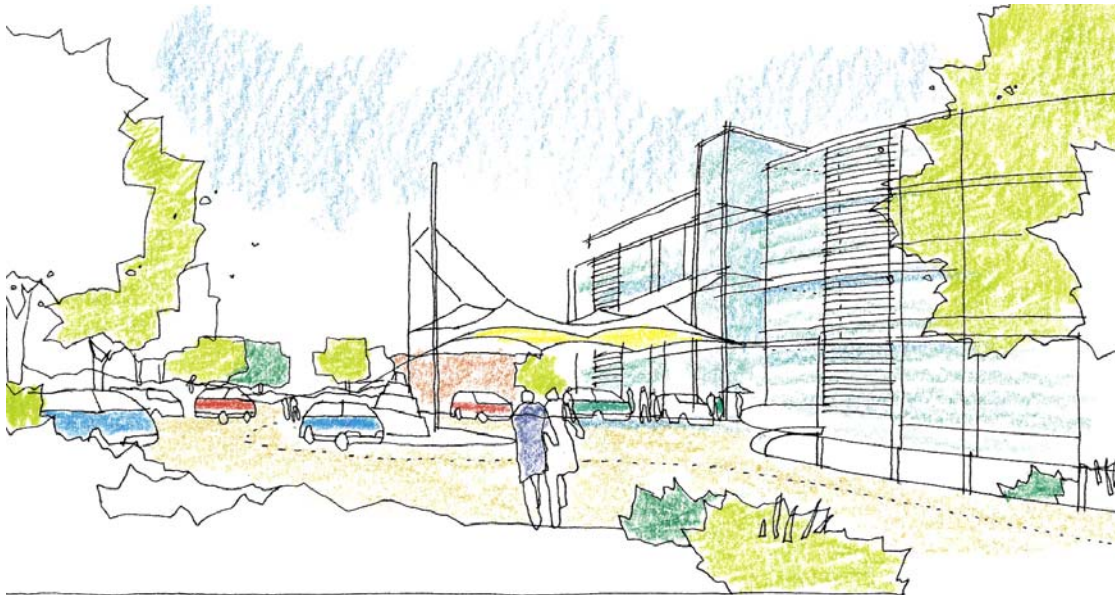


The Centralisation and Modernisation Of Acute Services on the Broomfield Site



Project Summary

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1 Introduction

Since the 1970's there have been long held plans to centralise acute services in Chelmsford. In this PFI scheme, the Trust will both centralise and modernise acute services from St. Johns and Chelmsford and Essex Hospitals onto the Broomfield Hospital site with other schemes being developed within the health economy. This will offer an integrated service strategy for health care in Mid Essex. The plan is consistent with Essex Health Authority's HIMP and Acute Service Strategy. Project delivery is essential to improve patient safety, quality, clinical efficiency and productivity in line with the NHS Plan.

This project summary sets out:

- The background to the project.
- The Future Vision for the scheme
- The changed models of care that have been developed for the modernisation of services.
- The activity levels which define the requirement.
- A summary of the Trust's vision for design quality.

2 Background

North Essex Health Economy has an agreed strategy of three District General Hospitals (DGH) within a network of Primary Care Organisations (PCT's). The PCT's will support the DGH by the provision of intermediate care beds, outpatient facilities including plain film X-ray and facilities for blood testing, as well as a range of therapeutic and GP specialist services where it is both economic and the appropriate physical infrastructure exists.

The Essex Health Authority (EHA) has already approved the creation of a single site community hospital for Braintree. This, along with the concurrent development of proposals for Maldon and Chelmsford residents by their respective PCT's, forms a network of care for the residents of Mid Essex. It will enable patients to be seen in the most appropriate setting and provide seamless transfer both to and from a secondary care setting.

MEHST has a vision of radical change to address the principle challenges of:

- Significantly reducing patient risk by moving an isolated large Maternity Unit onto a DGH site.
- Addressing the significant clinical risk for other acute specialities and gross inefficiencies posed by split site working;
- Fundamentally changing the capacity, process and organisation of acute services to deliver the targets of the NHS Plan, including resolving the inadequate provision of day stay services; changing the way in which patients with Chronic Disease are managed jointly with primary care; enabling the split in emergency and elective workload flows to be introduced and facilitating the streaming and re-modelling of emergency referrals and their management;
- Reducing backlog maintenance of the Trust's estate estimated at £25m over 10 years;

- Creating a financially sound and efficient acute Trust of high quality.

