Advisors

The Trust recognises the complexity of the programme of works which requires a wide range of specialist skills and experience. Where applicable, specialist advice has been sought from external organisations or providers. The table below summarises main areas of expertise required and their sources.

Figure 104. Specialist Advisors

Company	Role
Ryder Architecture	Principal Architects
O'Neil & Partners	Cost Advisors
Spencer Harrison	Healthcare Planner
Ridge and Partners LLP	BREEAM Consultants
Sutcliffe	Structural Engineers
Sutcliffe	Civil Engineers
TBC	Heritage Consultants
PwC	Business Case Advisors
Hempsons	Legal Advisors
CAD21	Mechanical Engineering
Lichfields	Planning Services
BDO	Tax Advisors

7.3. Contract Management Arrangements

Contract management has been broadly considered across 3 key areas as follows:

- Procurement;
- Facilities management; and
- Service maintenance during construction.

The contract management team, described below, will be responsible for providing the Trust with assurance on contract management across these three key areas. Of importance will be the relationship between these individuals, the core project team and existing clinical services governance mechanisms to ensure risk assessments are undertaken where any disruption to services is suggested or a potential during the construction phase.

7.3.1 Contract Management Team

The construction works have been procured under the P22 framework agreement. P22 is a Construction Procurement Framework administrated by the DHSC for the development and delivery of NHS and Social Care capital schemes in England. The framework continues to build on the principles of its predecessors: to streamline the procurement process and create an environment in which Clients, PSCPs and their supply chains develop stronger partnerships to drive increased efficiency and productivity, whilst supporting enhanced clinical outputs for patients and improved environments for staff and visitors. Therefore, the agreement provides a detailed and structured set of guidelines for the management of building contracts with the support of professional advisors and appropriate NHS leads.

The Trust made the following additional key appointments to complement the existing project team:

- **P22 Project Manager (PM)** – will manage the day-to-day progress of activities of the E&UCC scheme and will be responsible for administering and managing the contract as well as engaging stakeholders. They need to ensure that the processes and procedures in the P22 NEC3 Contract Template Part A and Part B are adhered to by all. They will be the single point of contact for the development and alteration of the Works Information (scope of works).
- **Client Cost Advisor** – the Trust will retain the services of O'Neil & Partners to support the PM in the development and agreement of the GMP and associated contractual documentation, review of assessments submitted for payment, open book audit and control of expenditure.

The above two roles will be required to work closely with the PSCP through the PSCP PM. The PSCP PM will be responsible for the management and delivery of the development of design options and associated costing, detailed design and activity schedules, risk management, cost control and reporting, and all activities associated with construction and commissioning and handover. The PSCP will also be the principal contractor under the CDM Regulations.

The following table represents the key roles and responsibilities of the contract management team.

Figure 105. Roles, Responsibilities & Experience of the Contract Management Team

Role	Responsibilities	Experience
Rider Hunt - Construction Consultants		
P22 Project Manager	<ul style="list-style-type: none"> • Directly works to the Estates Lead and Capital Project Lead • Support the production of the commercial/estates cases of the OBC and FBC • Single point of contact for Supply Chain on behalf of the Client; • Reviews communications structures and sets up task teams; • Assists the Project Director with option appraisal and final report; • Prepares business case documentation; • Develops scheme budget and expenditure plan with cost advisor; • Ensures relevant operational policies, room data-sheets and surveys have been completed. Ensure site's availability and access; • Implements risk management activities; • Oversees contract document preparation, agrees with PSCP the stage activities and associated costs. Agrees GMP; • Operates the scheme contract using the P22 contract template and proformas; • Reviews PSCP programme and expenditure forecast; • Controls early warnings and compensation events; • Only person with ability to change the brief (Works Information); and • Oversees final accounts. 	<p>The Trust appointed Rider Hunt as their professional advisors to support with all of the design and build elements of the project.</p> <p>The P22 Project Manager is a senior figure at Rider Hunt. He has provided project management to over 40 ProCure21/21+/22 projects (including some of the other "Wave 4" capital schemes) and is an expert on capital building projects within the NHS.</p> <p>He brings a depth and breadth of experience of both previous and current schemes to the benefit of the E&UCC project and the Trust project team.</p>
O'Neil & Partners - Chartered Quantity Surveyors & Construction Cost Advisors		
Client Cost Advisor	<ul style="list-style-type: none"> • Advises on conceptual scheme construction cost to establish financial envelope for inclusion in scheme information pack for PSCP selection process; • Assistance in the preparation of PSCP selection information and scheme contract documentation; • Transfers BRD information into scheme contract, ensures on going PSCP compliance; • Advises on contractual matters including the development of the Works Information and Site Information with the PSCP and PM; • Monitors expenditure against profile; • Risk management appraisal; • Monitors VAT advice; • Validation of life-cycle costs; • Drafting compensation events notifications for action by PM; • Assesses and advises on PSCP quotations; • Checks payments and assessing prices of work done to date; and • Administrates and signs off final accounts. 	<p>The Client Cost Advisor is a partner and a member of the senior management team at O'Neil & Partners, and has considerable experience in the various sectors.</p> <p>Recent health sector construction projects include:</p> <ul style="list-style-type: none"> • Aintree University Hospital • Salford Royal Orthotics • RBH Critical Care Unit • Moorside Unit Alterations

