

EXTRAORDINARY TRUST BOARD MEETING

Thursday 15 July 2021

15:00 – 17:00

To be held via Microsoft Teams

AGENDA

AGENDA ITEM	TITLE	PURPOSE	COMMS	PRESENTER
OPENING BUSINESS				
01/0721	Apologies for absence and quorum	Assurance	Verbal	Chair
02/0721	Declarations of interest	Assurance	Verbal	Chair
03/0721	Questions from the Public	Assurance	Verbal	Chair
Strategic Issues				
04/0721	Forest of Dean Hospital Development - Full Business Case	Approve	Paper	DoSP
Board Committee Summary Assurance Reports (Reporting by Exception)				
05/0721	FoD Assurance Committee (23 June)	Information	Paper	FoD Chair
Closing Business				
06/0721	Any other business	Note	Verbal	Chair
07/0721	Date of next meeting Thursday, 29 July 2021	Note	Verbal	All

AGENDA ITEM: 04

REPORT TO: Trust Board – 15 July 2021

PRESENTED BY: Angela Potter – Director of Strategy & Partnerships

AUTHOR: Angela Potter – Director of Strategy & Partnerships

SUBJECT: Full Business Case – Development of a new Community Hospital in the Forest of Dean

If this report cannot be discussed at a public Board meeting, please explain why.	
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This report is provided for:

Decision X	Endorsement <input type="checkbox"/>	Assurance	Information
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The purpose of this report is to:
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Present for approval the Full Business Case for the development of the new Community Hospital and to confirm that the decision will result in the closure and relocation of services from the existing Dilke Hospital in Cinderford and the Lydney and District Hospital in Lydney.

Recommendations and decisions required

Trust Board Members are asked to:

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| <ul style="list-style-type: none">• Approve the Full Business Case (FBC) for the development of a new community hospital in the Forest of Dean at a value of £23.9m and the confirmation that this is affordable in both capital and revenue terms.• Confirm that this decision will result in the closure and relocation of services from the existing Dilke Hospital in Cinderford and the Lydney and District Hospital in Lydney when the new hospital opens in 2023.• Approve the next phase of design development and the commitment of the associated expenditure in order to progress the detailed design and planning application through a Pre-Construction Services Agreements (PCSA) with our construction partner Speller Metcalfe at a value of c£925k + VAT.• Note that scheme falls above the threshold for a material transaction and dialogue with NHSEI colleagues will continue as to appropriate next steps• Note that the process to complete and submit the full planning application process will be taken forward on approval of this FBC. |
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Executive summary

The Full Business Case (FBC) seeks approval for Gloucestershire Health & Care (GHC) NHS Foundation Trust to invest £23.9m in the development of a new community hospital to serve the people in the Forest of Dean. The scheme is funded from Trust cash reserves and the sale of the Dilke and Lydney Hospital sites.

This FBC represents the culmination of over five years of planning and preparation and is a significant step change in the ability to provide a modern, fit for purpose environment and enhanced service facilities for the people of the Forest and beyond.

Investment in this new facility will enable the re-provision of services, and subsequent closure of the existing two community hospitals, namely Lydney & District Hospital and the Dilke Memorial Hospital when the new hospital opens in 2023.

The new hospital is considered a key part of the wider system investment proposed in the Forest of Dean to address primary and community infrastructure needs. This investment will ensure that the Forest of Dean services support the delivery of models place-based integrated care as part of the One Gloucestershire Integrated Care System's (ICS) plans.

Gloucestershire Clinical Commissioning Group (GCCG) confirmed the service strategy regarding the range of services to be delivered from the single hospital site in January 2021. These have been the subject of two Stage 2 Assurance Meetings and have met all five tests associated with service change prior to the final stage of public consultation which concluded in December 2020.

Although the new community hospital will be the main clinical hub for the area for hospital based services, GHC will continue to base staff at other locations across the Forest to facilitate the closest possible working with primary care and communities and to provide local clinics and group activities. The new hospital will also work as part of the wider network of community hospitals and community services across the county.

This FBC is developed in line with the 5-case model as per HM Treasury guidance and includes the following sections:

Section 1 - The Strategic Case sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme. The Case for Change remains consistent with that outlined within the Outline Business Case which was previously approved by Gloucestershire Care Services NHS Trust Board and builds on the extensive engagement and consultation processes that

have taken place in relation to this programme. Five strategic investment objectives have been identified as part of this FBC.

Section 2 – The Economic Case demonstrates that the preferred option and associated investment meets the future needs of the service and demonstrates value for money (VFM) from the investment made. The preferred option from the OBC – the development of a single hospital on the Steam Mills site in Cinderford, has been compared to a business as usual option which would be the option if the investment were not to proceed. No additional options have been identified since the OBC was approved in 2019. A Comprehensive Investment Appraisal (CIA) model has been completed which has confirmed that four non-cash releasing benefits plus two societal benefits have been identified. When costed, these demonstrate that the preferred option offers good value for money when compared with the business as usual option.

Section 3 - The Commercial Case demonstrates that we have taken a considered and viable approach to the procurement of our construction partner and Speller Metcalfe have been appointed as our lead construction contractor utilising the Gloucestershire County Council (GCC) procurement framework. We have worked collectively to develop a detailed schedule of accommodation and associated design that has undergone rigorous confirm and challenge and been the subject of soft market testing for pricing and cost packages. This has led to the development of the not to be exceeded price (NTBEP) for the construction elements of the costings contained within this FBC. A clear schedule of works is in place to move this to a Guaranteed Maximum Price (GMP) by November 2021 and there is an agreed construction contract structure to be entered into at this point.

Section 4 – The Financial Case confirms the Trust has the necessary funding arrangements to take forward this business case and support its five year capital plan which includes the Forest of Dean new community hospital at a cost of £23.9m. Revenue affordability has been modelled and confirmed as affordable and we have confirmed that approval of this FBC will not have a negative impact on the overall financial standing of the Trust.

Section 5 – The Management Case demonstrates that the scheme is achievable and can be successfully delivered to cost, time and quality. It outlines the governance arrangements in place through the Programme Board and the Forest of Dean Assurance Committee and the key milestones and gateways over the coming phases including a process for management of risk and post project evaluation.

Conclusion – the FBC demonstrates that the preferred option being taken forward from the OBC delivers a viable and affordable solution to meeting the requirements laid out in the case for change. The Trust has been presented a NTBEP price from its construction partner, Speller Metcalfe and we have

confirmed that these costs are affordable from a capital and revenue perspective. The economic modelling demonstrates that the scheme offers good VFM when compared to business as usual.

It is recognised that the business case is a multi-year scheme and that future year's capital envelopes are only released on an annual basis therefore we do not know the 22/23 or 23/24 position at this point in time. We have confirmed the associated phasing expenditure within our FBC and can confirm that the anticipated cost plan is within the available cash but that future capital envelopes will continue to pose a potential risk to the Trust. However, this should be viewed in the context that both the ICS and the Regional team are aware of the scheme and will have input into the approval process. Approval of this FBC should demonstrate its priority across the system and significantly reduce the risk moving forward.

This FBC is therefore commended to the Trust Board for approval to enable the progression of developing a new community hospital in the Forest of Dean.

Following Trust Board approval this FBC will be shared with the ICS Board for wider consideration and support.

We have reviewed the final costings for the scheme against the NHSEI approval thresholds contained within the *Capital regime, investment and property business case approval guidance for NHS and FT providers*. We can confirm that the scheme falls above the threshold for a material transaction and therefore we will continue dialogue with NHSEI colleagues as to next steps within their processes.

Next Phase of Development Work

In order to progress the next phase of work the Trust needs to enter into a further Pre Construction Services Agreement (PCSA) with Speller Metcalfe at a value of c£925k+VAT.

The funds associated with this expenditure are within the 2021/22 capital expenditure for the FoD project and cover the work and associated design fees necessary to enable us to complete the detailed design at 1;50 level and the work associated with the submission of the full planning application. This will then enable us to finalise the tendering processes through Speller Metcalfe on the various work packages to derive the final Gross Maximum Price (GMP) and subject to a further approval gateway enter into the construction contract for the works.

As previously approved, we will also continue to progress the Multi Use Games Area upgrade works and the re-provision of the Skate Park development.

Next Steps

Trust Board Members are asked to:

- **Approve** the Full Business Case for the development of a new community hospital in the Forest of Dean at a value of £23.9m and the confirmation that this is affordable in both capital and revenue terms.
- **Confirm** that this decision will result in the closure and relocation of services from the existing Dilke Hospital in Cinderford and the Lydney and District Hospital in Lydney when the new hospital opens in 2023.
- **Approve** the next phase of design development and the commitment of the associated expenditure in order to progress the detailed design and planning application through a Pre-Construction Services Agreements (PCSA) with our construction partner Speller Metcalfe at a value of c£925k + VAT.
- **Note** that scheme falls above the threshold for a material transaction and dialogue with NHSEI colleagues will continue as to appropriate next steps
- **Note** that the process to complete and submit the full planning application process will be taken forward for submission end July/early August.

Risks associated with meeting the Trust's values

Corporate considerations

Quality Implications	Failure to deliver the scheme increases the ongoing risks associated with maintaining service delivery at the existing sites both from an environmental and backlog maintenance perspective and staffing resilience risks.
Resource Implications	The amendments to the NHS capital regime may place further constraints on the Trust's freedoms regarding capital expenditure. Regulatory approval may add further delays and potential costs to the scheme.
Equality Implications	Failure to deliver the scheme may result in a reduction in services that can be delivered locally for the population of the Forest of Dean.

Where has this issue been discussed before?

FoD Programme Board
FoD Assurance Committee

Appendices	Full Business Case, Executive summary and suite of FBC appendices
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Report authorised by: Angela Potter	Title: Director of Strategy & Partnerships
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Development of a New Community Hospital for the Forest of Dean

EXECUTIVE SUMMARY

Full Business Case July 2021



Executive Summary

1.1 Introduction

This document provides an Executive Summary of the Full Business Case (FBC) for the development of a new community hospital for the Forest of Dean (FoD). The document is structured in accordance with the 'Five Case Model' as per Her Majesty (HM) Treasury guidance.

The FBC seeks approval for Gloucestershire Health & Care (GHC) NHS Foundation Trust to invest £23.9m in the development of a new community hospital to serve the people of the Forest of Dean funded from its cash reserves and the sale of the Dilke and Lydney Hospital sites in the Forest of Dean.

This FBC represents the culmination of over five years of planning and preparation and is a significant step change in the ability to provide a modern, fit for purpose environment and enhanced service facilities for the people of the Forest and beyond.

Investment in this new facility will enable the re-provision of services, and subsequent closure of the existing two community hospitals, namely Lydney & District Hospital and the Dilke Memorial Hospital.

The range of services to be provided in the new hospital was confirmed by the Governing body of NHS Gloucestershire Clinical Commissioning Group (GCCG) after the public consultation at the end of 2020 and can be summarised as follows:

- 24 inpatient beds with ensuite bathrooms in single rooms with provision for bariatric patients.
- An urgent care facility, open from 8am to 8pm, seven days a week, supported by a range of diagnostic services.
- Outpatient services, including a range of consultation, treatment and group rooms and additional areas for online consultations for the provision of outpatient services.
- Diagnostic services, including a dedicated endoscopy unit, x-ray, ultrasound and blood-testing (phlebotomy) and space for mobile units such as the Chemotherapy Bus and Breast Screening Service.
- Flexible meeting space that can be accessed by health and care organisations plus wider voluntary sector organisations.

2.0 Strategic Case

2.1 Case for Change

The review into the future of health and social care services within the Forest of Dean was established in 2015 and undertaken by GCCG, overseen by the Forest of Dean Locality Reference Group. The Case for Change received support from both Gloucestershire Care Services (GCS) NHS Trust Board and the GCCG Governing Body in July 2017.

The original Case for Change led to the following agreed outcomes:

- More consistent, reliable and sustainable community hospital services, e.g. staffing levels, opening hours.
- A wide range of community hospital services, including beds, accommodation to support outpatient services and urgent care services.
- Significantly improved facilities and space for patients and staff.
- Services and teams working more closely together.
- Better working conditions for staff and greater opportunities for training and development to recruit and retain the best health and care professionals in the Forest of Dean.

2.2 Strategic Investment Objectives

Five strategic investment objectives have been agreed as part of the case for change along with the benefits that will be measurable after completion of the project. These are summarised as:

1. To facilitate the delivery of sustainable models of care
2. To facilitate an inpatient service that integrates nursing and therapies maximising the rehabilitation potential of patients and maximising the flow and discharge of inpatients in the One Gloucestershire system
3. To facilitate a reliable and consistent Urgent Care service for the Forest of Dean as part of the One Gloucestershire integrated urgent care system
4. To provide a building that meets all foreseeable modern standards, meets the needs of users, is economic to operate and maintain and which will be flexible for current and future requirements.
5. To contribute significantly towards the environment and local sustainability by supporting the journey towards Net-zero carbon emissions.

2.3 Equality Impact Assessment

An Equality Impact Analysis (EIA) for the location of a new community hospital in the Forest of Dean was undertaken by independent assessors in 2018. This focused on;

- scoping the potential impact of locating the new hospital in the different towns of Lydney, Coleford and Cinderford
- establishing whether any specific groups or communities would be disadvantaged if the hospital was to be built in any one of the towns.

A further EIA Assessment was undertaken by the CCG in October 2020 focusing on the Communication and Consultation Strategy and Plan for the new hospital. Analysis of responses by various demographics, e.g. age, gender, health and care professionals, did not show any significant variation when compared with the overall themes from the other respondents.

2.4 Consultation & Engagement

The proposed development has been subject to an extensive consultation and engagement process over many years, covering a large number and wide variety of stakeholders, including:

- patients, carers and their representatives, in how the design will benefit them and accords with their wishes;
- Trust clinicians/frontline staff who have been engaged fully in the design of the scheme and are fully engaged in the assessment of quality, safety and infection control aspects also;
- local residents, members of the public, community groups and public representatives (Local Councillors, MPs etc.) and how this will impact on their lives;
- other health and social care partners, including commissioners (Clinical Commissioning Groups, NHS England) and how it meets their intentions and planning imperatives.

There will ongoing engagement with all key stakeholders throughout the next phase of the scheme and beyond once occupation of the new hospital has taken place as part of the benefits realisation work.

2.5 Conclusion to the Strategic Case

The Case for Change remains unchanged from the OBC stage, although the urgency of the investment has only increased in the intervening years. There are significant patient, quality and safety issues arising from having to continue to provide services from such aged, cramped and functionally unsuitable estate.

3.0 Economic case

In developing the economic case the preferred option developed from the OBC - a single new hospital on the Steam Mills site in Cinderford – has been compared to business as usual which would be the option if the investment were not to proceed.

The Economic appraisal includes the costs and benefits of the hospital facility itself, services moved from the Dilke Memorial and Lydney Hospitals, any new service developments and any remaining services that will continue to be provided in local facilities across the Forest.

No additional options have been identified since the OBC was approved in 2019.

The CCG have led an extensive exercise to understand the range of services to be provided from the new hospital facility and have completed the Stage 2 Assurance processes against all ‘five tests’ for service change. The commissioning requirements for the single hospital was confirmed in January 2021.

3.1 Schedule of Accommodation and derogations

In developing the Schedule of Accommodation, the following service provision assumptions have been considered:

- Inpatient beds will be configured as 100% single rooms with appropriate day and therapy space and direct access to a pleasant external environment.
- Provision for 2 bariatric beds as part of the inpatient ward.
- A range of outpatient clinic rooms including those designed for flexible use and specialist rooms to accommodate specialist equipment and requirements.
- In the iteration of the Schedule for the FBC, the impact of the COVID pandemic has been considered. It is assumed that there will be a continued demand for remote consultation. Space has been included for booths for virtual consultations. This space can subsequently be converted to a clinical room if experience shows this to be a better use.
- Therapy rooms to accommodate specialist equipment for physiotherapy, speech and language therapy and occupational therapy.
- A dental suite designed to accommodate patients with complex physical and mental health needs.
- The Minor Injuries and Illness Unit scoping has taken account of the planned changes to support minor illness being shifted to being treated within Primary Care as part of their core business.
- Diagnostic facilities including X-Ray and ultrasound plus an endoscopy suite designed to meet Joint Advisory Group (JAG) accreditation standards have been included.
- Clearly designated and separate waiting areas for children and a dedicated area for children’s clinics and parent group activity for children and antenatal services.
- A large multipurpose room that can be used both for community events and staff meetings.

Whilst we have challenged the design team to be as economic as practicable, we remain committed to operating to the Health Technical Memorandum (HTM) and Health Building Note (HBN) standards. As such we have made no major derogations.

Standardised rooms and future flexibility has been considered throughout the design process.

A 70-week construction period is anticipated starting in January/February 2022 with commissioning of the building and occupation from June 2023.