The Broomfield PFI proposes a change in the processes and models of care in the acute sector, describing a graduated model for emergency patients and provision of separate and dedicated facilities for elective patients. This combined with a concurrent project for an Essex health economy wide Electronic Patient Record (EPR), integral to the future model of care, will enable the capital investment of £105 million sought to provide greater efficiencies throughout the whole system of care in Mid Essex.

The Health Authority, PCT's, North Essex Mental Health Partnership, local authorities and other significant partners alongside the Trust's clinicians, have been fully involved in the development of the PFI project, which has their full support.

2.1 Planning Assumptions

The acute hospital service presently has a total of 792 inpatient and day stay beds split across two sites - St. John's and Broomfield Hospitals. The Trust presently provides a total of 62,100 Finished Consultant Episodes (FCEs). The future level of activity required to meet local health needs, assessed population change and to deliver the NHS Plan has been agreed with all parties by undertaking joint demand modelling. This projects an increase in total inpatients and day cases from 2001/02 to 2009/10 of 36.8% to 84,936 FCEs. Similarly, new outpatient attendees will increase by 30.5% by 2009/10.

Using the same demand and capacity assumptions the Health Authority and the PCT's have identified the need for 61 additional intermediate care beds or assisted placements.

2.2 Preferred Option

Four options were evaluated in the Outline Business Case (OBC). The plan from the preferred option is to build a new Diagnostic and Treatment Centre (Ambulatory Care facility) on the Broomfield site, which will provide a separate dedicated unit for all elective care, and will enable outpatient services to be brought together. There will be a new build for Obstetrics and Paediatrics, centralisation of all Pathology services, a High Dependency Unit, a new Breast Screening facility and Diabetic services accommodated within the overall development.

The scheme also enables the re-modelling of emergency facilities via a new Accident and Emergency department, the creation of a 114 bedded Emergency Assessment Area, co-located with an 8 bed Coronary Care Unit. The assessment area will take direct emergency referrals from GP's and will care for medically unstable patients. This preferred option allows rational and clear development of the Broomfield site ensuring the coherent and planned development of hospital facilities is accommodated whilst allowing for future expansion.

The key benefits that the preferred option will deliver are:

- NHS plan access targets will be delivered enabling patients to receive timely and appropriate care.
- New models of care will be introduced enabling an improvement in the quality and timeliness of the patient care process.
- Top ten performance in day case rates.

- 25th percentile performance for length of stay.
- Improved financial performance to the upper quartile as measured by the reference cost index.
- The flexible design will be responsive to the changing requirements of health services in the future.
- Identifies clear patient pathways for separately managing emergency and elective patients.
- Much of the historic backlog maintenance problem will be resolved.
- Single site working will ensure speciality accreditation is retained and improve the opportunities for multidisciplinary working.

The preferred option also allows for the proposed siting of the Elderly Mentally Ill Unit separately addressed by the North Essex Mental Health Partnership OBC, which is being developed in a similar timeframe.

The Development Control Plan included with these documents indicates proposed areas for development as identified in the Outline Planning Consent.

2.3 Timetable and Deliverability

Broomfield's PFI management structure has been agreed with external partners to support the development of the Full Business Case (FBC). Subject to approval to proceed, the FBC could be completed by the second quarter of 2004.

The timetable for delivery of the preferred option through a PFI route indicates that the scheme can be completed in 2008. To reduce the decanting costs, provide a rational framework for development, evidence value for money and provide a scheme attractive to the PFI market, the phasing and scheduling of this development suggests the emergency services are the first to be progressed.