7.3.2 Contractual Performance Management

The P22 pre and post-occupancy evaluation toolkit will be used to capture outcome measures across a range of areas, which the built environment can influence and support. These metrics will support 'before' and 'after' comparison of the development, across new build and refurbished areas of the project.

The evaluation involves the standard key performance figures (KPIs) as set out in the P22 framework, which are used to track PSCP and supply-chain performance, support development and to benchmark performance in (and against) the P22 Framework.

The KPIs will measure performance against the GMP agreed between parties; the dataset includes, but is not limited to, measures of:

- Patient experience
- Staff experience
- Physical environment
- CQC rating
- Activity
- Environmental (sustainability)
- Financial performance
- Operational performance
- Health & safety
- Business case benefits realisation

The KPIs will be reviewed and managed each month by the PSCP, Trust, and P22 Project Manager using the Monthly Monitoring System.

7.4. Communications and Stakeholder Engagement

7.4.1 Communications Plan

The Communications Plan, in Appendix 7.9, has been developed with the Trusts communications team. This communication plan aims to ensure that:

- All stakeholders including staff, patients, and the public are fully informed about the scope and impact of the project; and
- Impact on operational day to day activity is communicated.

The target audiences are clearly defined, and appropriate channels have been set out in the communications plan. In addition, user engagement is also taking place in conjunction with the planning application process.

Arrangements are in place to make the FBC and any addendum public within a month following FBC approval, with the executive summary (at least) available on the Trust's website.

7.4.2 Stakeholder Engagement

Throughout the development of the business case, the Trust has implemented a robust stakeholder management and engagement process that has involved the regular identification review/analysis, planning and implementation of actions designed to engage stakeholders that has included:

- Identification of stakeholders/stakeholder organisations and decision-makers through the process of stakeholder mapping;
- Analysis of the stakeholders to understand their influence and position in relation to the Project;
- Approval of the comprehensive stakeholder list through the Project Board;
- Development of a Stakeholder Management and Communications Plan which set out the approach, form and timing of communications with each stakeholder, or group of stakeholders; and
- Engagement of Stakeholders including the production of stakeholder specific communication materials.

The Trust has engaged with stakeholders whilst working under the constraints of the pandemic. A list of specialist advisors is provided in Section 7.2.9.

Significant consultation and engagement with clinicians and staff groups has been undertaken throughout the development of the design layout for the new department to ensure the design meets the needs of staff providing care within the clinical zones, in terms of a clinical environment as well as accommodation which is conducive to staff wellbeing.

Numerous engagement sessions have been held with teams, staff groups and professional disciplines such as infection control leads, pharmacy and security leads to develop the design. The design has been developed with clinical staff. The various levels of room loaded plans have been agreed/approved respective operational leads, clinical leads, subject knowledge experts and disciplines.

The Trust has engaged with staff throughout the development, and has recently refreshed the communications plan as described above, in light of the successful outcome of the OBC. Further engagement with staff has taken place regarding the detailed phasing plan to ensure that the project can be delivered safely within the challenges of live clinical environments.

There is a high degree of joint working in place between the construction and project teams and the clinical and operational teams to ensure that this scheme is fit for purpose and can be delivered in line with the programme.

Details of the options appraisal attended by key stakeholders, which sets out each area of consideration, option and conclusion is found in Appendix 4.1. The complete overview of engagement activities can be found in Appendix 7.10; a selection of activities is listed below:

- Data Modelling
- Design & Build Meetings
- Pacing Suite Relocation Discussion
- Project Board
- Clinical Directors
- Benefits - NCRBs and UBs
- Medical Gas AE Meeting
- Cost Review
- Radiology Waiting Room Relocation Discussion
- Pharmacy Discussion
- BI Discussion
- Room Loaded Plans Review & Sign Off
- FBC Weekly Meeting
- Options Appraisal
- Fire Consultant Engagement Meeting
- Data & Telecommunications Discussion
- FBC Weekly Meeting
- MSDEC Temporary Relocation
- Start of the Week

7.5. Benefits Realisation

The Trust is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources. This is one of the seven key principles set out in the NHS Constitution to guide the NHS in all that it does.