3.2 Costs

All costs included within this economic appraisal are expressed in “real” terms, so that all future costs are converted into current values removing the effect of general inflation. The Comprehensive Investment Appraisal (CIA) model takes into account opportunity costs, capital costs, lifecycle costs and avoided costs.

Revenue costs include the total clinical and non-clinical costs of delivering the service at a real price base, which will also be discounted over the 60-year life of this investment.

This investment creates considerable quality and environmental benefits and underpins the Trust and system requirements to deliver reliable, sustainable services and to meet environmental standards and expectations. Not all these benefits can be sensibly costed in economic terms.

3.3 Reduced costs – incremental benefits

Through the establishment of a new hospital replacing two separate hospitals, significant reductions in clinical inpatient costs, facility staffing costs and building running costs are achieved. Table 1 demonstrates at current values the comparison from current costs to costs operating within the single hospital when full reduction/redeployment of staff has been achieved by 2025/26.

Table 1: Costs at present (Base Case) and from 25/26 (Preferred Option)

Cost category	Existing cost (£'000s)	Costs from 2025/26 (at today's prices)
Nursing	4,152	3068
AHP	352	364
Other clinical	312	270
Clinical non-pay	433	496
Total clinical costs	5,249	4198
Non Clinical costs	1,175	958
Building running costs	499	288
Rates	63	169
Total non-clinical costs	1,737	1415
Total service costs	6,986	5,613

3.4 Releasing Benefits

The aim has been to gain benefits through efficiencies rather than making additional cash savings as a result of the investment.

- No additional cash savings have been added to the CIA model
- Four Non-cash Releasing benefits have been identified and costed
- Two benefits to society at large have been identified and costed

Table 2: Non cash releasing and societal benefits

Benefit	Type of benefit	Equivalent annual benefit (£'000s)	Discounted value over 60 years (£'000s)
7-day therapy input on the ward	Non cash releasing	219	5,743
Nursing to therapy posts	Non cash releasing	115	3,012
Reduction in MIU closures	Non cash releasing	52	1,374
Reduce of bed days due to infection	Non cash releasing	17	441
Endoscopy travel savings	Societal benefit	51	1,332
Carbon saving	Societal benefit	30	£787
Total		468	12,689

The economic analysis calculates the total incremental costs and benefits discounted over the 60 years of the building's life. Table 3 below shows that the benefit to cost ratio of 4.08 over the 60 year life of the new hospital and a risk adjusted Nett Present Social Value (NPSV) of £35,756m.

Table 3: Economic Summary (Discounted) - £'000

	Option 0 - Business as Usual	Option 1 - New Forest of Dean Hospital Build on Steam Mills site (£'000s)
Incremental costs - total	0	(11,595)
Incremental benefits - total	0	47,351
Risk-adjusted Net Present Social Value (NPSV)	0	35,756
Benefit-cost ratio		4.08

When the assessment of non-cash releasing benefits (NCRB) are considered, the Preferred Option continues to deliver significant benefits over the period compared with the alternative business as usual.

The cost to benefit ratio has been tested to demonstrate the impact of a number of sensitivities and scenarios to demonstrate the robustness of the Value for Money (VFM) exercise.:

The impact on the benefit-cost ratio is demonstrated in Table 4 below.

Table 4: Sensitivity of cost-benefit ratio to various scenarios

Sensitivity scenario	Benefit - cost ratio
Value-for-Money (VFM)	4.08
VFM after maximum risk impact and probability applied	3.69
VFM after maximum risk impact and probability applied and NCRBs and SBs @50%	3.20
VFM after maximum risk impact and probability applied and CRBs and SBs reduced to zero	2.71

With a high optimism bias and an already high allowance for risk, the economic analysis gives a benefit to cost ratio over the 60-year life of the new hospital of 4.08 and a risk adjusted Net Present Social Value of £35,756 million. The modelling has demonstrated that even taking account of the most adverse scenario identified, a benefit cost ratio of 2.71 would still be achieved. This confirms that this investment gives clear Value for Money.

4.0 Commercial case

4.1 Approach to Procurement

The Trust has considered the main procurement and contract routes for a project of this size and complexity. A formal appraisal exercise was undertaken with the conclusions that the scheme was best delivered via a Design and Build contract with a Construction Partner.

To ensure the timely delivery of the scheme a number of different framework options were considered for the appointment of the main contractor, with three shortlisted frameworks appraised and the Gloucestershire County Council (GCC) Construction Developer Framework selected as the preferred approach.

The Trust's own procurement team and the procurement lead from GCC supported and advised on the procurement process. Five contractors are on this framework. All were approached and submitted a compliant bid for consideration and a robust assessment process was undertaken leading to the appointment of Speller Metcalfe as our lead construction partner.

4.2 Price of contract

This Full Business Case has been completed on the basis of a Not to Be Exceeded Price (NTBEP) plus allowances for all fees, inflation, contingency, equipment and VAT.

A NTBEP differs from a Guaranteed Maximum Price (GMP) in that it is a price based on market rates, soft market testing, Quantity Surveyor judgement and Subject Matter Expert input rather than formal quotations from contractors. As such a NTBEP is caveated, particularly around inflationary pressures and scope creep.

The current construction market is experiencing high volatility and there is a risk of further construction inflation in the period between NTBEP and GMP which remains a Trust risk. Additional contingency allowances have been incorporated into the Economic and Financial modelling to account for this. Once GMP is agreed the fixed construction price results in these risks then sitting with the contractor.

There will be a single design and build contract with the construction partner with the architectural and structural designs the responsibility of the construction partner. There will be a series of works packages that will be market tested with three suppliers in an open book manner. The New Engineering Contract (NEC) standard form of contract will be utilised which allows for a fixed construction price.

4.3 Planning permission

In December 2020, a pre-planning application was submitted and ongoing dialogue with the local planners via the Trust's Planning Consultants has demonstrated this was positively received. Since that time, dialogue with the planners has continued and no areas of significant concern or issue have been raised. We therefore have a high level of confidence that our full planning application will be acceptable to the planning authority.

Following approval of this business case by the Trust Board, a full planning application will be submitted towards the end of July/early August with an anticipated time scale of 14 weeks over the period August to October. An allowance for a potential S106 contribution has been made in the costed risks within the Financial model.

4.4 Sustainability

An underlying principle has been that the new hospital should be as energy efficient as possible, minimising or eliminating carbon and fully prescribing to the principles of sustainable environmental design. The Trust is mindful of Net Zero Carbon targets for the NHS and to deliver the Sustainability Development Unit's requirements.

The building will be built to high thermal insulation standards, employ low energy and controllable lighting and will feature all electric air exchange heating systems. Power will be generated from solar roof panels.

In line with current national NHS Sustainability Policy, the project is pursuing a BREEAM (Building Research Establishment Environmental Assessment Method) 2018 New Build 'Excellent' rating as part of the organisation's commitment to sustainability.

4.5 Equipment

All serviceable equipment currently in use at the Dilke and Lydney Hospitals where it is required, will be transferred to the new hospital and fitted as when needed as part of the contract. Removal costs have been accounted for in the Economic and Financial Cases.

High level indicative capital cost estimates for new equipment or major transfers requiring specialist contractors are included in the costings both in the Economic model and in the Financial Case.

4.6 Land transfers and disposals

Ownership of the Steam Mills site has been transferred from Cinderford Town Council Council to GHC as part of a deal which involves;

- Transfer of the Trust's health centre building at Dockham Road, Cinderford to Cinderford Town Council.
- Relocating the skate park at Steam Mills site to a new site in Cinderford including the design and construction
- Re-providing the Multi-use Games area at Steam Mill site in Cinderford

The Trust Board gave approval to proceed with these works at its Board meeting in May 2021 as we anticipate that completion of these transactions will be cited as planning conditions to the new hospital scheme.

Successful disposal of the existing site at the Dilke and the two sites that make up Lydney and District Hospital is assumed within the financial modelling. The Trust is mindful that the sites have been registered as Assets of Community Value by the respective Town Councils. We are committed to exploring use by other public sector bodies and working in partnership with the local authorities, third sector organisations and local stakeholders to ensure that the all disposal opportunities that offer ongoing public benefit are explored and that our disposal strategy is in line with delivering Best Value.

4.7 Treatment of VAT

The Trust is continuing to work with Liaison Financial and has estimated the current level of VAT recovery which we will continue to review and anticipate that the level will increase once the final cost plan is agreed.

5.0 Financial Case

The high level comparison of capital costs between OBC and FBC are included in Table 5. This shows a significant increase in capital costs against the financial envelope set out at OBC and reflects the significant increase in general construction prices and the upward trend for construction inflation indices rather than a change in scope for the development of the new hospital. Area requirements have in fact reduced slightly since the OBC work with careful space planning.

In addition, there has been an inclusion of equipment costs of c £700,000 as a more detailed review of equipment needs has now been undertaken particularly in relation to the new endoscopy service as this space will be provided on a fully equipped basis to the main service provider (in this case GHT) in line with the arrangements in all our other community locations. This was not known at the point of OBC and costs were therefore not included. We have assessed and confirmed the viability of transferring

x-ray equipment from the existing sites and have confirmed that this will offer value for money as the kit still has circa 10 years of life expectancy.

Table 5: Summary Capital Cost movements between OBC and FBC

	OBC	FBC
	Buildings 4,000m2 @£ 2,403m2	Buildings 3,802m2 @ £3,653m2
Construction cost	9,615	13,890
External works		2,657
Equipment (Endoscopy and re-fitting of existing)		650
Fees	1,202	1,120
Inflation		697
Site acquisition & MUGA works	400	600
Contingency	481	816
VAT	1,748	3,487
Total	13,443	23,918

GHC is in a healthy financial position having delivered its portion of the Gloucestershire ICS control total in each year since its formation by merger in 2019.

Of particular note, at the end of 20/21 was the cash balance, which has been built up both from prior year surpluses, the charge to Income & Expenditure (I&E) of non-cash items such as depreciation and good management of working capital. This cash on the Trust balance sheet can be used for capital investment, as well as providing a buffer for working capital although an ICS Capital Delegated Expenditure Limit (CDEL) is also required for capital expenditure within current NHS guidance.

The plan assumes a small reduction in contracted income associated with overall bed reduction in the new hospital, the Trust is not expecting any other significant variation to contract income that would impact on the overall financial position. The position at the end of month 2 is confirmed in Table 6 below. The cash balance at the end of May 2021 was £54.4m.

Table 6: Forecast position based @M2 21/22

Statement of comprehensive income £000	Original Plan	YTD Actual	Full Year Forecast
Operating income from patient care activities	220,598	38,549	225,360
Other operating income	6,700	928	11,268
Other income	0	0	0
Employee expenses	(170,274)	(28,743)	(169,062)
Operating expenses excluding employee expenses	(53,533)	(10,317)	(64,908)
PDC dividends payable/refundable	(2,701)	(432)	(2,706)
Other gains/losses	0	3	0
Surplus/deficit) before impairments & transfers	790	(12)	(48)
Impairments/exceptional items*			
Remove capital donations/grants I&E impact	100	15	£48
Surplus (deficit)	890	3	0
Adjust (gains)/losses on transfers by absorption/impairments			
Revised Surplus/(deficit)	890	3	0

5.1 Capital costs

The capital costs outlined in Table 7 have been developed through a robust process utilising a combination of market rates, soft market testing with a range of suppliers, QS judgement and subject matter expert input rather than formal quotations at this stage.

Table 7: Capital costs

Description	£'000		
	Cost	VAT	Cost Incl VAT
Construction	13,890	2,778	16,668
External Works	2,657	531	3,188
Works Cost Total	16,547	3,309	19,856
Fees	1,120	224	1,344
Non Works including land & skate park	600	0	600
Equipment Costs	650	130	780
Planning Contingency	817	163	980
VAT Reclaim		(340)	(340)
Sub Total	19,734	3,487	23,221
Inflation Adjustments	581	116	697
Total			23,919

5.2 Capital Funding

The Trust is funding the scheme through its cash reserves and the sale of the Dilke and Lydney Hospital sites in the Forest of Dean. This is consistent with the assumptions contained within the OBC and despite the cost increases remains the preferred route. The Trust has consistently delivered surpluses over recent years and has a significant cash balance that will be utilised to support the agreed capital programme.

The Trust intends to dispose of the Dilke and Lydney sites in 2023/24.

The Trust's latest capital expenditure plan reflect in Table 8 incorporates the capital costs for the Forest of Dean Hospital of £23.9m. Detailed capital planning has been undertaken by the Trust to develop the five-year capital plan.

Table 8: Gloucestershire Health and Care Five Year Capital Plan

GHC Five Year Capital Plan	Final Plan	Final Plan	Final Plan	Final Plan	Final Plan	Final Plan
£000s	2021/22	2022/23	2023/24	2024/25	2025/26	Total
Land and Buildings						
Buildings	3,563	2,500	2,500	1,000	1,000	10,563
Backlog Maintenance	5,657	0	1,050	1,250	1,393	9,350
Urgent Care	750	0	0	0	0	750
LD Assessment & Treatment Unit	0	0	2,000	0	0	2,000
Cirencester Scheme	0	0	5,000	0	0	5,000
IT						
IT Device and software upgrade	200	600	600	600	600	2,600
IT Infrastructure	1,086	996	1,300	1,300	1,300	5,982
Medical Equipment	1,569	0	730	1,030	1,030	4,359
Unallocated	168	0	0	2,300	2,300	4,768
Sub Total	12,993	4,096	13,180	7,480	7,623	45,372
Forest of Dean	3,000	16,000	3,500	0	0	22,500
Total prior to proceeds/donations	15,993	20,096	16,680	7,480	7,623	67,872
Disposal Proceeds		(3,260)	(1,500)			(4,760)
Donations			(5,000)			(5,000)
Total after proceeds/donations	15,993	16,836	10,180	7,480	7,623	58,112

Nb £1.4m spent upto 31.03.21 on Forest of Dean

5.3 Financial Case Assumptions

The financial case assumes that the new hospital will provide all the services that are currently delivered from Dilke and Lydney hospitals (except for a small number retained for locality delivery).

The average annual revenue impact of Business as Usual and the proposed preferred option will enable reductions in clinical inpatient costs, facility staffing costs and building running costs. Table 9 shows the current costs of services operating from the Dilke and Lydney Hospitals and the operating costs from 2025/26 when the full reduction/redeployment of teams will be in effect. Costs are shown at in-year inflated values.

Table 9: Revenue Costs in financial case of 'as is' versus 'with investment' models

	Existing Annual Cost (£000s)	Existing Costs Inflated to 25/26 levels (£000s)	Annual Cost from 2025/26 (£000s)
Nursing	4,152	4,442	3,282
AHP	352	376	389
Other Clinical	312	331	289
Clinical Non Pay	433	463	527
Total Clinical Costs	5,248	5,613	4,487
Non-Clinical Costs	1,175	1,265	1,024
Building Runnings Costs	498	553	335
Rates	63	70	169
Cap charges / depn	697	815	2,024
Total Non-Clinical Costs	2,433	2,704	3,552
Total Service Costs	7,682	8,316	8,039
Directly attributable income (OPD/Endo)	(242)	(259)	(674)
Position Net of Directly Attributable Income	7,439	8,057	7,365

The changes to the recurrent cost base listed above reflect all of the assumptions outlined in the financial modelling section and include the significant movement in capital charges and depreciation which must be funded as a consequence of the new hospital. The overall position demonstrates that the annual service costs in 2025/26 are more favourable following the development of the new hospital than under the existing business as usual scenario.

5.4 Impact on Trust Statement of Financial Position

Table 10 below shows extracts from the Trust's long term financial modelling which demonstrates the balance sheet and cash flow positions each year. The Trust had a cash balances of £52.3m at 31st March 2021.



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The Trust's internal cash reserves are sufficient to fund the Trust's contribution to this project. The Trust does not anticipate the need for loans to support its cash position. Working Capital in the Statement of Financial Position (SoFP) is assumed to be consistent throughout the financial model.

The Trust has a strong balance sheet that enables it to make on-going significant investment in its capital programme in future years.

The main impact on the balance sheet is an increase in building assets as a result of this capital project sitting on the Trust's balance sheet as the new Hospital will be owned by the Trust. The Trust's cash flow projections show a reduction in cash from £52.3m in 2021 to a sustainable balance of c. £20m by 2030/31.