<i>Appointment of Financial and Legal Advisors</i>	<i>July 2002</i>
<i>Appointment of Technical Advisors</i>	<i>September 2002</i>
<i>OBC Approval</i>	<i>June 2002</i>
<i>OJEU</i>	<i>November 2002</i>
<i>Prequalification selection of 4 bidders</i>	<i>December 2002</i>
<i>Selection of 2 bidders</i>	<i>May 2003</i>
<i>Selection of preferred bidder</i>	<i>December 2003</i>
<i>Full Business Case Approval</i>	<i>May 2004</i>
<i>Financial Close</i>	<i>July 2004</i>
<i>Project completion, acute facilities open</i>	<i>September 2008</i>

2.4 Commissioner Involvement

All commissioners have been involved in the development of the OBC and are explicitly supportive of the establishment of these new facilities at Broomfield Hospital. Commissioners are members of, or have participated in, the Process Boards designing the

new models of care and the demand and capacity analysis, including benchmarking and cost comparisons.

2.5 Affordability

A financial model has been used to calculate the cost of implementing the NHS Plan based on the assumptions used in the OBC. To meet this increased workload the Trust needs a minimum additional investment of £18million from the Mid Essex Health Economy over the next 7 years. £3million of this is to cover the net change in capital charges. The OBC financial evaluation shows that achieving the clinical and support service efficiencies and eliminating split site working will release £5 million. The commissioners recognise that additional income will be required to deliver the NHS Plan, with an increase in resources up to 2006/07 already signalled by the Government in April 2002. Firm activity and associated additional income will be negotiated annually as part of the SaFF process. This case demonstrates an improved financial performance reflected in a projected reference cost index of 95 in 2009/10 from the 2000/01 102% index and the length of stay operating at the 25th percentile. A significant efficiency improvement is achieved with this investment alongside enhanced public amenity space and an environment that provides greater dignity for patients. The scheme also accommodates the revision in planning guidance for HCI Version 2, including consumerism.

2.6 Risk/Expansion Space

Given the latest information from the National Bed Inquiry and the sensitivity analysis on bed numbers, it would be prudent to allow some room and expansion space for risk. This can be accommodated in the design by a third floor on the emergency facility or an additional floor in the DTC. The NBI has undertaken further analysis on the impact of the government targets in the NHS Plan. Early indications are that recommendations for future planning should account for the following demand and occupancy factors:

- 6% increase in elective and day case demand each year.
- 82% occupancy rates should be assumed.

Should these two factors be changed in the activity and bed model, the Trust would require an additional 30 beds for growth and 20 for the change in occupancy, making an increase of 50 in total. The Trust will work with the SHA and PCT's at the next stage to determine a way forward.

3 Future Vision

Following approval of the Strategic Outline Case in March 2001, the Trust, through its clinical staff and in liaison with all local health economy partners, has continued to develop and refine the changes proposed to its models of care. This will see a fundamental re-organisation of emergency and elective care, in the organisation of both facilities and staff.

3.1 Drivers for Changing the Model of Care

Changes are required to deliver the Trusts vision of a radical change in the organisation and delivery of services necessary to address the principle challenges of: split site working, modernising services, and running an efficient Trust.

The hospital development and the changes planned by the three PCT's and North Essex Mental Health Partnership will enable the Trust and its NHS partners to deliver the services, which are necessary to enable both the access and quality standards set within the NHS plan to be achieved.

3.2 Emergency care process

In re-designing the emergency care process, the following principles have been agreed to provide a new vision for modern healthcare.

- Not all emergency admissions will be managed by the A&E department. The A&E department should focus on trauma, unsorted and walk-in patients. 'Unstable' emergency patients should be kept together in a designated area until they are fit to move on and a graduated model of care will be introduced to improve access to skilled staff and facilities.
- GP referrals should be directed away from the A&E department into dedicated receiving areas.
- Provision of a high-risk obstetric facility for all Mid Essex residents at Broomfield and a low risk facility for Chelmsford residents. Low risk obstetric services for Maldon and South Chelmsford and Braintree, Halstead and Witham residents will be provided locally to residents within PCT run facilities.
- The provision of specific treatment facilities for Paediatric emergency cases.
- Critical care facilities will be in a close logistical layout to all emergency services.
- Suitable facilities in the community will be provided as required to prevent inappropriate admissions, such as minor injury units.
- A process for dealing with known chronic disease will be agreed with PCT's, largely by community based care for admission avoidance and co-ordinated discharge.