Benefits management ensures that the cash and non-cash releasing benefits detailed in the Economic Case continued to be linked to the investment objectives of the Strategic Case; it is a planned and systematic process of:

- **Identification** – defining the benefits and the improvements that will be delivered from addressing the proposed change in terms of the expected investment objectives
- **Prioritisation** – of the benefit to confirm its importance;
- **Realisation** – developing a plan and identifying the management arrangements required for each benefit; and
- **Monitoring & Review** – undertaken throughout the delivery of the project from OBC to evaluation post-delivery of the new capital build and clinical pathways therein

The Trust has prepared a 'Benefits Management Plan' in the table below and in Appendix 7.13 which aligns the benefits to the investment objectives outlined in the Strategic Case.

Figure 106. Benefits Management Plan

Investment Objective(s)	Benefits	Indicator(s)	Source	Target(s)	Owner	Review Frequency
Future proofing capacity for urgent & emergency care	a) To secure recent improvements in urgent care hospital flow in line with national and regional LTP expectations b) Reduction in delays and waiting time for patients needing E&UCC services. c) To limit the amount of time patients spend in hospital.	Improved and sustained delivery of the Urgent Care access standards.	Stockport NHS Foundation Trust	National UEC Standard	Urgent Care & Delivery Board	Monthly

Improved Streaming	<ul style="list-style-type: none"> a) To effectively deflect patients suitable for direct access to specialty along pre-defined clinical pathways away from the Emergency Department and direct to the right clinical workforce and environment for their need b) To provide best possible opportunity for admission avoidance for these E&UCC patients and to limit time spent in acute care 	Increase in number of patients seen in an SDEC environment. Reduction in ED attends for patients subsequently referred to a specialty (10% reduction) i.e., direct referrals from NHS 111, GPs and Ambulance services.	GM Tableau	In line with peer benchmarking	Urgent Care & Delivery Board	Monthly
Clinical Strategy - Same Day Emergency Care	<ul style="list-style-type: none"> a) Reduction in admissions due to earlier decision making from senior specialists working to pathway designed delivery models b) Improvements in performance against clinical standards for SDEC from rapid transfer out of the ED to specialty 	Increase zero length of stay admissions from 30% to 45%. Increase in Direct admissions from GP by 20%.	GM Tableau	In line with peer benchmarking	Urgent Care & Delivery Board	Monthly
Responding to demand for patients presenting in mental health crisis	<ul style="list-style-type: none"> a) To improve the environment for patients presenting in mental health crisis b) To provide an efficient pathway for patients that reduces length of stay in the E&UCC service 	Improve the Urgent Care access standard performance for patients presenting with mental health crisis.	Stockport NHS Foundation Trust	National UEC Standard	Urgent Care & Delivery Board	Monthly
Clinical strategy – Ambulances turnaround	<ul style="list-style-type: none"> a) To ensure ambulances can promptly handover care ensuring ambulance availability in the community for emergencies b) To ensure patients are cared for in an appropriate, safe environment 	To sustain ambulance turnaround times within national standards. Zero tolerance for handovers over 60 minutes.	North West Ambulance Service	National Standard	Urgent Care & Delivery Board	Monthly
Economic	<ul style="list-style-type: none"> a) Reduction of estate footprint, in turn releasing key estate for potential future development b) Reduction of back log maintenance c) Improved transport infrastructure, car parking facilities and access to the hospital site. 	Reduction of back log maintenance by 15% (after 10 years)	Stockport NHS Foundation Trust	National Standard	Finance & Performance Committee	Quarterly
Patient Experience	<ul style="list-style-type: none"> a) Enhanced patient environments that improve the experience of urgent care through sensitive design and clear patient pathways for acute presentations b) Capacity to ensure waiting times are reduced in line with urgent care access standards c) Increase in substantive staffing improves continuity of care 	Improved and sustained delivery of the Urgent Care access standards. Improved FFT scores by 20%. Reduction in complaints/increase in compliments.	Stockport NHS Foundation Trust	National Standards	Quality Committee	Quarterly
Staff & Well-being	<ul style="list-style-type: none"> a) Enhanced staff environments that improve the experience of urgent care through sensitive design and clear patient pathways for acute presentations b) Support positive health and wellbeing through environment design c) Increase in substantive staffing improves professional relationships 	Improvement in monthly pulse surveys and annual staff surveys and perceptions of the Trust as an employer - top quartile for workplace recommendations in national survey. Urgent care recruitment and retention metric improvement - turnover reduces by 10% and commensurate vacancy rate reduction. Staff sickness rate reduction. Improved Statutory & Mandatory Training Compliance.	Stockport NHS Foundation Trust	National Standards	Divisional Performance Reviews People Performance Committee	Quarterly

The delivery of these benefits will be robustly managed, reported and escalated through the Project Board, drawing on the expertise of transformation resources, and adopted as business as usual within Divisional structures through integration with operational delivery plans and assurance processes.