Table 10: The Trusts SOFP for years 1-5 and year 10

Statement of Finance Position (all figures £000s)		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2030/31
Non-current assets	Intangible assets	488	488	488	488	488	488	488
	Property, plant and equipment: other	110,388	119,681	130,167	133,847	134,726	135,548	134,697
	Total non-current assets	110,876	120,169	130,655	134,335	135,214	136,036	135,185
Current assets	Inventories	718	418	218	218	218	218	218
	NHS receivables	6,077	5,877	5,827	5,777	5,777	5,777	5,777
	Non-NHS receivables	5,928	5,928	5,428	5,328	5,328	5,328	5,328
	Cash and cash equivalents	52,333	40,695	30,959	27,429	24,907	24,085	24,936
	Property held for Sale	0	0	0	0	0	0	0
	Total current assets	65,056	52,918	42,432	38,752	36,230	35,408	36,259
Current liabilities	Trade and other payables : capital	(5,108)	(5,108)	(5,108)	(5,108)	(5,108)	(5,108)	(5,108)
	Trade and other payables: non-capital	(23,762)	(20,262)	(20,262)	(20,262)	(20,262)	(20,262)	(20,262)
	Borrowings	(107)	(107)	(107)	(107)	(107)	(107)	(107)
	Provisions	(3,526)	(1,526)	(1,026)	(1,026)	(1,026)	(1,026)	(1,026)
	Other liabilities: incl. deferred income	(2,273)	(773)	(773)	(773)	(773)	(773)	(773)
	Total current liabilities	(34,776)	(27,776)	(27,276)	(27,276)	(27,276)	(27,276)	(27,276)
Non-current liabilities	Borrowings	(1,363)	(1,363)	(1,363)	(1,363)	(1,363)	(1,363)	(1,363)
	Provisions	(1,423)	(1,423)	(1,423)	(1,423)	(1,423)	(1,423)	(1,423)
	Total net assets employed	138,370	142,525	143,025	143,025	141,382	141,382	141,382
Taxpayers Equity	Public dividend capital	126,578	126,733	126,733	126,733	126,733	126,733	126,733
	Revaluation reserve	6,826	6,826	6,826	6,826	6,826	6,826	6,826
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	(1,241)	(1,241)	(1,241)
	Donation reserve	0	0	0	0	0	0	0
	Income and expenditure reserve	6,207	10,207	10,707	10,707	9,064	9,064	9,064
	Total Taxpayers' and other equity	138,370	142,525	143,025	143,025	141,382	141,382	141,382

5.5 Impact on Trust Cash Flow

Table 12 below demonstrates that taking account of the current cash balance, future year's depreciation, anticipated disposals and predicted balance sheet movement this five year capital plan can be securely funded.

We have assumed that the Trust will not generate a surplus in future years. Our assessment demonstrates that we would have sufficient cash available each year through to 2025/26 to fund the capital programme, including the FoD scheme at a cost of £23.9m.

Our forecast has indicated this level of expenditure would enable the Trust to continue to operate a significant Operational Cash buffer which we believe is sufficient to cover all contingencies.

Table 11: Impact on Trust Cash Flow

Statement of Cash Flow £000	21/22	22/23	23/24	24/25	25/26	30/31
Cash and cash equivalents at start of period	52,333	40,695	30,959	27,429	24,907	24,736
Cash flows from operating activities						
Operating surplus/(deficit)	2,300	2,300	2,300	657	2,300	2,300
Add back: Depreciation on donated assets	0	0	0	0	0	0
Adjusted Operating surplus/(deficit) per I&E	2,300	2,300	2,300	657	2,300	2,300
Add back: Depreciation on owned assets	6,700	6,350	6,500	6,601	6,801	7,200
Add back: Impairment	0	0	0	0	0	0
(Increase)/Decrease in inventories	300	200	0	0	0	0
(Increase)/Decrease in trade & other receivables	200	550	150	0	0	0
Increase/(Decrease) in provisions	(1,500)	0	0	0	0	0
Increase/(Decrease) in trade and other payables	(1,500)	0	0	0	0	0
Increase/(Decrease) in other liabilities	0	0	0	0	0	0
Net cash generated from / (used in) operations	6,500	9,400	8,950	7,258	9,101	9,500
Cash flows from investing activities						
Interest received	0	0	0	0	0	0
Purchase of property, plant and equipment	(15,993)	(20,096)	(16,680)	(7,480)	(7,623)	(7,000)
Sale of Property	0	3,260	6,500	0	0	0
Net cash generated / (used) in investing activities	(15,993)	(16,836)	(10,180)	(7,480)	(7,623)	(7,000)
Cash flows from financing activities						
PDC Dividend Received	0	0	0	0	0	0
PDC Dividend (Paid)	(2,145)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)
Finance Lease Rental Payments	0	0	0	0	0	0
Net cash generated / (used) in financing activities	(2,145)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)
Cash and cash equivalents at end of period	40,695	30,959	27,429	24,907	24,085	24,936

5.6 Sensitivities, Downsides and Mitigations

The Trust has approached the financial modelling in a very prudent way, as demonstrated by our capital contingency, alongside introducing an optimism bias into our operating cost model.

The Trust has utilised a not to be exceeded price, with an additional c.£0.8M contingency, which will be superseded by a guaranteed maximum price arrangement. Therefore, a sensitivity analysis on capital cost has not been completed at this stage. The model is, however, sensitive to assumptions around pay and income inflation rates. The table below identifies some of the key sensitivities and their effect on the overall financial benefit over 60 years.

5.7 Conclusion of Affordability

The preferred funding route for the capital programme remains the utilisation of the Trust's cash reserves and disposal proceeds. The finance section demonstrates that the preferred option is affordable to the Trust and continues to offer a significant reduction in risk associated with backlog maintenance and risk of service failure. This

scheme results in cost efficiencies from bringing services onto a single site which outweigh the additional capital charges of the new hospital so the scheme is affordable from a revenue perspective.

6.0 Management Case

6.1 Project governance arrangements, roles and responsibilities

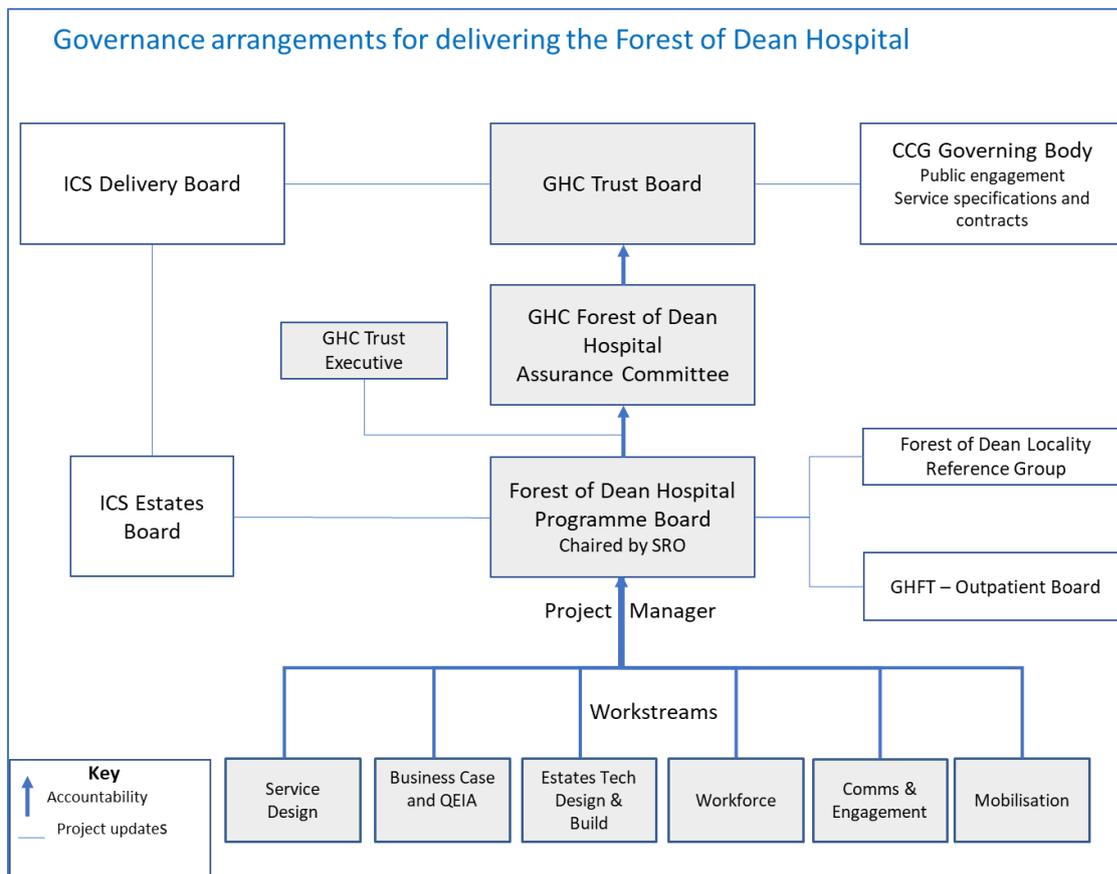
The planning for a new community hospital for the Forest of Dean has been integral to the Trust’s estates strategy and is a key part of the strategic planning for the One Gloucestershire ICS and the investment is included within the ICS Estates strategy.

The Trust has established a robust project management structure that is accountable to the Trust Board but will also continue to maintain important liaison and joint working with other groups within the ICS. The governance structure is set out in Table 13 below which shows accountability lines, and key internal and external relationships.

The Trust Board will have overall accountability for the programme and on the basis of this viable and affordable business case will ensure delivery of the agreed investment objectives and the successful completion of a new hospital for the Forest of Dean.

The Senior Responsible Officer (SRO) is the Executive level Director of Strategy and Partnerships who chairs the Programme Board.

Figure 1: Governance arrangements for delivering the Forest of Dean Hospital



A robust change control process is in place to monitor service design and ensure a thorough confirm and challenge process is in place to prevent design creep or cost impacts following design freeze. The SRO is responsible for the sign off of any service change requests following the design freeze stage.

A number of workstreams will be key to planning the detail of the transition, benefits realisation and commissioning of services in the new building along with the ongoing engagement with stakeholders including neighbours, colleagues and wider interested parties. These include the:

- Workforce workstream
- Engagement and Communication workstream
- Mobilisation workstream

All workstreams will provide regular updates and escalation reports to the Programme Board and the FoD Assurance Committee as appropriate.

6.2 Project plan

Key milestones for the investment are set out in the Table 13 below.

Table 12: Key milestones for the investment

Key Milestones	Start date	End date	Key assumptions
Trust Board approves FBC	7 July 21	15 July 21	
RIBA 3 design for planning	14 June 21	13 August 21	
Submission of Full Planning Application	23 July 21	End of October 21	Assuming maximum of 14 weeks and that Pre-planning expectations correctly inform application
RIBA 4 Design	19 August 21	29 October 21	
Tender of packages	1 November 21	10 December 21	Assuming Full Planning Permission is granted
Finalised costs	13 December 21	23 December 21	Assuming tender programme proceeds to plan
Trust Board agrees Guaranteed Maximum Price	12 January 22	12 January 22	

Key Milestones	Start date	End date	Key assumptions
Contractors appointment and mobilisation	12 January 22	8 February 22	Ability to mobilise in given period
Construction starts	8 February 22		
Construction period (70 weeks)	7 Feb 22	12 June 23	
Commissioning of new building and transfer of services from Dilke and Lydney	June 2023	June 2023	Dependent on construction timescale /unforeseen delays
Closure of Dilke and Lydney and availability for disposal	July 2023		

Table 13 outlines the internal gateways which have been agreed to enable detailed review prior to progression to the next stage. Gateways will be overseen by the Trust Board, delegated as appropriate to the Assurance Committee.

Table 13: Internal gateways

Internal Gateways	Date in line with Project plan
Approval of Full Business Case	Trust Board 15 July 2021
End of Design Phase - completion of technical design (RIBA Stage 4)	Assurance Committee October 2021
Confirmation of any NHSEI approvals	November 2021
Final GMP cost and entering into the Construction Contract	Trust Board January 2022
End of construction phase (RIBA Stage 5)	Assurance Committee May 2023
End of Commissioning of new building (RIBA Stage 6)	Assurance Committee June 2023
End of initial operation (RIBA Stage 7)	Assurance Committee Sept 2023
End of Post Project Evaluation	Assurance Committee December 2023
Final sign off and Project Closure (equivalent to OGC Gateway 5)	Trust Board January 2024

6.3 Contingency planning and business continuity

A draft comprehensive transition and implementation project plan has been developed to cover the period leading up to opening the new hospital and the initial operational phase. This sets out broad level tasks for each of the service areas, based on the requirements for the move and informed by the extensive experience gained by managers undertaking similar community hospital commissioning exercises.

The plan covers three phases:

- Preparation phase from July 2021 to November 2022;
- Mobilisation phase from December 2022 to June 2023;
- Initial Delivery Phase from July 2023 to January 2024 when the project is scheduled to be handed over to Trust Operational Management.

Development of the plan will be a regular reporting feature of the Programme Board and will continue to be refined as the scheme progresses.

6.4 Workforce

Detail of the planned changes in staffing structures will involve:

- A reduction of facilities staff of 8.8 wte.
- An overall reduction of ward staff of 35 wte (after conversion of nursing posts to additional therapy posts).
- A reduction in MIU staff of 2.6 wte.
- An increase in staffing of 9.5 wte for endoscopy.

In addition, the management of change requires close attention to supporting staff, communicating openly and in a timely manner, engaging with staff where possible in the decision-making process, taking staff views into account.

6.5 Communications and Engagement

The aims of the Communications and Engagement workstream are to:

- ensure a dialogue with service users, residents, stakeholders and colleagues to enable input and support in the design and development of the new hospital
- maintain trust with colleagues, the community and stakeholders
- maintain the reputation of the Trust
- ensure timely and factual updates on progress.

To support these goals, regular briefings with Forest colleagues and stakeholders will take place to ensure they are aware of significant developments in advance and to provide assurance and respond to any questions. The Trust has formed a working group with residents of Springfield Drive, on one boundary of the site, and liaises with owners on the other boundary.

A stakeholder mapping exercise was completed by the Communications and Engagement workstream in January 2021. This identifies stakeholders, risk around

non-engagement, methods of engagement and planned frequency of contact. This is being regularly monitored and updated.

6.6 Benefits realisation

The Benefits to be achieved by this investment can be categorised as follows:

- Benefits that will be realised through the agreed design and the satisfactory completion of the building – these will have been achieved in June 2023 when the building is commissioned.
- Benefits enabled by the building but requiring specific action to fully realise. Realisation will be over a period June 2023 to the end of 2025 (beyond the period of Programme Board oversight).
- Benefits as perceived by patients and staff using the building (these will be assessed by the end of the initial operational phase (September 2023 and again before project closure (January 2024)).

Benefits realisation will become a key responsibility of the Programme Board in the period leading up to the completion of construction, the transfer of services into the new facility and the initial period of operations (to January 2024).

6.7 Project risks, mitigation and management

The Trust has a well-established approach to risk management which is set out in the Trust's Operation Risk Management Policy. The Trust has a Risk Management Framework in place to steer the way we identify, prioritise, manage and mitigate any risks we face. This approach has been applied throughout the planning process for the Forest of Dean Hospital.

The Programme Board will review programme risk registers on a monthly basis to ensure that all risks have appropriate mitigation strategies and that actions are completed to reduce the risks in a timely manner. Any new risks identified will be appropriately risk rated and assigned a senior risk owner and where appropriate escalated to the Assurance Committee for detailed review.

6.8 Post project evaluation

The Trust is committed to evaluating both the project processes and the success of the investment created through this programme. The Trust has demonstrated its capacity to learn lessons from its previous investments in community hospitals in Gloucestershire.

The programme has already been engaged in the Design Quality Indicator Process (DQI). The process focuses on functionality, build quality and impact for healthcare buildings and is undertaken at various stages over a project's lifecycle and further events will take place at future stages including *Ready for Occupation* stage (around June 2023) and the *In-Use* stage DQI Process around November 2023. These are included in the implementation and transition project plan.



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7.0 Conclusion

This FBC represents the culmination of over five years of planning and preparation and is a significant step change in the ability to provide a modern, fit for purpose environment and enhanced service facilities for the people of the Forest of Dean and beyond.

Investment in this new facility will enable the re-provision of services, and subsequent closure of the existing two community hospitals, namely Lydney & District Hospital and the Dilke Memorial Hospital

This FBC demonstrates that the preferred option being taken forward from the OBC delivers a viable and affordable solution to meeting the requirements laid out in the case for change. The Trust has been presented a NTBEP price from its construction partner, Speller Metcalfe and has confirmed that these costs are affordable from a capital and revenue perspective. The economic modelling demonstrates that the scheme offers good VFM when compared to business as usual.

Development of a New Community Hospital for the Forest of Dean

Full Business Case July 2021



Forest of Dean Hospital FBC - Introduction

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Forest of Dean Hospital FBC - Introduction

Introduction

This document presents the Full Business Case for the development of a new community hospital for the Forest of Dean (FoD).

The Full Business Case seeks approval for Gloucestershire Health & Care (GHC) NHS Foundation Trust to invest £23.9m in the development of a new community hospital to serve the people in the Forest of Dean funded from its cash reserves and the sale of the Dilke and Lydney Hospital sites in the Forest of Dean.

This FBC represents the culmination of over five years of planning and preparation and is a significant step change in the ability to provide a modern, fit for purpose environment and enhanced service facilities for the people of the Forest of Dean and beyond.