3.3 Elective admission process

The Trust needs to split its elective activity into two types; patients who can be treated on a day or short stay basis and patients with a complex surgical need who may require access to critical care support during their stay. The Trust Clinicians have agreed that:

- It is appropriate to split most patients with a stay of less than 3 days (2 nights) and group them with day cases
- It would be more efficient to establish a separate receiving area (adjoining theatres or close by) for patients to be admitted to, on the morning or afternoon of their operation, rather than bearing the cost of transferring patients to theatres. Patients would transfer to the appropriate designated area post surgery.
- Most diagnostic treatments should be carried out in the Diagnostic and Treatment Centre with outpatient services concentrated together and provided in this facility.
- Paediatric activity will have designated areas for treatment.
- Outpatient clinics need to be aligned to support one-stop clinics to ensure that appropriate specialities are working in the same area at the same time.

3.4 Process Boards

In order to deliver the changes necessary for the project and to meet the NHS plan targets and address local health improvement priorities, four Clinical Process Boards, chaired by a Senior Clinician were established immediately following the SOC approval. Membership included a wide range of disciplines within the Trust and GP's, Social Services, NEMHPT, Ambulance Services, the CHC and SDC Consulting, an external consultancy providing health planning expertise. The Process Boards have looked at and agreed how models of care and patient processes should change.

Based on the principles and models of care defined in the SOC, the Process Boards have further developed the detail and design requirements for the following areas of care. They also considered the impact and consequences of changes in IM&T, medical equipment and staffing. The four Process Boards centred around delivering care for:

- Elective Care including short stay and diagnostic services.
- Emergency Care
- Women's and Children's Services and
- Hospital Non Acute Care

The process has led to the development of high level operational policies to assist the design process and have been used for the PSC.

3.5 Hospital Zones

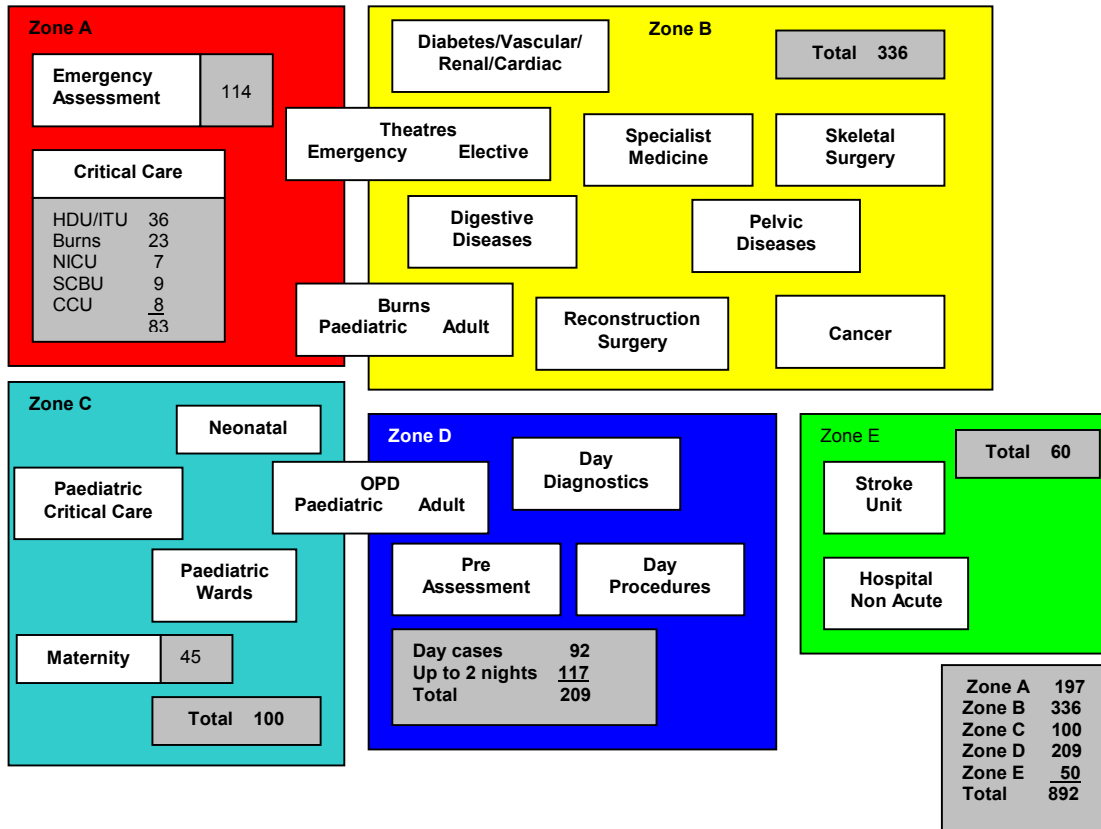
In considering what changes in the patient pathway should be introduced by the Trust, the clinical process boards also reviewed emerging good practice across the NHS by participating in the NHS Confederation's "Future Hospitals Network".