Benefits will be continuously reviewed through the established project governance arrangements, and in particular in connection with any documented risk, forming a key part of the Post Project Evaluation Process described below.

7.6. Risk Mitigation

The Project Board has responsibility for assessing and managing and escalating risks relating to the project. The Project Risk Register aligns to the Trusts Risk Management process.

Risk Management incorporates risk assessment, which is an ordered approach to risk analysis. The risks are logged and scored by matrix analysis to determine whether the levels of risk are acceptable. A 'RAG' rating is applied for easy identification of key risks.

Risks are scored out of 5 for likelihood, and 5 for the magnitude of the impact. These two scores are then multiplied to produce an overall risk score out of a possible 25.

Risk management techniques offer a systematic approach to the identification, assessment and control of the significant risk factors affecting the progress of the project. Areas of high risk are reviewed to ensure that all reasonably practicable measures have been taken to mitigate them.

The risk management process is designed to ensure that as far as is reasonable:

- All significant risks are identified;
- Risk exposure is understood and reduced to acceptable levels;
- Risk control measures are implemented; and
- Control measures are reviewed and managed to close out.

The projects risk register was developed by members of the Project Board, Clinical Modelling and Design Team and is based upon risk identification, classification and mitigation measures. It is reviewed regularly to ensure updates to control measures are provided and appropriate actions taken accordingly, and in a timely manner. It is a 'live document' enduring throughout the life of the project, and is updated regularly in line with score and/or new developments.

Figure 107. Project Risks – Accountability & Review Frequency by Score

Score	Review and escalation
1-6	Monitored at the discretion of the project team
8-12	Monitored weekly by project team and raised at the Project Board meetings
15-16	Managed through the Project Board & raised to the Executive Team Meeting by the SRO
20-25	Reported immediately to relevant Divisional Director / Executive Director

A detailed risk register with clear owners for the management and mitigation of each risk, and associated costs, is included in Appendix 7.6; an extract summary is captured in the table below.

Figure 108. Project Risks

Risk	Impact	Likelihood	Consequence	Risk Rating	Mitigation	Likelihood	Consequence	Residual Risk Rating
War between Russia and Ukraine has wider repercussions, with the timing impacting on the GMP and/or construction phases.	The impact could include: <ul style="list-style-type: none"> - fixed price tender returns - capital costs- due to increases in fuel and energy costs - Unavailability of labour, plant, and/ or materials 	4	4	16	Cost mitigation plans and contingency as described above, and potentially scaling back the programme of works e.g. façade, until a later date.	4	4	16

Affordability: - the design exceeds £30.5m criteria - insufficient PDC for to fund the scheme	Change of schedule of accommodating impacting on cost and programme. Rejection of OBC by NHSE/I given costs.	3	5	15	<ul style="list-style-type: none"> • Design stage has been thorough • Detailed costs plans from QS • Use of specialist cost advisors • The programme governance will control mission creep and limit changes • Robust governance arrangements and controls • NHSE/I confirms funding available 	2	5	10
Project does not achieve the milestones for close out by Apr-24: - FBC approval - enabling schemes - construction period	If NHSEI & DHSC do not approve FBC then unable to proceed with the scheme. Delayed JISC approval means that construction cannot start on time.	4	4	16	<ul style="list-style-type: none"> • NHSE/I agreed milestones. • OBC and FBC compelling case for change and economic benefits • Project Board approval of milestones and construction phasing strategy • Weekly FBC review meetings. • Seek opportunities to claw back /accelerate phases 	2	4	8
Trust's ability to maintain operational services during construction	Inability to meet operational performance standards	4	4	16	<ul style="list-style-type: none"> • Phasing plan co-developed and approved by Project Board to minimise disruption to operational services. • Review of Business Continuity Plans, Major Incident Plans and OPEL actions • Operational teams continually assess staffing during construction. 	2	4	8
Efficiencies will not be achieved	Optimal efficiency of new pathways, estate and ways of working will not be achieved, and measurable benefits will fall short of expected	4	4	16	<ul style="list-style-type: none"> • Detailed costs analysis has been undertaken, drawing on benchmarking data such as the Model Hospital. • Sensitivity modelling has been completed to ensure an achievable efficiency gain to bring the Trust in line with national performance • Workforce modelling/reviews with clinical teams 	2	4	8
Changes in volume of demand	The available capacity is insufficient to meet demand, impacting on performance, patient and staff experience	4	4	16	Key principle of the design is to ensure there is operational agility to allow the space to be repurposed or directed to meet demand.	2	4	8
Further Covid-19 variants and surges	Increase in space and therefore cost or increased flexibility required in the design and MEP systems	3	4	12	<ul style="list-style-type: none"> • Development of a design that can adapt in the event of a future pandemic. Zonal approach to design will support this • Involvement of Infection Prevention & Control team & policies/procedures 	2	4	8
Current building and estates deteriorate beyond repair or fail	Building, mechanical and infrastructure, plant and equipment may fail before they can be replaced.	3	4	12	Issues identified via 6 facet survey to understand and mitigate issues	2	4	8
Price increases e.g. energy costs	Potential draw on internal Trust funds to meet any additional expenditure	2	5	10	Cost mitigation plans and contingency provides enough coverage.	1	5	5