Investment in this new facility will enable the re-provision of services, and subsequent closure of the existing two community hospitals, namely Lydney & District Hospital and the Dilke Memorial Hospital

This new hospital is considered a key part of the wider investment proposed in the Forest of Dean to address primary and community infrastructure needs. This investment will ensure that the Forest of Dean services support the delivery of models of place-based integrated care as part of the One Gloucestershire Integrated Care System's (ICS) plans.

Although the new community hospital will be the main clinical hub for the area for hospital-based services, GHC will continue to base staff at other locations across the Forest to facilitate the closest possible working with primary care and communities and to provide local clinics and other sessions. The new hospital will also work as part of the wider network of community hospitals and community services across the county.

The two community hospitals currently support three broad areas of service provision for the residents of the Forest of Dean and surrounding areas including people living on the border with Wales:

- Ambulatory care services including a variety of outpatient services (many of which are provided by GHT)
- Urgent care and diagnostic facilities to support the assessment and treatment of minor injuries and illness including supporting access to the out of hours provider
- Inpatient bed facilities to support patients with subacute and rehabilitation needs

Forest of Dean Hospital FBC - Introduction

Timeline of Forest of Dean project

Since 2015, NHS Gloucestershire Clinical Commissioning Group (GCCG) and Gloucestershire Care Services (GCS) and (since 2019), GHC have undertaken extensive public and staff engagement to arrive at a carefully reasoned and evidenced approach to addressing the Case for Change in the Forest of Dean and developing the range of services to be provided in the new hospital. Details of the final stage of the public consultation process and the consultation output report along with the subsequently confirmed service strategy are contained in Appendix 0.1 and Appendix 0.2 respectively.

Key steps and the associated outputs/decisions are summarised in table 1 below. Outputs of the various engagements and the process of appraising options have been documented in detail both in the preceding SOC and OBC and other papers.

Table 1: Time line up to the approval of the OBC and final stage of consultation

Time line	Key step	Output
September 2015 to June 2016	Review into the future of health and social care services in the Forest	Forest of Dean Locality Reference Group report to NHS Gloucestershire
July 2017	Case for Change agreed	
12 Sept 2017 to 10 December 2017	12 weeks of consultation to consider future options for the two hospitals	Health and wellbeing for the Future: Community Hospitals in the Forest of Dean - Outcome Consultation report
25 January 2018	GCCG and Gloucestershire Care Services NHS Trust receive consultation feedback, endorse recommendation and agree actions for the appraisal of Location through further engagement and consultation	Actions agreed: <ul style="list-style-type: none"> • To undertake a further six weeks of public engagement on the location of the new community hospital • To commission independent equality impact analysis for each of the three potential locations • To commission an independent travel analysis to consider access to each of the three potential locations; • To appoint a Community Interest Company (CIC) to run an independent Citizens Jury, to consider information and make a recommendation regarding the general location of the new hospital.

Forest of Dean Hospital FBC - Introduction

Time line	Key step	Output
February to April 2018	Hands Off Lydney and Dilke (HOLD) initiate legal challenge to decision to build a single hospital for the Forest of Dean	Legal representatives for the CCG issue Judicial Review Pre-action Protocol letter in response (13 April 2018)
30 August 2018	Board of GCS and Governing Body of CCG approve the general location	Location to be in or near Cinderford. The Boards also confirmed additional actions identified by the Citizens Jury
September 2018 to March 2019	Exploration and appraisal of potential sites within the Cinderford area was undertaken and documented in the Outline Business Case presented to the GCS Board in May 2019	Options appraisal concluded the preferred site as Steam Mills Skatepark, Cinderford
2 May 2019	Board of Gloucestershire Care Services NHS Trust approved the Outline Business case	Approval given to secure the Steam Mills site and to proceed to Full Business Case.
December 2019	Site for the new hospital was formally announced	
July 2020	CCG legal advisers (Bevan Brittan) issue guidance on the link with the Fit for the Future systems wide consultation and the Forest of Dean and the robustness of the decision making regarding the closure of the Dilke and Lydney Hospitals	Concluded that a formal consultation on the service design of the new hospital was required as a separate exercise to Fit for the Future. Concluded that there was no need to re-engage or consult on the decision to close the Dilke and Lydney.
22 October 2020 to 17 December 2020	Gloucestershire CCG leads on further engagement and consultation on the scope of services to be provided	Output of Consultation Report and appendices was published online by NHS Gloucestershire in January 2021 (see Appendix 0.1 for details)

Forest of Dean Hospital FBC - Introduction

Scope of the Full Business Case

This Business case focuses on the investment to replace two existing hospitals – the Dilke Memorial Hospital in Cinderford and the Lydney and District Hospital in Lydney - with a new community hospital in Cinderford. The new hospital is expected to open in 2023.

The main emphasis is to re-provide the existing services operating from these hospitals to address the Case for Change set out in Section 1

The range of services to be provided in the new hospital was confirmed by the Governing body of NHS Gloucestershire CCG in January 2021 after the public consultation at the end of 2020. The detailed analysis is outlined in Appendix 0.2. A summary of the key services required include:

- 24 inpatient beds with ensuite bathrooms predominantly in single rooms with provision for bariatric patients.
- An urgent care facility, open from 8am to 8pm, seven days a week, supported by a range of diagnostic services.
- Outpatient services, including a range of consultation, treatment and group rooms and additional areas for online consultations for the provision of outpatient services.
- Diagnostic services, including a dedicated endoscopy unit, x-ray, ultrasound and blood-testing (phlebotomy) and space for mobile units such as the Chemotherapy Bus and Breast Screening Service.
- Flexible meeting space that can be accessed by health and care organisations plus wider voluntary sector organisations.

No significant changes were recommended as a consequence of the public consultation.

Statement of support from Partners

A letter setting out Gloucestershire CCG commissioning intentions for services at the hospital is at Appendix 0.3.

Forest of Dean Hospital FBC - Introduction

Structure of the Business Case

This business case follows the standard HM Treasury 5-case model with the following sections:

Section 1 - The Strategic Case sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme

Section 2 – The Economic Case demonstrates the choice for investment meets the future needs of the service and optimises value for money (VFM)

Section 3 - The Commercial Case outlines the context and structure of the proposed contract

Section 4 – The Financial Case confirms funding arrangements and affordability and explains the impact on the Trust's financial standing.

Section 5 – The Management Case demonstrates that the scheme is achievable and can be successfully delivered to cost, time and quality

Conclusion.

Supporting evidence for this business case is included in the Appendices.

Forest of Dean Hospital FBC Strategic case

1 Strategic case

1.1 Purpose of the Strategic Case

This section summarises the rationale for this major investment in a new community hospital for the residents of the Forest of Dean. It takes into account the factors that have informed thinking since the Outline Business Case was approved by the Gloucestershire Care Services Trust Board in August 2019.

The Case for Change set out in the Strategic Outline Case (SOC) and Outline Business Case (OBC) is strengthened by the extensive engagement with public, staff and other stakeholders as well as the detailed analytical work that has been undertaken over the last four years. The Case for Change reflects the requirements of the *One Gloucestershire* Integrated Care System (ICS).

Clear investment objectives are detailed that address the Case for Change and lead to measurable benefits that will be realised from the investment.

1.2 Strategic Context

1.2.1 Key developments since the Outline Business

Continued evolution of the One Gloucestershire Integrated Care System

The One Gloucestershire Integrated Care System (ICS) has been continuing to work in partnership and develop joint collaborative plans following selection as one of the initial fourteen Integrated Care System in May 2018. This brings together NHS Gloucestershire Clinical Commissioning Group (GCCG), Primary Care Providers, Gloucestershire Health and Care NHS Foundation Trust (GHC), Gloucestershire Hospitals NHS Foundation Trust (GHFT), South Western Ambulance Service NHS Foundation Trust (SWAST) and Gloucestershire County Council (GCC) in a formal collaboration. The ICS is taking a place/population-based approach to delivering new models of care for integrating community and primary services.

The ICS Priorities are to:

- Place a far greater emphasis on personal responsibility, prevention and self-care, supported by additional investment in helping people to help themselves
- Place a greater emphasis on joined up community based care and support, provided in patients' own homes and in the right number of community centres, supported by specialist staff and teams when needed

Forest of Dean Hospital FBC Strategic case

- Continue to bring together specialist services and resources in to centres of excellence that deliver a greater separation of emergency and planned care and, where possible reduce the reliance on inpatient care (and consequently the need for bed-based services) across our system by repurposing the facilities we have in order to use them more efficiently and effectively in future
- Develop new roles and ways of working across our system to make best use of the workforce we have, and bring new people and skills into our delivery system to deliver patient care
- Have a continued focus on ensuring Parity of Esteem for Mental health.

The NHS White Paper *Integration and innovation, working together to improve health and social care for all*, proposes that ICSs will become statutory bodies and will be responsible for better health and wellbeing for everyone in their areas, better quality of health services, and sustainable use of NHS resources. The ICS is continuing to explore how we take forward the anticipated changes and the new partnership arrangements that will be put in place.

Under the umbrella of *One Gloucestershire*, the *Fit for the Future* consultation and planning for hospital services in the county has focused attention on the best location for sustainable high-quality hospital services and the need for local services to continue to proactively prevent avoidable admission and to facilitate care pathways that enable people to return home in a timely manner.

Alongside the *Fit for the Future* programme the Forest of Dean Community Services review has been running since the summer of 2015. Through this period a wealth of evidence has been gathered to support future thinking around a services model for community services in the district and the wider strategic context has been evolving,

There has been considerable complexity in navigating the political landscape of effecting service change in the NHS, and the Forest review has at times found itself linked to the wider context of the evolving *Fit for the Future* services review for the county. The inter-relationship has meant that the two programmes have been brought together for specific phases of engagement.

The two programmes of work have been fully considered by the ICS and it has been confirmed that the two work programmes will be developed in tandem but are no longer inter-connected or inter-dependent in any way.

Formation of Gloucestershire Health and Care Services NHS Foundation Trust

In October 2019, Gloucestershire Care Services NHS Trust, which had led the development of the SOC and OBC came together with ²gether NHS Foundation Trust to form Gloucestershire Health and Care NHS Foundation Trust. This strengthens the basis for further integration of services and also expands the range of services that could use the hospital site in the future.

Forest of Dean Hospital FBC Strategic case

In March 2021 the Trust signed off its first five-year strategy which outlined four key aims which are outlined below in Figure 1.

Figure 1: Strategic aims of Gloucestershire Health and Care Services NHS FT



Delivery of the Trust's Strategy is underpinned by a place-based approach of working with people in their local communities that embraces:

- Working with system partners and our Integrated Locality Partnerships (ILP) to focus on developing services around the needs of our communities.
- Understanding the root causes of health inequalities and working with community partners to combat widening inequalities
- Developing use of technology to improve access and investing in buildings to improve efficiency, working conditions and thus enhance the experience of people who use our services and colleagues who work there.
- Developing our Quality Improvement Framework to drive forward service improvement and innovation.
- Working towards 'university status' along with our Gloucestershire health and education partners
- Proactively developing our Green plans to be an environmentally proactive organisation working with our communities to minimise and mitigate the health impact on pollution and climate change.
- Embedding a strong culture of co-production, engagement and the Universal Personalised Health Care Model.

All these are relevant to the development of a new facility linked closely to the local community.

Forest of Dean Hospital FBC Strategic case

Place-based care and Primary Care Networks

Nationally and locally, the emphasis is on placed-based population health that enables us to better target the right services to those most in need. By working together, ICS organisations along with wider voluntary sector partners are more effectively able to support service delivery to deliver shared health and well-being priorities. This includes supporting those people with long term conditions through more joined up care and support in people's own homes, General Practice (GP) surgery, community venues or in a hospital setting.

There are six Integrated Locality Partnerships (ILPs) across the county with a single ILP covering the Forest of Dean. This comprises three Primary Care Networks (PCNs).

The PCNs in the Forest locality have been pivotal in the development of new primary care facilities with one already operating in Cinderford, one in the development stage for Coleford and positive steps are now being take to develop a new facility for Lydney. The new Forest of Dean Hospital will function in a network with these hubs.

Public engagement and consultation

A number of periods of engagement and consultation have already been conducted on the Forest of Dean hospital predominately led by GCCG. These have covered aspects such as the proposal to build one hospital to replace the existing two ageing facilities and then subsequently to determine the location of the hospital - which was decided ultimately by an independent citizen's jury. A final phase was then concluded in December 2020 which focused on the confirmation of the service model that the new hospital will provide.

A Forest of Dean website has been set up by the CCG and GHC, providing a repository of all information that has supported the range of public conversations regarding the proposal to build a new hospital in the Forest of Dean <https://www.fodhealth.nhs.uk/>.

This site includes dates for current and previous engagement and consultation events, Frequently Asked Questions and documents that have supported the process. GHC has continued the extensive engagement with local stakeholders and residents and feedback and learning from this engagement has continued to influence the design of services and the building.

Impact of the pandemic

Planning for the new hospital has understandably been affected by the demands of the Covid pandemic. Our experience over the past year has re-emphasised the need for local facilities of the right standard (e.g. maximum infection control in inpatient wards, flexibility in using and zoning clinical rooms) and also the key role that local services can play in keeping activity away from major acute hospitals. The pandemic

Forest of Dean Hospital FBC Strategic case

has confirmed our ability to work closely with partners and this will form a sound basis for service collaboration in the future.

The economic aftermath of the pandemic will be one where value for money will be an even greater concern. The back-log of routine and increasingly urgent outpatient appointments plus the backlog in endoscopies means that every available outpatient facility will be required across the county, a demand that will extend to beyond 2023 when the new hospital is functioning. We also recognise that the landscape for outpatient services has changed now that it is clear from experience that some demand can be successfully met with alternatives to conventional face-to-face appointments. The new hospital will be part of a system operating both secondary and community services outpatient appointments in new ways.

1.2.2 How the Trust will work with partners in the Forest of Dean

The new community hospital will embody the Trust's vision for working with its partners in the Forest of Dean. The hospital will provide economies of scale and critical mass to allow certain services to operate to effective modern standards. This will enable services such as therapies, child health and podiatry to operate a hub and spoke model bringing together expertise at the centre when required but also maintaining close contact and access at a very local level.

The Trust works alongside Primary Care practices who themselves are increasingly working as Primary Care Networks. The Trust's Integrated Care teams (ICTs) (which comprise Community Nurses, Occupational Therapists, Physiotherapists, Social Workers, and Reablement Workers) work as one united team to serve a local area alongside GP teams for those who need care to be provided in their place of residence or in the community. Work is ongoing to understand how further integration and new ways of working with PCNs will bring even greater benefits in managing population health and reducing inequalities.

Our vision for the new hospital is one of a "hospital without walls" with our teams working closely with colleagues and other services throughout the Forest. We will increasingly work with stakeholders and groups from local communities and encourage wider stakeholders to use facilities at the new hospital for their own activity enabling active promotion of the population's health and wellbeing. Links with Community Health & Well-being providers and with the local Social Prescribing Link Workers will ensure that people can be sign-posted to appropriate support services and mechanisms and we see the new community hospital as a focal point for collaboration and heart of the community for well-being.

1.2.3 Estates planning

The development of a new community hospital in the Forest of Dean was initially outlined in the GCS Estates Strategy and is a clear priority within the developing GHC Estates Strategy which identifies the need for flexibility in approach to estates and

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property to ensure that it is a key enabler to high quality, effective service delivery and is the cornerstone of effective service reconfiguration.

The new community hospital is clearly supported in the ICS Estates strategy (One Gloucestershire Joint Estate Strategy document 19 December 2020) and therefore remains a key system priority. The Gloucestershire ICS Estates vision is for a modern, flexible estate infrastructure, supporting the service ambitions and day to day working of Gloucestershire's Integrated Care System to maximise health and well-being, improve the quality of care and patient experience, and deliver financial efficiency. The strategic estate objectives are:

- Key strategic capital investment priorities include the reconfiguration of the two acute hospital sites, a new community hospital in the Forest of Dean, key mental health facilities and a number of new larger primary care centres.
- A right-sized estate, where organisations have identified their core assets, successfully disposed of surplus requirements and used this finance to deliver longer term financial sustainability and/or reinvested in a clear forward maintenance and investment programme agreed between organisations.
- Common operational policies for all sites covering both clinical and non-clinical areas, standardising work practices for the use of buildings, including digital solutions to enable smarter working and access to enable 7 day working, between organisations, making it as easy as possible to do business across the ICS.
- There is a thorough understanding of assets and the utilisation of those assets to maximise efficiency of joined up care and support operational delivery;
- Continuing to develop understanding of the costs of running the estate and there is continual reviewing of further opportunities to drive costs down further.
- There is a clear strategy and programme between health and all local authorities maximising estates to impact on the wider determinants of health.
- Fully supporting sustainable development.