Details of the patient flows, bed allocation and service models to be introduced by the Trust and supported by this project summary are described in more detail below.

The Process Boards allocated the Trust an overall bed complement of 892 beds in the preferred option by calculating the beds needed for:

- Emergency services
- Elective services
- Day Stay
- Hospital Non Acute beds
- Paediatric and Maternity

This resulted in a space relationship diagram shown below, which converted the Hospital plan into zones for the different care processes. These zones are operational rather than spatial and described on the following page.



3.5.1 Zone A – Emergency Care

This provides for the emergency care 114 assessment beds and the more specialist provision for HDU, CCU, ITU, Burns, NICU and SCBU.

The increased capacity and new service model will enable staff to concentrate on patients who are potentially medically unstable, requiring continuous review and nursing and medical intervention. It also ensures that appropriate treatment is provided.

In addition, the assessment unit facilities Zone A will also provide facilities for the more traditional aspects of critical care including ITU, HDU and the Burns Unit. As the Trust is not building a whole new hospital and plans to utilise some of the existing facilities on the Broomfield site, the ideal co-location of some of these facilities cannot be fully realised. However the Public Sector Comparator option has achieved a design and model for patients, which clinical staff have confirmed as considerably better than the current situation.

3.5.2 Zone D – Diagnostic and Treatment Centre

This includes Short Stay surgery, Day Stay and Outpatients.

Having modelled elective activity, the Trust has determined that it is feasible to treat 75% of elective patients as either day, 23 hour or as short stay cases of up to 2 night's length of stay. It is proposed that these are delivered in Zone D which will be a dedicated Diagnostic and Treatment Centre (DTC). Dedicated facilities for paediatrics will be provided.

3.5.3 Zone B – Inpatient Accommodation for complex elective and continuing care for emergency admission.

With the configuration of acute inpatient beds needing to be redefined if 75% of elective patients are to be treated in the DTC, remaining inpatient beds will be grouped by disease. Details of the groups are shown on page 11 . This zone will also provide facilities for the treatment of those elective patients requiring complex elective care that need access to ITU or HDU facilities and who stay in excess of 2 nights in hospital. Where there is an adequate critical mass of patients, facilities will be ring-fenced for elective surgery, e.g. Skeletal Surgery. This will also ensure that the necessary control of infection requirements for certain Orthopaedic cases is ensured.

This zone also includes the Cancer Ward for Mid Essex cancer inpatients, including the patients transferred from Essex Rivers. Palliative care will be co-ordinated in conjunction with this ward.

3.5.4 Zone E – Hospital Non Acute

This includes those areas for specific specialised acute rehabilitation i.e. Stroke Unit and the existing acute rehabilitation ward.

Patients treated in this zone require significant rehabilitation prior to discharge. A dedicated area for stroke patients will be provided within this area. Following an audit of patients in the hospital over a period of 3 days, it is feasible that a range of other cases may benefit from treatment in this zone. The Trust is currently looking at ways to pilot this model in order to evaluate more accurately whether there would be benefits from the physical move for some patients between zones. The proposed build and public sector comparator bid contains adequate flexibility to address any shift within beds between zone B and zone E.

3.5.5 Zone C – Paediatric Ward and Maternity Unit.

This provides for the dedicated beds and space needed on the transfer from St. John's.

4 Activity

4.1 Introduction

The Trust has worked closely with the EHA and PCT's to develop a model to reflect the demand and capacity requirement in the whole health system. The Trust has used the Checklist model to develop these predictions, a well recognised capacity modelling tool, to ensure this links to the year-on-year capacity assessment required in the interim.