7.7. Change Management

Change management is the planning and implementation of any workstream required in order for a project to be delivered successfully. This section highlights key areas considered whilst progressing the project. As part of FBC developments, the Project Board will oversee key elements of change management including:

- Equality, diversity and inclusion;
- Workforce planning;
- Adapting to technology; and
- Interfacing with the communications and engagement plan.

7.7.1 Equality Impact Assessment

To ensure compliance with public sector equality duty (Section 149 of the Equality Act 2010) and public bodies, in the exercise of their functions, must pay 'due regard' to the need to eliminate discrimination, victimisation and harassment; advance equality of opportunity; and foster good relations. This is paramount when planning any service changes.

The Equality Act 2010 makes certain types of discrimination unlawful on the grounds of the following "protected characteristics":

- Age;
- Being or becoming a transsexual person;
- Being married or in a civil partnership;
- Being pregnant or on maternity leave;
- Disability;
- Race including colour, nationality, ethnic or national origin;
- Religion, belief or lack of religion/belief;
- Sex; and
- Sexual orientation.

A full Equality Impact Assessment has been produced to support development of this FBC and can be found in Appendix 7.7.

7.7.2 Security and Confidentiality

The Trust is maintaining security and confidentiality as part of the project; and in line with the Trust's Security and Confidentiality Policies. The Standard Operating Procedure for Information Governance and Security Incident Reporting and Management is provided in Appendix 7.11.

7.7.3 Organisational and Cultural Impact

The project represents a change in operational practices and ways of working, for instance in the adoption of digital technologies in the day-to-day delivery of healthcare, or the use of smart building management systems. These new ways of working may require new skills to be acquired and the scale of the project means that the organisational and cultural change will be felt across the Trust.

7.7.4 Workforce Planning

This project is primarily estate redevelopment, focused on improving accommodation standards, adjacencies and functionality to meet the current and future needs of a modern E&UCC. However, this will necessitate a new clinical model to be developed in order to provide high quality, safe care in the new environment.

The project has been designed to realign clinical services so that patients are directed to the specialties they require in a new fit for purpose environment. The investment objectives from a clinical perspective is to reduce waiting times, reduce delays to specialty review and reduce operationally unproductive elements identified in the current E&UC pathways and ultimately avoid admission wherever possible.

A workforce planning group has been led by the Divisional Nurse Directors. The Trust will also explore innovative digital approaches in the urgent care service to support patient experience and timely discharge of patients. See Appendix 5.5 Digital Strategy. This innovation is being factored into the workforce plans for the E&UCC.

Workforce modelling has been undertaken with clinical leads, operational leads and rota managers, as part of the appraisal for the preferred option. The movement in WTE and skill mix can be found in Appendix 7.12, but essentially the future workforce will not significantly change, with the exception of allowances for population demand growth.

The shape of the future workforce takes into account feedback from our stakeholders and key clinical and operational leads, lessons learnt from other project where workforce issues have been prevalent, learning from staff surveys, new ways of working along with career progression opportunities.

7.7.5 Design and Contract Change Management

The project will use a robust change control process to manage any requirements for change to the initial scope of the project. All changes will be documented in the change control log maintained by the project manager.

At the beginning of the project a change matrix will be developed to identify the tolerance levels that will be used to determine the sign off level required. This will be based on the impact to cost, quality and time. These tolerance levels will be agreed by the project team and approved by the Executive Team before commencement of the project.

Changes to scope may originate from various sources and will be raised by the relevant workstream lead to the project manager, who will undertake an initial assessment of the impact of the change with the workstream lead.

The change will also be checked against the benefits realisation plan to identify if there is an impact on the benefits expected. Dependent on the level of impact this will be taken by the project manager to either the project team or project board for approval.

The project manager will record the decision in the change log and notify the work stream lead of the outcome.

7.7.6 Public Consultation

After consideration of statutory duties in line with the NHS Act 2006 and Equality Act 2010, as well as NHSE's 2018 guidance '*Planning, assuring and delivering service change for patients*', the Trust and in SCCG's Letter of Support (Appendix 1.4), agree that formal public consultation is not required for the following reasons:

- There will be no substantial change over how services will be delivered; and
- There will be no change in geographical location from where services will be delivered.