1.2.4 The Trust's financial context

Gloucestershire Health and Care NHS Foundation Trust is in a healthy financial position having delivered a small surplus to 2020/21. The Trust's financial position is detailed in Section 4.3 of the Financial Case below. At the end of 20/21 the cash balance was £54.4m.

The Trust plans to breakeven in the first half of 2021/22.

1.3 Case for change

The review into the future of health and social care services within the Forest of Dean was established in 2015. The vision for the review was to:

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develop a plan for delivering high quality and affordable community health and care services to the people of the Forest of Dean which meet their needs now and, in the future, and is developed with patients, the public and our key partners. The review will encompass all community services in the Forest of Dean, including those within the community hospitals

The review was undertaken by GCCG, overseen by the Forest of Dean Locality Reference Group between September 2015 and June 2016. Following extensive engagement throughout the lifetime of the Forest Health and Care Review, and with the support of the wider One Gloucestershire ICS, the Case for Change received support from the respective organisational Boards in July 2017.

The Case for Change detailed in the SOC and OBC for a new community hospital developed out of the aforementioned review. Table 2 below shows the original drivers identified in the OBC case for change and how the current context means these remain relevant for this FBC.

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Table 2: The Case for Change

SOC and OBC Case for Change	How the context has influenced the Case for Change
<p>The ability to maintain some essential services across two community hospital sites is becoming increasingly difficult with healthcare professionals working across different sites and the challenge of recruiting and retaining enough staff with the right skills.</p>	<p>The difficulties in maintaining services across two sites have continued since 2016 leading to temporary closures of MIU.</p> <p>In 2019/20 the MIUs at the Dilke and Lydney suffered a total 323 hours of closure between 8am and 8pm due to work load and staffing issues. Much of this would have been avoided if resources had been concentrated in a bigger unit on one site.</p> <p>There are insufficient radiologists to cover both sites across a 5-day period and an inability to provide sickness or absence cover resulting in loss of service provision at short notice.</p>
<p>There are significant issues relating to cost of maintenance of the existing hospitals and restricted space for services,</p>	<p>Despite essential works being undertaken, backlog maintenance issues have grown and further delay in the project will necessitate expenditure that could be avoided through replacement with a new building.</p> <p>The operational impact of running two hospitals instead of one remains unworkable and the ability to reconfigure the space appropriately to create a fit for purpose solution within the existing space is not possible.</p> <p>An increased understanding of how new models could operate has highlighted the inflexibility of current space configurations including the difficult in co-locating activities and the space required for multi-disciplinary work.</p>
<p>The current physical environment within the hospitals makes it increasingly difficult to ensure privacy and dignity for all patients and manage infection control.</p>	<p>Infection prevention and control (IPC) limitations have been highlighted in the pandemic with ward areas at both Lydney and the Dilke having beds closed and other services suspended due to a lack of</p>

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SOC and OBC Case for Change	How the context has influenced the Case for Change																		
	<p>separation. The MIU at the Dilke could not be made Covid secure and closed since March 2019.</p> <p>The table below demonstrates the number of bed days lost due to closure as a result of IPC measures at the Dilke and Lydney where beds are in open bays and a Covid secure environment couldn't be maintained.</p> <p><i>Table 3: Bed days lost at Community Hospitals through infection</i></p> <table border="1" data-bbox="786 846 1382 987"> <thead> <tr> <th></th> <th>Dilke</th> <th>Lydney</th> <th>NCH</th> <th>Tewkesbury</th> <th>Vale</th> </tr> </thead> <tbody> <tr> <td>2019/20</td> <td>96</td> <td>81</td> <td>0</td> <td>0</td> <td>39</td> </tr> <tr> <td>2020/21</td> <td>115</td> <td>148</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table>		Dilke	Lydney	NCH	Tewkesbury	Vale	2019/20	96	81	0	0	39	2020/21	115	148	0	0	0
	Dilke	Lydney	NCH	Tewkesbury	Vale														
2019/20	96	81	0	0	39														
2020/21	115	148	0	0	0														
<p>Too many people from the Forest of Dean are having to travel outside the local area to receive care that should be provided more locally, such as endoscopy.</p>	<p>Endoscopy continues to be a service area of growth with demand across Gloucestershire rising at approximately 4% predominately driven by demographic growth.</p> <p>Feedback from the consultation and engagement events confirms the need to retain outpatient services and develop endoscopy services locally.</p> <p>Problems with providing consistent x-ray and ultrasound locally and a consistent reliable MIU have led to additional journeys to Gloucester and Cheltenham and additional use of the county's Emergency Department (ED).</p> <p>Consolidation of diagnostic services and the locality Minor Injury & Illness units (MIU) onto a single site will increase overall resilience and deliverability.</p>																		

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SOC and OBC Case for Change	How the context has influenced the Case for Change
The current healthcare system can be fragmented and disjointed from both a patient and professional perspective	The continued development of the ICS and the ILPs has greatly increased the partnership working across each locality and the proposals here enable us to continue to work collaboratively within a network of modern facilities in partnership with communities on the ground.
Healthcare needs within the Forest of Dean are not always being met effectively.	The Trust continues to develop an integrated model of service delivery with a focus on personalised care across both physical and mental health services. The development of the new hospital is a key part of ensuring that services are delivered from fit for purpose, modern estate.
	Environmental concerns did not form part of the original Case for Change. There is a need to minimise the impact of services on the local environment and to ensure the greatest contribution possible to local sustainability.

The original Case for Change led to the following agreed outcomes:

- More consistent, reliable and sustainable community hospital services, e.g. staffing levels, opening hours.
- A wide range of community hospital services, including beds, accommodation to support outpatient services and urgent care services.
- Significantly improved facilities and space for patients and staff.
- Services and teams working more closely together.
- Better working conditions for staff and greater opportunities for training and development to recruit and retain the best health and care professionals in the Forest of Dean.

In the following section the original Investment Objectives have been revised in light of the developing context and a better understanding of the evolving models of care.

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1.4 Strategic Investment Objectives

Five strategic investment objectives have been agreed as part of the case for change along with the benefits that will be measurable after completion of the project. Where possible, benefits will be quantified in the Economic modelling. Timescales for realisation of benefits are given in section 5.6 of the Management Case.

Investment objective 1	
<i>To facilitate the delivery of sustainable models of care</i>	
<p>Specifically, this means providing:</p> <ul style="list-style-type: none"> • A co-located suite of standardised consulting and treatment rooms to Health Building Note (HBN) specification. This will enable flexibility of use for multidisciplinary consultation and will meet the demands for secondary care Outpatient clinics and community-based services. • On-site diagnostic suite incorporating 7 day a week radiology and ultrasound service providing direct booking from primary care and supporting on-site diagnostics for outpatients and urgent care activity. • High quality children’s health consultation and clinic area separating this unit out with its own waiting areas – meeting of CQC standards around separation of adults and children. • New therapy gym area and access to multipurpose group/activity space • A segregation of adults and children’s services within the MIU to ensure that children’s urgent care needs are appropriately met and they and not unduly distressed. 	<p>The benefits that will be created include:</p> <ul style="list-style-type: none"> • The ability to operate multidisciplinary clinics bringing together a range of different skills and activities thus improving clinical effectiveness and efficiency and enabling patients to avoid multiple visits through a one-stop approach. This will benefit: <ul style="list-style-type: none"> - Secondary outpatients - Child development services with the potential of greater joint working between midwifery and health visiting - Therapy services. The new facility provides the opportunity to bring together Musculoskeletal services with the Assessment and Rehabilitation Unit (ARU) to share a multidisciplinary therapy space enabling Physiotherapists, Occupational Therapists and an Osteopath to work alongside each other thus improving learning and professional development opportunities for both students and qualified staff, improve recruitment and

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<ul style="list-style-type: none"> • Access to large meeting/group room spaces for group clinics/ activity which will also enable use by local community groups enabling a wide range of health and well-being activities. • Fully JAG (Joint Advisory Group on GI Endoscopy) compliant endoscopy facility available up to 7 days a week. • Re-providing dentistry and podiatry in clinics where staff can work together • Clinical skills and training space providing opportunities for professional development through working alongside other clinicians. 	<p>retention plus provide an enhanced patient experience and outcomes.</p> <ul style="list-style-type: none"> • A new endoscopy service meaning patients can avoid travel to Cheltenham for their procedures resulting in both cost and time benefits for patients and carers • Community initiated use of rooms for health and well-being creating activity • Training and professional development activity arising from joint working and use of the centre's facilities including the skills lab. • Improved ability to cover staff shortages which are currently covered by staff travelling between the two sites. • Greater resilience in staffing radiography to enable potential operation 7 days a week • Increased patient and user satisfaction.
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Investment objective 2

To facilitate an inpatient service that integrates nursing and therapies maximising the rehabilitation potential of patients and maximising the flow and discharge of inpatients in the One Gloucestershire system

Specifically, this means:

- Providing a modern ward with 24 single ensuite rooms with maximum flexibility and the space for bariatric patients and those with disabilities
- Co-locating the inpatient ward with the new therapy gym area and space for group activity to enable 7/7 rehabilitation
- Enabling a single 7-day integrated nursing and therapy staff team to be in place by September 2023 developed from combining resources from the two existing teams
- Co-locating the ward with the Rapid Response team enabling prompt in-reach to the ward enhancing the step-up capacity
- Access for inpatients to on site X-ray and Ultrasound services.

The benefits that will be created include:

- Improved ability to cover staff shortages which are currently covered by staff travelling between the wards on the two sites.
- A reduced total nursing staff cost by 2025-6
- Bed days saved in getting patients ready for discharge. Due to the anticipated increasing complexity of patients, the average Length of Stay (LoS) is not expected to reduce overall. However, the integrated nursing and therapy model available 7 days a week, will reduce the overall time needed to enable patients to reach their optimal recovery goals and thus be ready for discharge quicker than if the therapy service was not in place.
- Single rooms provide greater compliance IPC standards and reduce risk of transmission of infectious disease. Single rooms improve bed availability regardless of patient sex and infection status and increase overall privacy and dignity for people
- Efficiency gain in switching staff resources from nursing to therapies (non-cash releasing benefit)

Investment objective 3

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To facilitate a reliable and consistent Urgent Care service for the Forest of Dean as part of the One Gloucestershire integrated urgent care system.

Specifically, this means:

- Providing a single modern assessment and treatment suite for minor injuries with separate children and adult waiting
- Providing a facility of the right capacity to enable the resources of two existing teams to be brought together to ensure consistent and reliable 7-day availability of the right MIU skills and expertise from 8am to 8pm daily.
- Co-locating the MIU with reliable X-ray and ultrasound provision
- Co-locating the MIU with Rapid Response to strengthen admission avoidance or avoidable escalation to hospital ED
- Co-locating MIU with Out of Hours Primary Care with shared reception and waiting enabling close clinical collaboration where required.

The benefits that will be created include:

- Consistent service 365 days per year with no/minimal closures due to staffing and skill mix issues
- Increased public confidence in being able to access a reliable service therefore reducing demand in the Gloucester and Cheltenham ED's and enabling people to be treated locally
- Evidence of joint working with Rapid Response to avoid admission and avoid escalation to Gloucester ED
- Evidence of collaborative work with OOH primary care and impact with a positive impact on both services
- Patient satisfaction

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Investment objective 4

To provide a building that meets all foreseeable modern standards, meets the needs of users, is economic to operate and maintain and which will be flexible for current and future requirements.

Specifically, this means:

- A new building which initially will have no backlog maintenance or other structural/physical issues that need addressing.
- Rooms sizes and specifications predominantly aligned to HBN (Health Building Note) standards enabling modern multidisciplinary care
- Design to ensure efficient patient and user flow taking into account the need for key adjacencies between clinical functions
- A physical environment in both ambulatory care and inpatient areas that ensures privacy and dignity with sufficiently sized waiting areas and single ensuite rooms in the inpatient ward.
- Appropriate separate facilities for Children and Young People’s services
- Fully Disability Discrimination Act (DDA) compliant patient and staff areas enabling all the capacity to be used – neither of the current buildings are fully DDA compliant.
- Building and environs that are dementia friendly - a design that ensures that the building can be safely and successfully used by people with dementia and enables them to maintain their independence and dignity
- A high standard of service provision within the building. This includes full IT coverage throughout the building and piped

The benefits that will be created include:

- Avoidance of the need to fund the backlog maintenance for the existing sites
- Improved building performance Key Performance Indicators (KPIs) including room utilisation
- Full Disability Discrimination Act (DDA) compliance
- Patient satisfaction relating to privacy and dignity, dementia etc
- Staff satisfaction relating to working environment, clinical space and adjacencies etc

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oxygen to each ward room and to the MIU.	
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Investment objective 5

To contribute significantly towards the environment and local sustainability by supporting the journey towards Net-zero carbon emissions.

Specifically, this means:

- A new hospital building that is designed and constructed to be energy efficient and minimise the output of carbon emissions.
- A new building that is designed to generate power from renewable energy sources and offset carbon emissions.
- A design that has reduced embodied carbon emissions from its construction by incorporating the use of local and sustainable building materials.
- Facilities that are designed to promote active forms of travel and improve air quality by lowering transport emissions.
- A health facility that adds social value to the economy by enabling community use and through the Trust's evolving sustainability planning supporting local businesses and creating jobs.
- A new hospital that makes the most use out of the available greenspace for patient therapy, and creating areas of natural biodiversity where wildlife can thrive (in line with the NHS Forest Programme).

The benefits that will be created include:

- Optimised energy efficiency (demonstrated through both reduced costs and reduced carbon emissions).
- Contributing to the Trust's reduced organisational impact on the Climate Health Emergency.
- Demonstration of a high level of Corporate Social Responsibility.
- Opportunity for social cohesion, self-management of health and local community projects with physical and mental health benefits.

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1.5 Constraints and dependencies

Constraints pose limitations to the project whilst dependencies relate to the sequence of events and developments which can affect the overall delivery of the scheme. Both may come to be reflected in the risks that the project faces.

A set of constraints and dependencies were identified at the OBC stage. The following tables demonstrate the current situation and how both constraints and dependencies have been treated.

1.5.1 OBC constraints

Table 3: Update on constraints identified in the OBC

Constraints as defined in the OBC	Update for the FBC
The availability of capital and revenue funding	This will always remain as a potential constraint. In the Financial Case of this FBC, it is shown how both capital and revenue requirements are affordable.
The ability to acquire the preferred site option	The chosen site at Steam Mills has been secured as part of a land exchange agreement (as set out in detail in the Commercial Case).
Ability to secure associated planning permissions	Indications from pre-application discussions with the planning authority Forest of Dean District Council and discussion with Gloucestershire Highways have been positive and there are no indications that problems will arise in obtaining planning permission. The process for securing planning permission is set out in Section 3.6.
Ensuring service plans are developed in the context of the available workforce	<p>The main thrust of workforce planning has been to consolidate teams on one site, reducing the overall impact of vacancies.</p> <p>With ward staffing the plans include a shift of resources from nursing to therapies to enable 7/7 therapy input to inpatients. The scale of these changes is unlikely to present difficulties in recruitment. Planning for the change will commence before the construction</p>

Forest of Dean Hospital FBC Strategic case

Constraints as defined in the OBC	Update for the FBC
	<p>of the building starts (see the discussion in the Management Case).</p> <p>Recruitment and retention are continuous challenges in all health service planning and the Trust is continually surveying the employment market (including international nursing opportunities) and will exploit all opportunities the new building provides to attract the right staff.</p>

1.5.2 OBC dependencies

Table 4: Update on dependencies identified in the OBC

Dependencies as defined in the OBC	Update for FBC
Securing the support of Integrated Care system (ICS) partners	System partners have formally supported the project (see statement of support in the FBC Introduction)
Ensuring effective engagement and consultation with local communities to support the proposed development	<p>The programme of engagement and consultation undertaken by the CCG, GHC and its predecessor GCS has been very extensive and can be seen as an exemplar of community involvement. (Details are summarised above in the Introduction).</p> <p>The Trust will continue to work with local residents and groups to ensure their input in the development of the new hospital and that local residents will have a key part to play in the building's design and future. This is discussed further in the Management Case.</p>
Ensuring effective engagement and involvement of staff who will be essential to sustaining current services	Staff engagement has taken place throughout the various stages of the project and a robust engagement plan

Forest of Dean Hospital FBC Strategic case

Dependencies as defined in the OBC	Update for FBC
pending the commissioning of the new hospital	will need to continue – this is discussed further in the Management Case.
Ensuring the development of alternative pathways for “out of locality” patients (e.g. Gloucester city residents) such that the new hospital capacity is able to support the needs of the Forest of Dean and its local surrounding areas.	<p>The actual need for inpatient beds for Forest residents has been modelled carefully. It remains the intention that beds at Cinderford will not be used where-ever possible by patients from areas in Gloucestershire outside the Forest of Dean.</p> <p>The CCG has access to a range of spot purchase beds across both Gloucester and Cheltenham for utilisation by local residents should inpatient rehabilitation be required.</p> <p>See Appendix 1.1</p>
Ensuring that the design and planning assumptions for the new hospital provide sufficient flexibility to respond to future changes and needs identified and agreed through the One Gloucestershire STP	<p>There has been continual engagement in the design of the facility including a Design Quality Indicator (DQI) workshop involving a wide range of stakeholders and ongoing design development to take account of feedback from Highways and the site investigations. Plans at a 1:200 scale were assessed for the Functionality dimension. Further work at 1:50 scale will ensure flexibility and the ongoing design work will involve people with lived experience and colleagues to ensure we listen to feedback from those who will both use and/or work in the building.</p>
Ensuring this development is progressed in parallel with associated primary care estates developments to maximise the opportunities for integration	<p>There is a commitment within the Trust to contribute fully to the planning for new primary care hubs at Coleford and Lydney. The CCG is actively progressing engagement in the South of the Forest regarding urgent care services and they have included a new</p>

Forest of Dean Hospital FBC Strategic case

Dependencies as defined in the OBC	Update for FBC
	<p>primary care premises in Lydney as a priority in their premises plans.</p> <p>The move of GHC services off the Lydney Hospital site is not dependent on the development of Lydney Primary Care hub.</p>

1.5.3 Current dependencies

In addition to the dependencies set out above, the programme depends on:

- ICS review and support of this business case.
- NHS England/Improvement verification of the business case.
- Securing the Guaranteed Maximum Price through the process explained in Section 3.
- Delivering the transition and implementation plan without disrupting services as explained in Section 5.