In undertaking this work the following guidance and previous documents have been used:

- The NHS Plan¹.
- Local Modernisation Review².
- The National Beds Inquiry³.
- The Eastern Region steer on capacity modelling⁴.
- The former North Essex HA profile of population and demography.
- The Trust's own analysis of workload and pressures.

The activity model is designed to forecast the improved operational performance of the hospital and addresses:

- The impact of the new model of care.
- More elective cases being performed on a day case basis to achieve top ten performance.
- Improved lengths of stay for procedures to achieve top 25th percentile performance.
- Meeting the NHS Plan targets.
- Sensitivities in the assumptions that drive the model.

4.2 Impact of Demand

The demand and capacity model takes account of the latest projections from OPCS, covered in the OBC. Projections show that the adult population will increase by 0.67%, the elderly by 1.75% and children to decrease by 0.2% by 2008. These changes have been reflected in key specialities, particularly those where an ageing population will have a more marked demand increase.

The North Essex Health Authority Health Intelligence Unit identified that there were no particular epidemiological issues that should be addressed above and beyond those that had been accounted for in reflecting the ageing population on the general demand trends.

¹ The NHS Plan: Investment and Reform for NHS Hospitals, Department of Health, February 2001.

² Mid Essex Hospital Services Local Modernisation Review, November 2001

³ NBI – Capacity Planning. HSC (2001) 3 LAC (2001) LMR

⁴ Shaping the Future NHS: Long Term Planning for Hospitals and Related Services – Consultation Document on the findings of the National Beds Inquiry.

The different demand pressure of a Regional/Supra Regional Plastic Surgery and Burns tertiary provider has also been accommodated in the analysis. However no account is taken of any potential changes from the National Burn Care Review.

Examples of schemes designed to reduce emergency referrals to the hospital have been described above. Elective treatment practices will also change with the introduction of GP specialists and with AHP and Nurse Practitioners undertaking treatments to prevent admission.

Linked to this, the Trust plans to reduce the number of re-attenders for outpatient appointments with a simultaneous transfer of outpatient services to primary care facilities, where and when a critical mass of patients is evidenced and the service is economically viable.

The assumptions for both emergency and elective demand and the requirements for the reduction in waiting time for surgery will have a direct impact on the activity predictions. The following table summarises the current position and the consequential impact on activity for these factors.

Baseline Activity	Elective FCE's	Day Case FCE's	Emergency FCE's	Specialist	Total FCE's
2001/02	11,544	16,849	26,828	6,879	62,100
Waiting list adjustment	4,219	4,154	0	0	8,373
Growth adjustment	3,667	5,208	5,474	114	14,463
Day Case Adjustment	(6,678)	6,678	0	0	0
Predicted activity 2009/10	12,752	32,889	32,302	6,993	84,936

Impact of demand and waiting list reductions on activity

A detailed analysis of the 2009/10 activity is contained in the OBC.

4.3 The Baseline Year

The chosen baseline year is 2001/02. The 62,100 FCE's represents the commissioned activity for the year.

4.4 The Bed Model

The calculation of bed numbers is a consequence of:

- The predicted activity (as described above).
- The length of stay assumptions
- The percentage occupancy assumed.

4.4.1 Specialist Services

The predictions for the specialist beds have been calculated as follows:

- **Burns**

Following on from the work undertaken by local and National Burns Care Review Project teams and the Eastern Region Burns and Strategic Review Group, capacity planning for Burns has been based on no further growth in adult Burns cases and a 2% annual growth in child Burns cases. The total requirement for Burns beds in 2009/10 is 23 beds. The OBC does not address any further increase in activity resulting from further 'importing' of activity from the non local population, which may arise as a result of the National Burn Care Review.

- **ITU/HDU**

An internal audit was undertaken by the Trust to identify all patients who required critical care support. This identified that between 3 and 13 patients were outside ITU requiring critical care support at a time when ITU was 85% occupied. The audit showed that to meet critical care needs fully within a designated ITU/HDU arrangement, additional capacity is required.

Projecting required capacity forward using the anticipated growth, a unit consisting of 18 ITU beds and 18 HDU beds is required.