However, the Trust intends to undertake wider engagement as part of the planning process which is endorsed by stakeholders.

7.8. Post Project Evaluation

The post project evaluation (PPE) is a process used to capture the learning from a project, communicate this learning to all parties associated with the project and use it to drive future improvements. This process also allows the Trust to test the effectiveness of the policies and procedures used to undertake the project.

Clinical, operational, financial and transformation expertise, experience and best practice has been adopted in the delivery of this project which will continue in conjunction with the established robust governance arrangements to ensure effective evaluation upon completion of the project.

The end stage of the project will result in the completion, handover and commissioning of the new facility. The SRO is responsible for providing assurance that the project has been delivered in terms of product and quality in line with the business case.

DHSC guidance states that business cases for capital projects will not be approved without planning for PPE. The Project Team recognise that learning is an active process which should not be constrained by a one-off exercise. Although PPE check point dates are identified below, quality improvement mentality and methodology is routinely embedded throughout the organisation, from Ward to Board, and learning/transforming/improving between these dates would not be discouraged; it would be captured at the evaluation check points. In addition, there will be synergies with the P22 post-occupancy evaluation toolkit referred to above.

In accordance with best practice and existing Trust Management arrangements for the evaluation of capital projects, the Trust will ensure that a thorough post-project evaluation is undertaken to ensure that positive lessons can be learnt from the project.

Figure 109. Post Project Evaluation Checkpoints

PPE Check Point		Description	MMM-YY
PPE-1	JISC FBC Approval	<ul style="list-style-type: none"> • Lessons learned workshop between FBC parties 	Aug-22
PPE-2	Handover & Commissioning	<ul style="list-style-type: none"> • Lessons learned workshop between all construction period 	Apr-24
PPE-3	Post-occupancy Review	<ul style="list-style-type: none"> • Lessons learned workshop between all stakeholders • Post-occupancy evaluation report 	Oct-24
PPE-4	Operations Review	<ul style="list-style-type: none"> • Lessons learned workshop between all stakeholders • Post-occupancy evaluation report • Gateway 5 Operations Review • Review of the project 1 year after commissioning <ul style="list-style-type: none"> - Monitor progress - Evaluate the project outputs 	Apr-25

		- Evaluate benefits realisation.	
PPE-5	End Project Report	<ul style="list-style-type: none"> • End Project Report • Review of the project 2 years after commissioning - Evaluate benefits realisation. 	Apr-26

As described above, the Trust will utilise the Post Occupancy Evaluation Toolkit. The toolkit allows for:

- Standardised post occupancy evaluation methods and metrics aligned with NHS Improvements Model Hospital;
- Findings/conclusions that are widely accessible;
- A focus on technical performance and outcomes related to patient-centred care and staff experience; and
- Lessons learned accessible to all.

This PPE approach will align with, and satisfy, the requirements of the Department of Health's Good Practice Guide: Learning Lessons from Post Project Evaluation (Department of Health 2007) and will incorporate a detailed review of specific outcomes from the project.

The Trust is committed to ensuring that a thorough and robust evaluation is undertaken to ensure that positive lessons are learnt, and benefits are clearly realised.

Evaluation will be completed by the Project Team who may choose to co-opt other individuals that have been involved in the project as required. There is no specific budget identified for evaluation; services transferring to the new clinical capacity will be required to report as usual on operational and quality indicators as part of the BAU option that constitute the key elements of the Benefits Management Plan.

An evaluation report will be completed and the full report or executive summary, as appropriate, will be made available to the Trusts Executive Team and a summary report made available to all stakeholders.

7.9. Gateway Approval Process

Up until 2015, the Department of Health operated a "Gateway" Service for large projects and having a Gateway review at each Business Case stage was a pre-requisite to NHS approval where NHS Capital or approval for private finance was required. A Gateway Review was, essentially, a review of the substance of a scheme which allowed the level of delivery confidence to be assessed together with the actions to address any perceived shortfalls.

Figure 110. Gateway Reviews

Gateway	Description	Stage in Project
Gateway 0	Strategic Overview	Project initiation
Gateway 1	Business Justification	Pre-SOC submission
Gateway 2	Delivery Strategy	Pre-OBC submission
Gateway 3	Investment Decision	Pre-FBC submission
Gateway 4	Ready for Service	During construction / before handover
Gateway 5	Operations Review (benefits realisation)	During operation, prior to End Project Report.

Currently formal Gateway Reviews are compulsory for NHS capital schemes over £50m. The Gateway Review process is a series of short, focussed, independent peer reviews at key stages of a project. The reviews highlight risks and issues, which if not addressed would threaten successful delivery of the project.