1.6 Equality Impact Assessment

An Equality Impact Analysis (EIA) for the location of a new community hospital in the Forest of Dean was undertaken by independent assessors in 2018. This focused on;

- scoping the potential impact of locating the new hospital in the different towns of Lydney, Coleford and Cinderford
- establishing whether any specific groups or communities would be disadvantaged if the hospital was to be built in any one of the towns.

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The full report is included at Appendix 1.2. The key conclusion was:

“It is clear to see that the Forest of Dean has an increasingly elderly population, who have a higher incidence of long-term conditions such as heart failure and diabetes. There is also recognition that compared to Gloucestershire as a whole there are pockets of higher level of economic inactivity, deprivation and social isolation in the Forest of Dean District. These kinds of issues are important in understanding health inequalities, however, having analysed the data for this EIA it is clear there is no differential impact between the three locations. There are pros and cons for each that are just as valid as they are for the others. It is inevitable that different individuals and groups will experience change differently as a result of factors associated with their identity however there is no evidence that people bearing any particular protected characteristic will be disadvantaged by either of the three options of town”. (p28 Equality Impact Analysis (EIA) for the location of a new community hospital in the Forest of Dean July 2018).

The 2018 EIA advocated repeating the Equality Impact Assessment as part of the development of the project through relevancy testing with members of Protected Characteristics and targeting specific groups as required. This theme is developed further in Section 5.9.

It also highlighted the importance of:

- Maintaining Targeted Engagement and where specific groups within the Forest are too small to reach using countywide ‘gate-keepers’ who can help create links into the smaller communities.
- Considering an EIA on staff as part of the change management of services.

A EIA assessment was undertaken by the CCG in October 2020 focusing on the Communication and Consultation Strategy and Plan for the new hospital. This sought to address issues identified in the 2018 EIA by seeking out views from the particular groups listed below during the consultation to gain a better understanding of the potential impact on them and to identify ways to lessen any potential negative impacts:

- Over 65s who are more likely to have long term conditions such as cardiovascular disease, obesity or diabetes and are higher users of community hospital services.
- People from Black and Minority Ethnic (BAME) communities
- People living with a disability (includes physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions).
- Adult Carers and Young Carers
- People living in low income areas.

The outcome from the targeted activities that took place during the Consultation and the collected data on all protected groups, showed that there was a broad representation of most groups in the survey responses. Further analysis of responses

Forest of Dean Hospital FBC Strategic case

by various demographics, e.g. age, gender, health and care professionals, did not show any significant variation when compared with the overall themes from the other respondents.

1.7 Conclusion to the Strategic Case

The Case for Change remains unchanged from the OBC stage, although the urgency of the investment has only increased in the intervening years. There are significant patient, quality and safety issues arising from having to continue to provide services from such an aged, cramped and functionally unsuitable estate.

This strategic case has demonstrated that there continues to be a strong fit between the new community hospital for the Forest of Dean and the strategic aims of the ICS as well as with the strategic aspirations of GHC to ensure delivery of high quality services as close to home as possible for the local population. The Strategic Investment Objectives have been updated and refined in light of changes in the context and local needs. The project continues to receive the full support of ICS partners and remains an ICS priority.

Forest of Dean Hospital FBC Economic case

2 Economic case

2.1 Purpose of the Economic Case

The Economic Case demonstrates the value of the investment to society as a whole compared with not investing in a new hospital for the Forest of Dean. It is a requirement of NHS England/Improvement (NHSE/I) acting on behalf of HM Treasury, for Trusts to provide assurance that any capital investment provides the best value possible for the taxpayer. To demonstrate this, the Economic Case contains an appraisal in line with the guidance setting out clearly the costs and risks and how these relate to the benefits and, therefore, whether the investment will achieve Value for Money (VFM).

Benefits can be defined in a range of ways and include benefits to other parts of the system and to society. As such, the Economic Case is concerned with more than the Trust's finances whereas the financial impact of the investment to the Trust and the affordability of the investment is the subject of the Financial Case.

In developing this section, the preferred option developed from the options appraised in the OBC - a single new hospital on the Steam Mills site in Cinderford – is compared to business as usual which would be the option if the investment were not to proceed. The Economic appraisal includes the costs and benefits of the hospital facility itself, services moved from the Dilke Memorial and Lydney Hospitals, any new service developments and any remaining services formerly provided at Lydney Hospital that must continue to be provided in Lydney to support local delivery models.

2.2 Summary of options appraisal at OBC stage

The preferred option outlined in the SOC was for the two hospitals at Lydney and Cinderford to be replaced by a new single hospital building at a location which at that point was undecided. As part of the extensive public engagement undertaken, a Citizen's Jury exercise led to the selection of Cinderford as the general location for this new hospital.

A land search exercise in and around Cinderford confirmed 5 possible site options (see map below) that met minimum capacity requirements and which were thought to have the potential to meet a series of site assessment criteria agreed by the GCS Trust Board.

Forest of Dean Hospital FBC Economic case

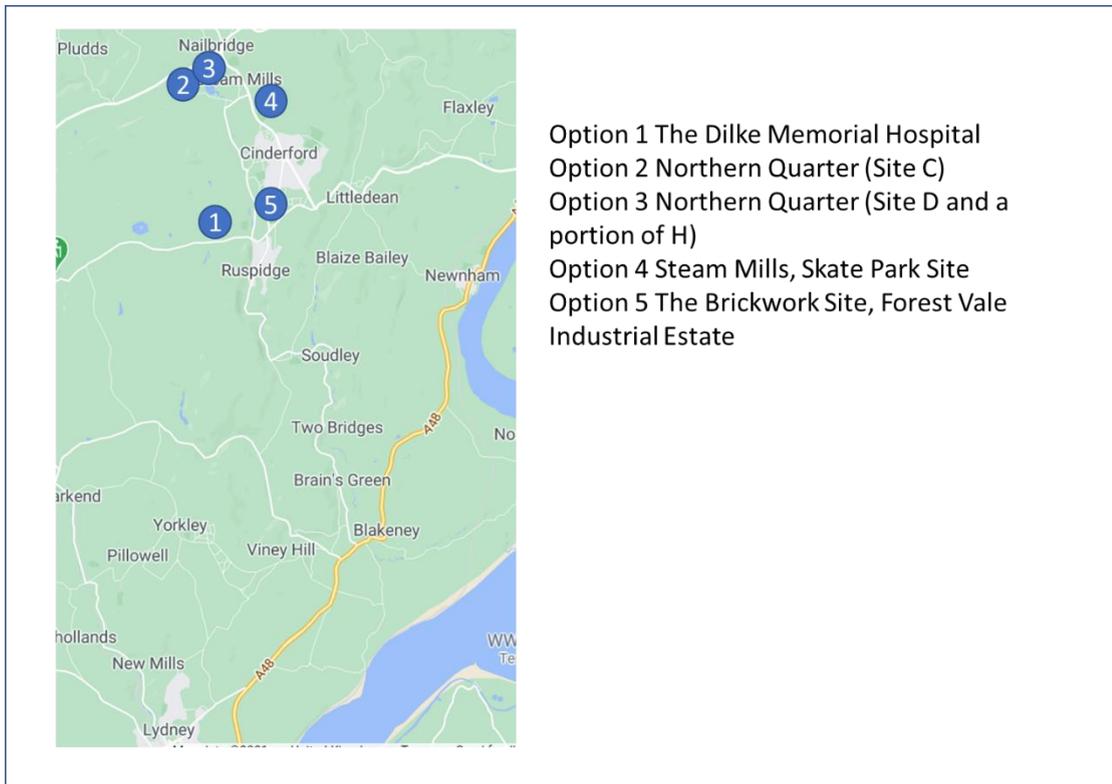


Figure 2: Site options in Cinderford assessed at OBC stage

Details of the five sites and the non-financial options appraisal undertaken for the OBC were reviewed and the criteria and conclusions are set out in the following table 6.

Three options - Option 1 The Dilke Memorial Hospital site; Option 3 Northern Quarter (Site D and a portion of Site H) and Option 4 Steam Mills, Skate Park were subjected to further appraisal in the OBC which concluded that the *Preferred Option* would be Option 4 The Steam Mills Skate Park site.

Forest of Dean Hospital FBC Economic case

Table 5: Summary of options appraisal for sites within Cinderford

Options	Option 1	Option 2	Option 3	Option 4	Option 5
Sites	The Dilke	NQ Site C	NQ Site D & H	Steam Mills	The Brickworks
Ability to accommodate future service requirements	A	A	Yes	Yes	A1
Accessible by car or public transport	Yes	B	B	Yes	Yes
Ability to secure planning permission	C	C1	C1	C1	C1
Offers the potential for pleasant surroundings	D	Yes	Yes	Yes	E
Offers a design development which provides best value for money	F	G	G	Yes	H
Enables completion of works by 2021/22	Yes	I	I	Yes	Yes
Service Continuity	J	Yes	Yes	Yes	Yes

A	The site is not large enough for expansion in the future and comes with development restrictions.
A1	This site is within a flood zone and therefore future service requirements could be compromised'
B	Site cannot be accessed until a new link road and bridge is constructed
C	There is a covenant on the site restricting development within 6m of the boundary and the pavilion are considered to hold non-designated heritage interest.
C1	Planning designation would need to be changed for each of these sites – Initial discussions have taken place however decisions are subject to final applications.
D	The current hospital site is surrounded by the forest but in a remote location to the edge of the town.
E	This is in a very industrial area of Cinderford with no pleasant surroundings
F	The site would require demolition and significant levelling works
G	Infrastructure / enabling works and land costs are significantly higher on these sites than some of the other options
H	This site is being privately marketed and therefore land costs are higher than the other options – flood alleviation works would be extensive for this site.
I	Due to the two-year ecology removal and enabling works programme these sites could not be delivered in 2021/2022
J	Current Services cannot be maintained if this site is used

Forest of Dean Hospital FBC Economic case

2.3 Developments since the OBC

No additional options have been identified since the OBC was approved in 2019.

This preferred option at the Steam Mills site is the only site that has been considered at FBC stage. The Economic appraisal has been undertaken with the preferred option compared to the existing hospital sites as the *Business as Usual option*. Given that an underlying rationale is to replace two hospitals which are not fit for purpose with a new facility, there is no scope for an intermediate *Do Minimum* option between Business as Usual and the Preferred option.

Since the OBC was completed, GHC secured the ownership of the Steam Mills site in December 2019 and have continued to progress this option by:

- Working with the CCG in the 2020 public engagement exercise on the range of services and agreeing with the CCG the final scope of provision
- Appointing property and construction consultants (Gleeds), health facility planners and architects (MJMedical) and the Construction partner (Speller Metcalfe).
- Working with One Creative architects appointed by Speller Metcalfe in April 2021.
- Working with specialist advisers to ascertain the constraints of the site in relation to:
 - Old mine workings
 - Drainage
 - Ecology and other environmental issues
 - Access requirements (including transport studies and highways requirements)
- Submitting a pre-planning application in December 2020 and ongoing engagement with the planning authority
- Engaging with staff and other stakeholders to develop 1:200 layout plans
- Gaining a detailed understanding of construction costs through collaborative working with the Construction partner and cost advisers.

2.4 The proposed investment compared with Business as Usual

2.4.1 Overall scope of care

The new hospital development at Cinderford re-provides services currently delivered at the Dilke Memorial and Lydney and District Hospitals whilst fulfilling the investment objectives set out in the Strategic Case.

The new hospital will continue to support three broad areas of service provision:

Forest of Dean Hospital FBC Economic case

- Ambulatory care services including a variety of outpatient procedures including endoscopy.
- Urgent care and diagnostic facilities to support the assessment and treatment of minor injuries and illness.
- Inpatient bed facilities to support patients with subacute and rehabilitation needs

The GCCG led an extensive exercise to understand the range of services to be provided from the new hospital to support the final phase of public consultation in October – December 2020. The outcome of their commissioning requirements was confirmed to the Trust in January 2021 which formed the key scope of services to be included within the new hospital in the Forest of Dean.

This process included satisfying the service change requirements that can be found in the *NHS England, Planning, Assuring and Delivering Service Change* document. In summary these requirements are to:

Meet the Governments' five key tests for service change, which are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear, clinical evidence base
- Support for proposals from clinical commissioners
- NHS England's test for proposed bed closures (where appropriate which was introduced in April 2017)

Where plans to significantly reduce hospital bed numbers are included NHS England expect commissioners to be able to evidence that they can meet one of the following three conditions:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

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The Forest of Dean service proposals were subject to a Stage 2 Assurance review by NHS England in August 2017 which concluded that the schemes were assured against the four key test of service change:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear clinical evidence base
- Support for proposals from clinical commissioners

A further stage 2 assurance review took place in October 2020 which confirmed the fifth element of assurance regarding the NHSE Beds / Patient Care test.

The service modelling analysis and commissioning strategy is at Appendix 0.2 and formed the basis of the capacity and activity requirements for the new facility, including the number of inpatient beds to be provided and the confirmation of the requirement to commission a new endoscopy service to meet the needs of the Forest of Dean residents.

2.4.2 Services out of scope

As part of the CCG Service Strategy development, consideration was given to providing a birthing unit. However, it was concluded that the number of deliveries would be insufficient for a safe service that would ensure value for money and a birthing unit has not been included in the plans.

Volumes of elective day case activity accessed by the population of the Forest of Dean were also assessed. The only procedure likely to have sufficient demand would be cataract surgery and this is already provided in the community at Tewkesbury, Cirencester and Tetbury, with Forest of Dean patients accessing Tewkesbury and the service at Cheltenham General Hospital. An additional cataract surgical facility at Cinderford would detract from existing community sites, and would be unviable with the current level of demand from patients in the Forest.

2.4.3 Services operating a hub and spoke model

The Trust also considered which services needed to retain a very local presence and operate on a hub and spoke model. This included services such as MSK physiotherapy, child health and podiatry and whilst the bulk of service delivery will take place at the new hospital, some service provision will continue in the various localities across the Forest.

2.4.4 Future Scope

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Early dialogue took place with South Western Ambulance Service Trust (SWAST) over the co-location of an Ambulance Station and with Gloucestershire County Council (GCC) over possible co-location of the Adult Social Care Team. These proposals have failed to develop into firm proposals that could be included in this phase of development. In addition, the emerging constraints on use of the site have limited the footprint available.

A new primary care facility is being developed in Coleford and one is intended for Lydney which may provide accommodation in the future for expanding community or other health services.

2.5 Summary of the proposed hospital investment at the Steam Mills site

2.5.1 Overview of the site and the development

Cinderford lies on the eastern fringe of the Forest of Dean in Gloucestershire with a population of circa 11,376 (in 2019). The preferred site in Cinderford is strategically located, lying north of the main residential area and east of the main commercial area off Steam Mills Road (A4151). The site is easily accessible from both Cinderford and the wider Forest of Dean. The site is an existing amenity/ recreational space on a former 'brownfield' site which includes a skate park and games area.