- **NICU**

In a similar manner to ITU, an internal audit identified a future requirement of 2 intensive care cots, 5 HDU cots and 9 general SCBU cots, amounting to 16 in total.

- **Maternity Services**

No further analysis of Maternity Services has been undertaken. Population trends and the benefits of centralisation in conjunction with a new service model for low risk births will result in a bed requirement of 45 beds– the same position as in the SOC.

- **Oncology**

The transfer of inpatient oncology services from Essex Rivers Trust is reflected in the capacity requirement. A total of 15 beds will be reprovided for this service, the same complement identified in the SOC.

4.4.2 Occupancy

In line with the National Beds Inquiry recommendations the Trust has used an occupancy level of 85%.

Paediatrics, Burns and ITU bed complements assume a 65% occupancy as guided by the Eastern Regional Office.

4.4.3 Bed Complement Calculation

As a result of the activity, length of stay and occupancy assumptions, the following bed complement is required:

Baseline Activity	Elective	Day Case	Emergency	Specialist	Total
2001/02	116	59	521	96	792
Waiting List adjustment	40	9	0	0	49
Growth adjustment	43	13	29	20	105
Day Case Transfers		11	0	0	11
Target LoS adjustment	(43)	0	(22)	0	(65)
Predicted Bed Complement 2009/10	156	92	528	116	892

Table : Bed Complement Calculation

A full breakdown of the beds by speciality is included in the OBC.

From the table above it is clear that the most significant factor is the growth adjustment. The Trust is conscious of the challenging nature of these targets and with this in mind, aims to achieve these targets as part of an overall modernisation and change programme that has already started implementation in 2001/02 as detailed earlier.

4.4.4 Graduated Model of Care

The total bed complement of 892 requires translation in terms of the graduated model of care as explained previously. As a result of a bed audit, the future bed analysis is described in numbers and conceptually in the diagram on page 8.

4.5 The Theatres Model

In linking the forecast activity requirements for 2009/10 and the theatre model, the following assumptions have been made:

- The proportion of surgical FCE's requiring theatres is the same as current practice.
- Theatre case throughput is benchmarked with other schemes in development.
- There will be a standard two session day for elective and day case operating.
- Where individual specialities already work an "extended day" these practices will continue.

Using the activity projections identified in table above, the following theatre complement is required.

Theatre Type	Projected Theatre FCE's	Projected Theatre No's
Main Theatres		
Day Case	25,209	10
Elective	9,559	8
Emergency	7,633	5
Sub Total Main Theatres	42,401	23
Specialist Theatres		
Endoscopy/Pain		3
Burns		1
Obstetrics		1
Total	42,401	28

This provides 23 general and 5 specialist theatres.

Theatre throughput has been benchmarked against other schemes in development, which identifies comparable or better performance.

4.6 Outpatients

Planning for the new hospital is based on 191,000 outpatient attendances on the hospital site with a reduced number of re-attendances decreasing from the current average of 2.7 to 1.9.

This assumes that 30% of all attendances will occur elsewhere and not on the Broomfield site. The Trust, in conjunction with the PCT's, has agreed these assumptions and our primary care partners have, or are, building sufficient capacity in their own OBC/SOC's. An analysis of the outpatient activity by speciality is included in the Outline Business Case.

In order to support and assist the primary care sectors desire to improve access, reduce waiting times and avoid unnecessary secondary referrals and follow up appointments, the Trust will extend existing pilot programmes to increase or initiate the use of telemedicine, direct booking, nurse and AHP referrals and GP specialist training. The collaborative IM&T OBC, which is running in parallel with the whole North Essex Health Economy, will encompass these requirements in the specification to assist in this process. The Trust will continue to collaborate with local initiatives to reduce the local outpatient referral rates.

5 Key Issues

5.1 Design Quality

5.1.1 Introduction

The Trust is committed to the aim of design excellence for Broomfield Hospital building and its surrounding environment. We fully endorse the recent NHS Estates guidance on design quality, and the design principles adopted in 'Better Buildings for Health' and by CABE and other organisations. The Trust believes firmly that investment in good design generates economic, social and clinical value throughout the lifetime of the building. The Trust has an appointed Design Champion and is in discussion with CABE.