A peer review of the OBC was undertaken by the Deputy Chief Operating Officer of the Trust. This review provided assurance to senior management, stakeholders, and the approving authority that the project can be successfully delivered.

In October 2021 the DHSC Capital Delivery Oversight Group recommended that all current UK Government manifesto related capital schemes £15m - £50m with a medium-high Risk Potential Assessment should also consider a Gateway 3 Review ahead of FBC submission to the JISC.

As part of JISC's conditional approval of the OBC, the E&UCC project team was asked by DHSC to consider a Gateway 3 review ahead of FBC submission. The project team contacted the DHSC Capital Delivery Programme Management Office to discuss the requirement for a Gateway 3 review ahead of FBC submission to JISC in July 2022.

On 30th March 2022 representatives from the project team met with DHSC Capital Delivery Programme Management Office (PMO) and regional NHSE/I to discuss the Gateway 3 review process. The following points were discussed:

- Gateway 3 was not mandatory, but was regarded as good practice;
- High level summary of the Gateway 3 process:
 - It could take up to 12 weeks to source and arrange an independent team; likely end June/early July 2022
 - The Gateway Review team would be on site for 1 week, requiring interviews with members of the project team - particularly the Senior Responsible Officer (SRO)
 - The following week the SRO would receive a final report for inclusion with the FBC;
- NHSE/I and DHSC Capital Delivery PMO reiterated that Gateway 3 Review was not mandatory, and it would be acceptable to seek additional assurance through other routes. For example, an Independent Peer Review from another health provider organisation - with no conflict of interest; and
- NHSE/I stated that the undertaking of a gateway review cannot create an FBC delivery risk due to the possible diversion of Trust resources away from the FBC and project delivery at a key time for the project. This statement was supported by the Trust, as resources would need to be diverted to support the Gateway 3 process.

Subsequently the E&UCC Project Board agreed to the following points and approach to the Gateway Review process:

1. The Gateway 3 Review timelines jeopardise the E&UCC FBC milestones for JISC, and thus the entire project given the expectation of completion by April 2024 as per UK Government manifesto commitment;
2. The Gateway 3 Review would draw on the availability of the project team at a time when resources may be limited due to NHSEI and DHSC FBC queries, Stage 3 stakeholder engagement, and annual leave associated with school holidays;
3. The project is <£50m so Gateway Reviews are not compulsory;
4. The Risk Potential Assessment of the E&UCC project (Appendix 7.8) is rated 'low' and as such falls outside of the medium-high bracket for UK Government manifesto related capital schemes which should consider a Gateway 3 Review;
5. The Trust recognises the value of an external assurance process. For the reasons listed above, instead of a Gateway 3 Review the Trust will seek an Independent Peer Review from another health provider organisation - with no conflict of interest - which will allow the level of delivery confidence to be assessed together with the actions to address any perceived shortfalls. In addition, this would demonstrate the Trusts commitment to external assurance which for the reasons listed above, unfortunately cannot be supported via a Gateway 3 Review; and
6. The Trust will commit to Gateway 4 and 5 Reviews.

8. Appendices

Appendix 1.1: DHSC Funding Approval Letter
Appendix 1.2: Trust Board – Approval of Full Business Case
Appendix 1.3: Stockport Metropolitan Borough Council – Letter of Support
Appendix 1.4: Stockport Clinical Commissioning Group – Letter of Support
Appendix 1.5: Greater Manchester Health & Social Care Partnership – Letter of Support
Appendix 1.6: NHSE&I Business Case Core Checklist
Appendix 1.7: NHSE&I Fundamental Criteria Checklist
Appendix 3.1: Stockport NHS Foundation Trust – Trust Strategy 2020-2025
Appendix 3.2: Stockport NHS Foundation Trust – People Strategy 2021 – 2023
Appendix 3.3: Future Clinical Pathways
Appendix 3.4: Capacity Modelling of the Emergency Department
Appendix 3.5: Letter from John Graham to NHSE/I re. Healthier Together
Appendix 4.1: Detail of Options Appraisal
Appendix 4.2: Option Description Templates
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Appendix 5.1: Procurement Options Process
Appendix 5.2: Rider Hunt P22 PSCP Selection Report
Appendix 5.3: Certificate of Incorporation on Change of Name
Appendix 5.4: Equipment Schedule
Appendix 5.5: Stockport NHS Foundation Trust – Digital Strategy 2021-2026
Appendix 5.6: Solicitor Approval – Hampson's Construction Legal Letter Stage 3
Appendix 5.7: Trust's Head of Procurement Letter
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Appendix 6.1: SoCI – Option 1 BAU
Appendix 6.2: SoCI, SoFP, SoCF – Option 3 Preferred Option
Appendix 6.3: Summary of Incremental Movement BAU v Preferred Option
Appendix 6.4: SoCI – Option 3 Preferred Option Incremental
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Appendix 6.6: SoCI, SoFP and SoCF – Option 3 Preferred Option Sensitivity Adjusted
Appendix 6.7: Financial Case Benefits and Risk Tables
Appendix 7.1: Stockport NHS Foundation Trust Constitution 2019
Appendix 7.2: Project Board – Terms of Reference
Appendix 7.3: Project Initiation Document
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Appendix 7.5: Project Delivery Tool
Appendix 7.6: Risk Register
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Appendix 7.11: Information Governance and Security Incident Reporting and Management SOP
Appendix 7.12: Movement in WTE and Skill Mix
Appendix 7.13: Benefits Management Plan