Figure 3: Aerial view of the Steam Mills site

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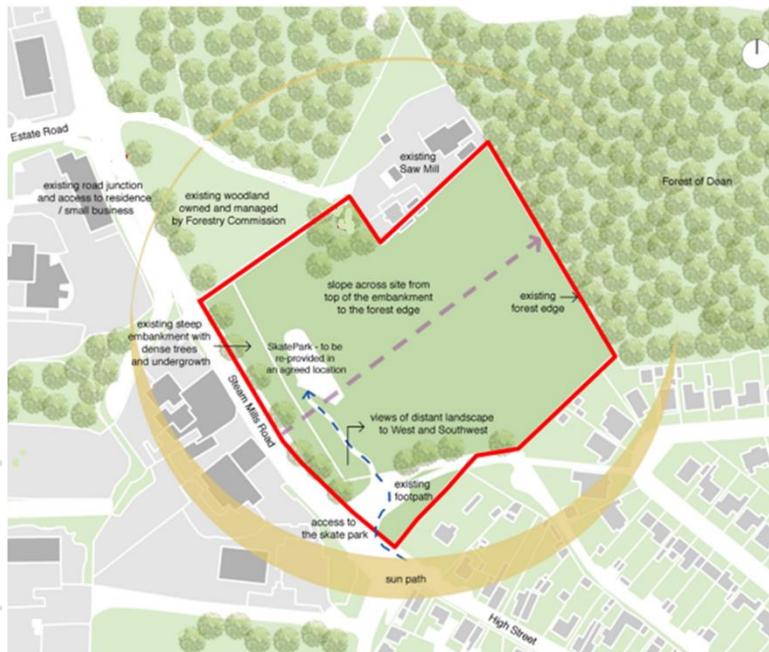


Figure 4: Plan of the Steam Mills site and surrounds

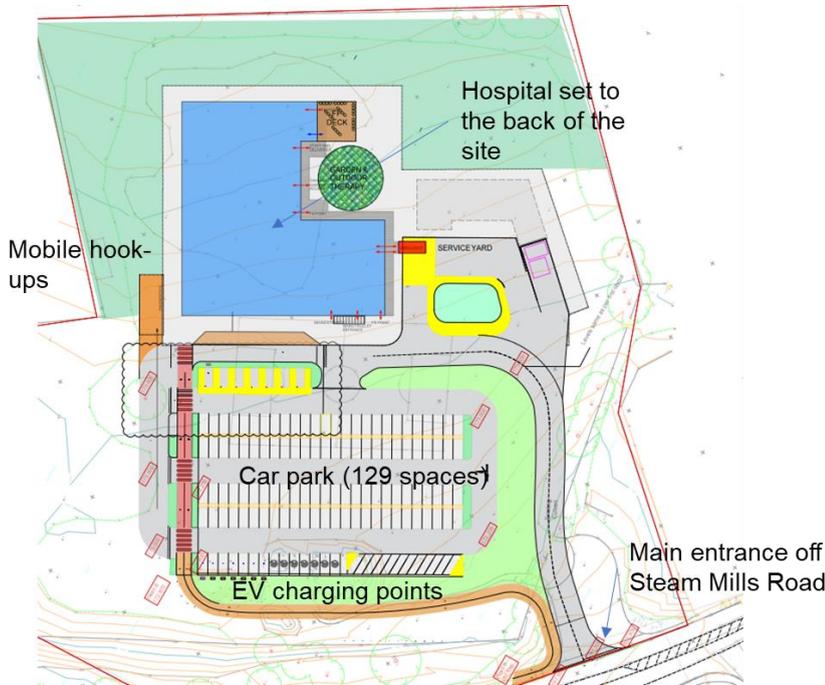
The site is bordered to the north and north-east by the edge of the Forest whilst the eastern boundary marks the edge of an existing residential area. To the south and south west the site is edged by Steam Mills Road.

To the west is located a small neighbouring property/ business along with the western edges of the Forest.

The site gently slopes from north to south with a steeper, tree and scrub embankment to Steam Mills Road. To the south of the road is located a number of commercial buildings accommodating a variety of small to medium businesses. At the south of the site is the Skate park and multi-use games area which the Trust will relocate to a new site in Cinderford as part of a land exchange deal with the Town Council (see Section 3.10).

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2.5.2 Overview of the proposed site layout



The hospital building will be set to the back of the site surrounded by landscaped grounds and planting. A segregated pedestrian walkway provides access from the road and a separate entrance leads to the main dropping off point, service yard and a large carpark complete with Electric Vehicle (EV) charging points. Fully serviced hook up points with data links will be provided to enable two mobile facilities (e.g. breast screening, chemo bus) to operate at the same time.

Figure 5: Plan of the Steam Mills site and surrounds

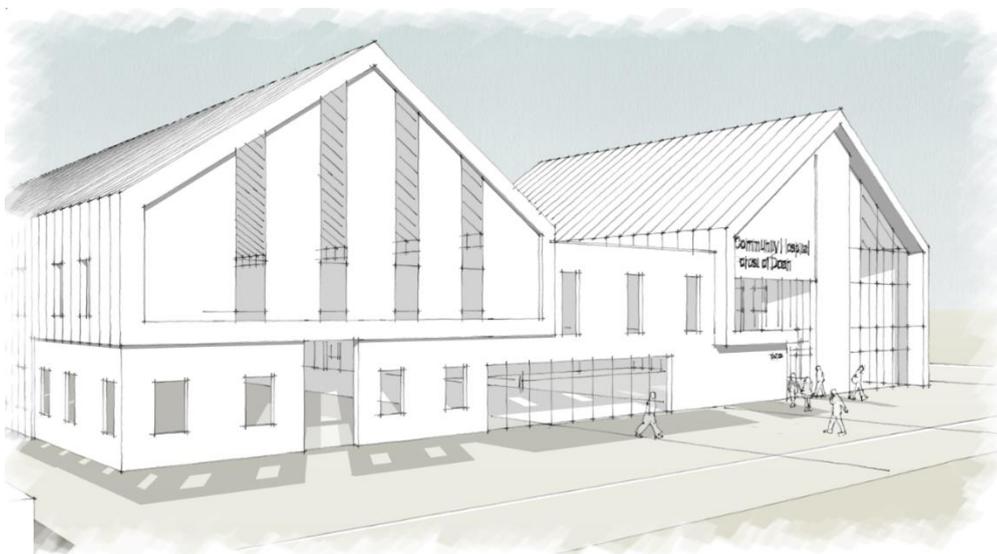


Figure 6: Entrance to the hospital from the drop off bay

2.5.3 Functional content

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The Trust is expected to provide high quality services to comply with regulatory standards. It also needs to ensure that its patients can receive care and treatment which is efficient and timely in its delivery, and its staff can work in a safe environment.

The building comprises two storeys. The functional content of the hospital is zoned in the layout plans below with detail at 1:200 scale. Clinical adjacencies were carefully considered to take account of travel distances and access for those people who may attend with mobility difficulties. Attention has been given to maximising access to natural light in all patient facing rooms although there are a small number of rooms (predominately for ancillary support services) that are deep plan.

The ground floor accommodates services that have the heaviest footfall with key departments arranged off a main street. Outpatients and Minor injuries (MIU) are co-located with the ability for MIU and primary care Out of Hours to extend into the Outpatient area in the evenings and weekends. Both departments are located close to imaging. The multi-disciplinary therapy area has direct access to outside therapy space.

It is essential that paediatric patients are provided with dedicated child-friendly facilities separate from adult patients. There is a dedicated paediatric area in the urgent care centre and within the ambulatory care area with dedicated waiting and consultation space.

The requirement for a reliable, rapid diagnostic imaging service as part of the new hospital is increasing with growing demand from primary care referrals for the assessment of patients for either management within primary care or onward referral to secondary care services. Urgent care demand is somewhat lower with approximately 6% of attendees requiring an x-ray facility however, having a diagnostic centre that is available 7 days per week will greatly increase patient confidence in attending the MIU rather than the large acute hospital Emergency Department (ED). The unit is located centrally between the urgent care and outpatients departments to enable easy access for ambulatory patients but also for those inpatients who occasionally require diagnostic investigations.

The design separates the flow of patients, visitors and goods as much as possible. A dedicated staff and goods entrance have been included to the rear of the building adjacent to the staff offices and Facilities Management (FM) areas.

Forest of Dean Hospital FBC Economic case



Ground Floor
1,901sqm (excl plant)

Figure 7: Main functional zones - Ground floor

Near the front entrance is another multipurpose room providing easy access to outside groups e.g. voluntary sectors providers using the room. Off the main hospital entrance is space for a small voluntary refreshment bar/shop or vending machine area.

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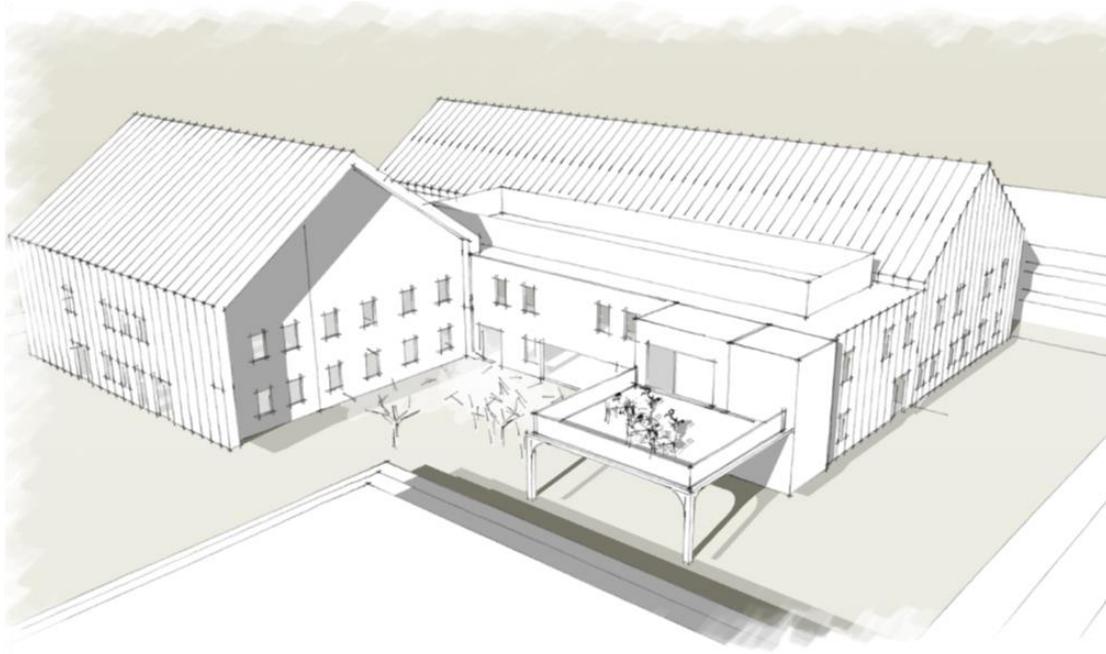


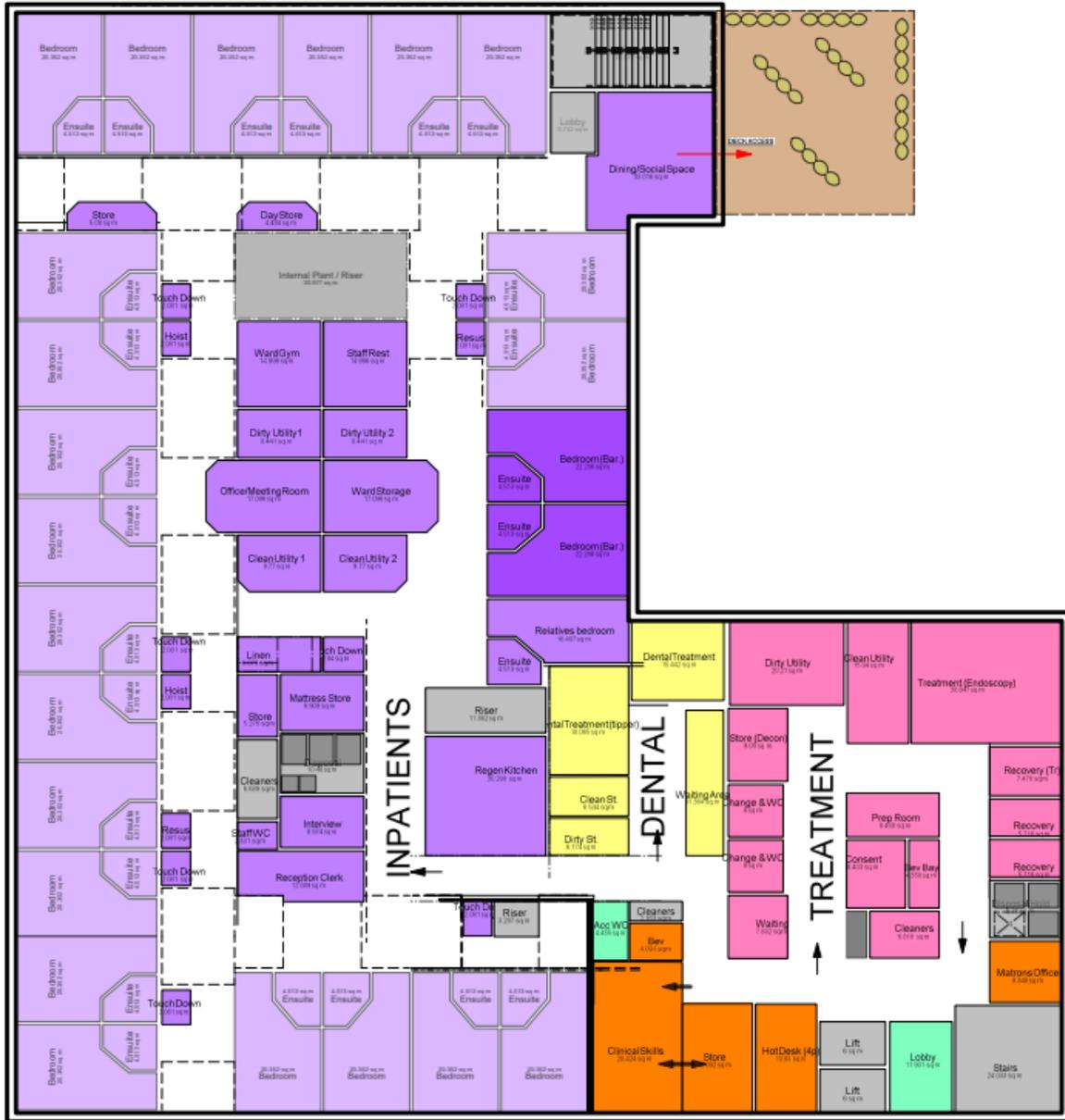
Figure 8: View showing external therapy area and inpatient outdoor deck

The upper floor comprises the inpatient ward, endoscopy unit, dental, staff training and clinical skills lab and some additional office/hot desking space.

The inpatient area comprises 24 single ensuite rooms enabling effective isolation of any infectious patients and ensuring privacy and dignity. Two of the rooms will accommodate bariatric patients. All inpatient rooms have access to natural light and outdoor views. The ward has access to an external deck which leads off a communal day/dining space.

Access to the upper floor is via two lifts and a staircase.

Forest of Dean Hospital FBC Economic case



First Floor
1,901sqm (excl plant)

Figure 9: Main functional zones – Upper Floor

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2.5.4 Schedule of Accommodation

To enable a design to be produced the project team completed a room by room schedule of accommodation for all proposed departments across the hospital based on the commissioning intentions contained in Appendix 0.2.

In developing the Schedule of Accommodation (See Appendix 2.5), the following service provision assumptions have been considered:

- Inpatient beds will be configured as 100% single rooms with appropriate day and therapy space and where possible direct access to pleasant external environments.
- Provision for 2 bariatric beds as part of the inpatient ward.
- A range of outpatient clinic rooms including those designed for flexible use and specialist rooms to accommodate specialist equipment and requirements.
- In the iteration of the Schedule for the FBC, the impact of the COVID pandemic has been considered. It is assumed that there will be a continued demand for remote consultation. Space has been included for booths for virtual consultations. This space can subsequently be converted to a clinical room if experience shows this to be a better use.
- Therapy rooms to accommodate specialist equipment for physiotherapy, speech and language therapy and occupational therapy.
- A dental suite designed to accommodate patients with complex physical and mental health needs.
- The scoping of the Minor Injuries and Illness Unit to account for the planned changes to support minor illness to be treated within Primary Care as part of their core business.
- Diagnostic facilities including X-Ray and Ultrasound plus an endoscopy suite designed to meet Joint Advisory Group (JAG) accreditation standards have been included.
- Clearly designated and separate waiting areas for children and a dedicated area for children's clinics and parent group activity for children and antenatal services.
- A large multipurpose room that can be used both for community events and staff meetings.

The Schedule of Accommodation (Appendix 3.1) was agreed following in-house review and group meetings attended by representatives from each of the departments, this has been used to inform the design brief.

There have been a series of robust confirm and challenge meetings to validate the space requirements and it is acknowledged that some aspirations such as the reprovision of administrative accommodation for integrated community teams are unachievable within the financial envelope. This led to a number of adjustments to the size and scope of the facility with the aim of minimal impact on clinical service delivery and functional delivery. This work has been overseen by the Programme Board and

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all departmental areas have been signed off by the Senior Responsible Owner (SRO) and the appropriate service lead.