The Trust's vision for the design and quality of the new hospital is clear. We wish to develop a hospital, which is well planned and creates a high quality, good working environment, both internally and externally for the delivery of excellent healthcare.

5.1.2 Flexibility and Adaptability

The design needs to be adaptable to rapid changes in the provision of healthcare. A number of National framework reviews are still on-going and could affect the future requirements for tertiary services at the hospital. We would wish to see the PFI process develop flexible solutions to the space planning of the new building while retaining the key clinical adjacencies described in the documentation.

Areas that could potentially be introduced into the scheme include:

- Neonatal Intensive Care Unit (12 cots at Tertiary Level for an Essex wide service)
- Plastic Surgery and Burns (Paediatric Burn Care)

While it is difficult to predict the extent of the changes, the Trust anticipates that the decision making on both these elements will be completed before the issue of the Final Invitation to Negotiate.

5.1.3 Design objectives

Design objectives for the Trust include the following:

- To provide buildings which relate well to their surroundings, and which stimulate civic pride
- To provide buildings that facilitate the delivery of healthcare in both existing and new elements of the hospital, and produce an integrated and functional hospital.
- To create a high quality, welcoming safe and therapeutic environment for patients, ensuring the patient is treated with dignity and privacy in safe and comfortable surroundings, and an excellent working environment for staff
- To implement good standards of space, form, scale and use of materials within and without the building.

- Make best use of natural light and ventilation to provide optimum working conditions for staff to enable the best possible care to be given to patients
- To provide good access for all using both public and private transport and provide designs which cater fully for the access and parking needs of the physically disadvantaged and all categories of pedestrians of all age groups.
- to ensure the site and buildings are legible internally and externally with wayfinding and signage integral to the design
- To meet fully the clinical and functional requirements and adjacencies set out in the output specifications and operational policies.
- To provide an energy efficient design which will reduce energy consumption as required in the output specifications
- To allow for the integration of the arts in all forms within the hospital environment

To achieve the raised standards and excellence implied in the design of the new hospital the Trust will be making use of a number of evaluation tools (AEDET, NEAT etc.) in the evaluation of bidder's design solutions.

5.2 Equipping

5.2.1 Introduction

The Trust sees equipment as a major contributor to the success of this project. To ensure this is achieved, the Trust has appointed an in-house Clinical Planning and Equipping Project Manager to lead the process. An equipping project board has been set up and will monitor the performance of the project team dealing with equipping for Broomfield Hospital.

5.2.2 Project Role

The equipping project team will ensure that a full equipping strategy and specification of equipment is available to the private sector partner chosen by the PFI scheme. The identification of equipment and policies for its future provision and maintenance will relate to the whole of the Trust. Areas relating to the new build will be separately identified but will form a part of the whole.

5.2.3 Equipping Input

The Trust expects that the core bids from the private sector will include Group 1 and some of the Group 2 equipment provision. At the FITN stage of the project the Trust may give further consideration to the possibility of a managed technology solution for the new hospital.

5.3 FM Services

5.3.1 Hard FM Services

The Trust will expect the inclusion of hard FM services for the whole site within the PFI project.

5.3.2 Soft FM Services

On the basis of an analysis of value for money VFM of soft services provision the decision has been taken that all five core soft FM services should be outsourced with the exception of ward housekeeping services and switchboard.

Ward housekeepers will be retained as a critical part of the ward team directly involved in patient care.

The Trust will implement the retention of employment model in line with current guidance so that Trust employees in the five core services are seconded to the private sector partner.

5.3.3 Risk Transfer

The Trust believe that the scope of services proposed for the PFI centralisation will offer good value for money and significant risk transfer under the PFI procurement. The services recommended to be outsourced are those which are attractive to the PFI market and present an opportunity for the Trust to increase the attractiveness of the PFI scheme to the market.

5.3.4 Consultation

The Trust has begun the process of informal consultation with the Joint Consultative and Negotiation Committee (JCNC). The Trust will jointly prepare Terms of Reference shortly with the JCNC for a PFI related sub group which will lead the process of informing staff of the issues around ROE and keep those staff affected involved in the progress of the PFI scheme.