9. Glossary

Acronym	Meaning
AVFM	Absolute Value for Money
BREEAM	Building Research Establish Environmental Assessment Method
CDM	Construction Design and Management
CIA	Capital Investment Appraisal
CQC	Care Quality Commission – an executive non-departmental public body of the Department of Health that regulates and inspects health and social care services in England.
CSFs	Critical Success Factors
DCF	Discounted Cash Flow – a valuation method used to estimate the value of an investment based on its future cash flows
DCP	Development Control Plan
DH	Department of Health – a Ministerial Department of the Government responsible for government policy on health and adult social care matters in England.
DHSC	Department of Health and Social Care
E&UCC	Emergency & Urgent Care Campus
EBITDA	Earnings Before Interest Tax Depreciation and Amortisation - net income with interest, taxes, depreciation and amortisation added back to it. EBITDA is used to analyse and compare profitability between Trusts because it eliminates the effects of financing and accounting decisions.
ED	Emergency Department
FBC	Full Business Case – this term is used in Treasury guidance regarding the development of capital business cases. It is associated with a required framework and structure to be used to enable clear thinking about capital spending proposals and a structured process for appraising, developing and planning to deliver best public value. Business Cases are required to be developed at four sequential stages of planning – the strategic outline case, the outline business case, the full business case and the final business case.
FF&E	Furniture, Fixtures and Equipment
GIRFT	Getting It Right First Time
GMP	Guaranteed Maximum Price
HBN	Health Building Note
HMT	Her Majesty's Treasury – The British government department responsible for developing and executing the government's public finance and economic policies.
HTM	Health Technical Memorandum
I&E	Income and Expenditure – a record showing the amounts of money coming into and going out of an organisation.
IM&T	Information Management and Technology
JCT	Joint Contracts Tribunal
JISC	Joint Investment Sub-Committee
LoS	Length of Stay – how long a patient is admitted to hospital for
LTP	Long Term Plan
MMC	Modern Methods of Construction

NHSE	National Health Service England - oversees the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England.
NHSI	National Health Service Improvement – the national regulator responsible for overseeing Foundation Trusts and NHS Trusts, as well as independent providers that provide NHS-funded care.
NPC	Net Present Cost
NPV	Net Present Value - is the difference between the present value of cash inflows and the present value of cash outflows. NPV is used in capital budgeting to analyse the profitability of a projected investment or project.
OB	Optimism Bias
OBC	Outline Business Case
OJEU	The Official Journal of the European Union
PDC	Public Dividend Capital - a form of long-term government finance which was initially provided to NHS Trusts when they were first formed to enable them to purchase the Trust's assets from the Secretary of State.
PFI	Private Finance Initiative - a method of providing funds for major capital investments where private firms are contracted to complete and manage public projects. Under a private finance initiative, the private company, instead of the government, handles the up-front costs.
PPE	Post Project Evaluation
PSCP	Principal Supply Chain Partner
PUBSEC	BCIS Public Sector Price and Cost Indices
SCCG	Stockport Clinical Commissioning Group
SDEC	Same Day Emergency Care
SFI	Standing Financial Instructions
SMBC	Stockport Metropolitan Borough Council
SOA	Schedule of Accommodation
SoCI	Summary of Comprehensive Income
SoFP	Statement of Financial Position - is another name for the balance sheet. It is one of the main financial statements and it reports an entity's assets, liabilities, and the difference in their totals.
SRO	Senior Responsible Officer
SURC	Stockport Urgent Referral Centre
TUPE	Transfer of Undertaking Protection of Employment
UTC	Urgent Treatment Centre
UEC	Urgent and Emergency Care
UECDB	Urgent and Emergency Care Delivery Board
VE	Value Engineering
VFM	Value for Money - the most advantageous combination of cost, quality, benefits and sustainability to meet requirements.
WTE	Whole Time Equivalent - The ratio of the total number of paid hours during a period divided by the number of available working hours in that period. The ratio units are whole time equivalent employees - one WTE is equivalent to one employee working full-time.



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