Whilst we have challenged the design team to be as economic as practicable, we remain committed to operating to Health Technical Memorandum (HTM) and Health Building Note (HBN) standards. As such we have made no major derogations

The main adjustments to the Schedule of Accommodation are listed below.

Table 6: Adjustments to Schedule of Accommodation since OBC scheme

- Based on projected patient flows the space in the entrance area has been reduced.
- Overall use is not sufficient to make a café viable – a smaller beverage area now replaces this.
- The ready acceptance and success of virtual outpatient appointments introduced during the pandemic has given assurance that the planned reduction in outpatient appointments of 30% is realistic. Additional cubicles for online video appointments have been included in the design.
- A small reduction in Physiotherapy space reflects the level of projected use.
- Analysis of local demand for endoscopy justifies the provision of one scope room and not two as previously planned.
- Analysis of local demand demonstrates the need for one X-ray room and not two as originally planned (an adjacent group room will be lead lined to allow for ongoing provision during planned maintenance and ensure service continuity whilst being multi-functional space the majority of the year).
- Administration space has been reduced in line with new ways of working and hot desking facilities.
- By designing-in flexibility, the large public group room can also be used for staff seminars removing the need for two separate rooms. There remains a large multi-functional space in the children's area which can also be accessed from the main hospital street to increase flexibility.

Due to the prolonged nature of this scheme and the change in SRO following the merger of the predecessor organisation it is acknowledged that there have been significant iterations to the Gross Internal Floor Area (GIFA). A detailed review of the drivers for these changes has been undertaken and a robust process of confirm and challenge has taken place to arrive at a GIFA of 3802 m².

Throughout the process, the design team have considered both standardisation of rooms where appropriate in areas such as consultation rooms and en-suite bedrooms as these areas form a significant proportion of the clinical accommodation. In addition, future flexibility of the space remains a key consideration in recognition that models of

Forest of Dean Hospital FBC Economic case

care, particularly ambulatory care and diagnostic modalities will continue to evolve and learning from the covid pandemic will continue for years to come.

2.6 Project time line – overview

A detailed Building Design and Construction project plan is included at Appendix 5.4 and key events are discussed in the Management Case (Section 5.4).

A 70-week construction period is anticipated starting in January 2022 with commissioning of the building and occupation from June 2023.

2.7 Introduction to the quantitative economic appraisal.

As explained in Section 2.1, the Economic Case is concerned with the impact of the investment to society as a whole and not just to the Trust. There is a need to bring together all elements of cost and benefit to establish a view of the Value for Money of the investment. The impact of the investment on the Trust's finances is dealt with separately in the Financial Case (Section 4).

In accordance with Treasury guidance and in line with the NHS England/Improvement requirements (NHSEI), a Discounted Cash Flow (DCF) analysis, assessing the relative costs, benefits and risks of investment options to society as a whole (and not just to GHC) has been undertaken using the standard Comprehensive Investment Appraisal (CIA) model. This model produces a single measure - the Net Present Social Value (NPSV) – to capture the total cost, benefit and risk implications of investing in the new hospital. In this case, the preferred option to build the hospital at Steam Mills, is compared to business as usual of operations at the existing Lydney and District Hospital and the Dilke Memorial Hospital (as explained in Section 2.3 above).

2.8 Costs

All costs included within this economic appraisal are expressed in “real” terms, so that all future costs are converted into current values removing the effect of general inflation. Costs and benefits are discounted in order to allow the comparison of costs, benefits and risks that occur in different time periods. A standard rate of discount is applied in the CIA model over the 60-year life span of this investment.

2.9 Opportunity costs and avoided costs

The CIA model takes into account opportunity costs. These represent the value that might have been obtained if the resources were used for some other purpose. As the CIA model assumes the value of the building itself is exhausted at the end of the 60-year investment period, the residual value is taken as the land costs.

Forest of Dean Hospital FBC Economic case

2.9.1 Capital costs

The capital costs are taken from the FB Forms included at Appendix 2.2. These have been arrived at through the detailed work with the Construction partner (see Commercial Case) and represent a not-to-be-exceeded price. Following further market testing of packages of work, a Guaranteed Maximum Price will form the basis of the contract. Therefore, for the purpose of the economic analysis, the not-to-be-exceeded price represents the highest price scenario.

Capital costs have been based on the agreed Schedule of Accommodation (Appendix 2.5). Expense incurred in engaging specialist advisers has resulted in both considerable savings through obtaining a detailed understanding of the site's potential, as well as its limitations thus enabling the most cost-effective use of the space available.

Close working with end users and with system colleagues has enabled a rationalisation of the original schedule of accommodation as outlined above.

2.9.2 Life cycle costs

In addition to the initial capital costs of building the hospital, the economic appraisal includes the lifecycle costs required to maintain the building throughout its 60-year life, including the capital costs of anticipated refurbishment and upgrades and associated costs for replacing equipment. This effectively maintains the building in a Category B state. The outputs of the Life Cycle Cost model are included at Appendix 2.1.

2.9.3 Avoided costs

The CIA model, in appraising value for money, is driven by incremental change between options and the base case, which in this situation is business as usual. Costs which appear in the base case but are not required in the preferred option by default become avoided costs. To maintain any service at the Dilke and at Lydney hospital sites would require substantial investment in backlog maintenance. This is estimated at £2.1m. Replacing the Dilke and Lydney would avoid spending an estimated £8m on essential refurbishment. It would however, be impossible to bring the buildings up to Category B status or to enable them to be configured to fully meet modern health care service requirements in the way that the new Hospital will. This capital expenditure is in addition to any life cycle costs moving forward after backlog maintenance and some refurbishment has been enacted.

2.9.4 Equipment costs

An allowance of £300,000 has been made in the construction costs for fixed group 1 items. In addition to this, the Trust has allocated £400,000.00 (as explained in Section 3.8) toward the purchase of new equipment and the relocation of the Lydney x-ray

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machine. A detailed exercise will also take place to determine which items of group 3 and 4 equipment will be transferred from the existing hospitals.

2.9.5 Operating (revenue) costs

Revenue costs include the total clinical and non-clinical costs of delivering the service at a real price base, which will also be discounted over the 60-year life of this investment. There is a significant difference in the revenue costs of operating from one site compared with the two existing sites. The CIA model captures this in comparing the costs of the preferred option with those of business as usual.

2.9.6 Treatment of costs in the Economic and Financial Cases

The costs may be treated in different ways in the Economic Analysis and the Financial Analysis (Financial Case, section 4).

- All costs included within economic appraisals are expressed in “real” terms, so that all future costs are converted into current values. By converting costs into “real” values, the effect of general inflation is removed and the real changes in values are isolated from inflationary effects. In the Financial case inflation is taken into account
- Costs/prices are discounted – this reflects the economic principle that generally, people prefer to receive goods and services now rather than later. As we are not proposing any Quality Adjusted Life Year (QALY) benefits, the economic appraisal uses the NHS non-QALY discount rates of 3.5% for the first 30 years and 3% for the final 30 years of the investment life.
- Instead of contingency which is included in the Financial appraisal, the Economic appraisal includes an optimism bias calculated through the mitigated factors included in the CIA model.
- Transfers of resources (e.g. gifts, VAT, grants, subsidies, capital charges) are excluded from the overall estimate of Net Present Social Value (NPSV). In economic terms these transfers pass purchasing power from one person to another and do not make society as a whole better or worse off.
- Income from other public bodies is a circular flow and is also excluded from the appraisal. No additional income streams have been included in this Economic appraisal as it is assumed that any contract will come from public sector commissioners, including any work that is undertaken by independent sector e.g. in endoscopy.
- No depreciation is assumed but we do include life cycle costs which are keeping buildings in a condition B standard (see above).

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2.10 Benefits

As demonstrated in the Strategic Case, this investment creates considerable quality and environmental benefits and underpins the Trust and system requirements to deliver reliable sustainable services and to meet environmental standards and expectations. Not all these benefits can be sensibly costed in economic terms.

2.10.1 Reduced costs – incremental benefits

Through the establishment of a new hospital replacing two separate hospitals, significant reductions in clinical inpatient costs, facility staffing costs and building running costs are achieved. The following table shows current costs of services operating from the Dilke and Lydney Hospitals and the operating costs from 2025/26 when the full reduction/redeployment of teams will be in effect. There are substantial reductions in Facilities Management and energy costs through operating from a single modern building. These are partly offset by a very large increase in business rates that is anticipated. Costs are shown at current values (as required in the economic modelling).

Table 7: Costs at present (Base Case) and from 25/26 (Preferred Option)

Cost category	Existing cost (£'000s)	Costs from 2025/26 (at today's prices)
Nursing	4,152	3068
AHP	352	364
Other clinical	312	270
Clinical non-pay	433	496
Total clinical costs	5,249	4198
Non Clinical costs	1,175	958
Building running costs	499	288
Rates	63	169
Total non-clinical costs	1,737	1415
Total service costs	6,986	5,613

In the CIA model, these reduced costs are accounted for by the model comparing the preferred option with the base case to provide a clear incremental benefit. As there will be a reduction in income to accompany these changes, these reductions are not classed as cash releasing benefits.

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2.10.2 Cash - releasing benefits

The aim has been to gain benefits through efficiencies rather than making additional cash savings as a result of the investment. No additional cash savings have been added to the CIA model.

2.10.3 Non cash releasing benefits

Non-cash releasing benefits are efficiency savings which enable resources to be used in a different way.

Four Non Cash Releasing benefits have been identified and costed:

- The use of resources previously used for some nursing posts for new therapy posts that enable the 7-day therapy input for inpatients. As the complexity of patients being discharged to the ward is increasing, no claims are being made for a reduction in average length of stay on the ward. However, the consistent availability of therapy without a break at weekends is anticipated to enable patients to be fit for discharge earlier than they would have been without this level of care. This is counted as an efficiency.
- The change of function from nursing to therapy post also counts as a resource efficiency valued at the total employment cost of the extended staff team.
- The anticipated reduction in closures of MIU as a result of bringing two teams together and providing greater capacity in one place with a more robust staffing structure can be counted as an efficiency for the health system measured in terms of the number of patients who would not be seen if the MIU was closed for a period. The Dilke and Lydney MIUs closed for a total of 323 hours between 8am and 8pm during 2019/20.
- The loss of bed days due to infection will be greatly reduced with single ensuite inpatient rooms. In 2019/20 before the pandemic, the equivalent of 177 bed days were lost from 47 beds in the Forest – the equivalent for 24 beds would have been 90 bed days. During the pandemic 2020/21, 263 bed days were lost at the Dilke and Lydney (an equivalent of 134 for 24 beds). At other Trust hospitals with single rooms, the number of bed days was zero.

2.10.4 Societal benefits

Two benefits to society at large have been identified and costed:

- The saving of travel time for patients having endoscopies at the new hospital instead of travelling to Cheltenham – this includes cost of travel and parking, the cost of time and fuel and the cost of the carbon created from the travel (adjusted over the 60 years of the model to account for the switch to electric vehicles).

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- The value given to the projected reduction in carbon (from fuel, electricity etc) gained from reducing from 2 sites to one, modern insulated and efficient building, the switch to all electric air heat exchange heating.

Table 8: Non cash releasing and societal benefits

Benefit	Type of benefit	Equivalent annual benefit (£'000s)	Discounted value over 60 years (£'000s)
7-day therapy input on the ward	Non cash releasing	219	5,743
Nursing to therapy posts	Non cash releasing	115	3,012
Reduction in MIU closures	Non cash releasing	52	1,374
Reduce of bed days due to infection	Non cash releasing	17	£441
Endoscopy travel savings	Societal benefit	51	1,332
Carbon saving	Societal benefit	30	£787
Total		468	12,689

2.11 Optimism bias

The Economic modelling accounts for a natural tendency to overstate benefits, and understate timings and costs, both capital and operational. Optimism bias is a measure that increases estimates of the costs and decreases and delays the receipt of estimated benefits. As the detail of the scheme becomes confirmed the optimism bias will be mitigated. The mitigated optimism bias for the Preferred Option is currently 17.1%.

2.12 Risk identification

The project actively maintains a risk register (see Section 5). Risks not encompassed by the Optimism Bias have been included in the model along with a costed risk around the sale of the two sites at Lydney Hospital and the Dilke.

2.13 Summary of quantitative analysis including Value for Money

The economic analysis calculates the total incremental costs and benefits discounted over the 60 years of the building's life. As shown in the table below. This gives a benefit to cost ratio over the 60-year life of the new hospital of 4.08 and a risk adjusted Net Present Social Value of £35,756 million.

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Table 9: Economic Summary (Discounted) - £'000

	Option 0 - Business as Usual	Option 1 - New Forest of Dean Hospital Build on Steam Mills site (£'000s)
Incremental costs - total	0	(11,595)
Incremental benefits - total	0	47,351
Risk-adjusted Net Present Social Value (NPSV)	0	35,756
Benefit-cost ratio		4.08

The following table provides a more detailed breakdown to show the comparison between Business as Usual and the new hospital.

Table 10: Detailed Cost, Risk and Benefit Summary (Discounted) - £'000

	Option 0 - Business as Usual (£'000s)	Option 1 - New Forest of Dean Hospital Build on Steam Mills site (£'000s)
Opportunity Costs	(1,835.00)	(600)
Capital Expenditure	(11,683.35)	(21,754)
Capital Expenditure Optimism	(2,829.32)	(3,730)
Bias Uplift		
Revenue Expenditure	(183,192.80)	(151,364)
Transitional Costs	0.00	(414)
Net Contribution Costs	0.00	(1,599)
Present Cost	(199,540.48)	(176,263)
Total Risk	(638.50)	(847.92)
Risk-adjusted Present Cost	(200,178)	(177,111)
Cash Releasing Benefits	0	0
Non-Cash Releasing Benefits	0	10,569
Societal Benefits	0	2,119
Total Benefits	0	12,689

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2.14 Sensitivity analysis

The cost to benefit ratio has been tested to demonstrate the impact of:

- The Risks materialising at 100% probability at maximum impact (including the complete failure to sell the existing sites).
- A scenario in which risks are maximised (as above) and only half the non cash releasing benefits and societal benefits are achieved each year.
- A scenario in which risks are maximised and none of the non cash releasing benefits and societal benefits are achieved.

The impact on the benefit-cost ratio is demonstrated in the table below.

Table 11: Sensitivity of cost-benefit ratio to various scenarios

Sensitivity scenario	Benefit-cost ratio
Value-for-Money (VFM)	4.08
VFM after maximum risk impact and probability applied	3.69
VFM after maximum risk impact and probability applied and NCRBs and SBs @50%	3.20
VFM after maximum risk impact and probability applied and NCRBs and SBs reduced to zero	2.71

This shows that even without delivering the expected non cash releasing benefits and societal benefits, the investment creates significant Value for Money.

2.15 Conclusion

Even with a high optimism bias and an already high allowance for risk, the economic analysis gives a benefit to cost ratio over the 60-year life of the new hospital of 4.08 and a risk adjusted Net Present Social Value of £35,756 million. The modelling has demonstrated that even taking account of the most adverse scenario identified, a benefit cost ratio of 2.71 would still be achieved. This confirms that this investment gives clear Value for Money. Given the range of benefits and the standard of the facilities described in this section, the investment is clearly worthwhile and will make a substantial contribution both immediately and in the long term, to the healthcare for the Forest.

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3 Commercial case

3.1 Purpose of the Commercial Case

The Commercial Case demonstrates that the preferred option will result in a viable procurement and a robust contract being in place between the public sector and its construction partners. This includes understanding what is realistically achievable by the supply side and the various procurement routes to deliver the best value. The Commercial Case demonstrates our understanding of the requirements of this investment and its outputs and how risk is distributed between the Trust and contractors.

3.2 Procurement to date - the use of external advisers

To date the following external advisers have been engaged in the full investigation of the site, design and applications for planning.

Table 12: External advisers engaged to date

Function	Specialists and advisers appointed
Architects	MJ Medical One Creative (from April 2021)
Mechanical and Electrical Engineers	Arup
Civil & Structural Engineers	Arup Barnsley Marshall (from April 2021)
Building/ Construction	Speller Metcalfe
Planning Advisors	Arup Avison Young (from April 2021)
Transport Planning	Cotswold Transport Planning
Ecology & Biodiversity Advice	Arup Focus Ecology (from April 2021)
Landscape Design	Astley Partnership
Background Noise Surveys	Mach Acoustics
Mine Surveys	M & J Drilling
BREEAM Advisors	Gleeds
Project management	Gleeds
Ground Investigations	WSP
Cost Advisors	Gleeds
Land disposal potential	Limbricks Alder King
VAT advisors	Liaison Financial

The original design team took the project to RIBA Stage 2. It was agreed with the Construction Partner (see Section 3.4 below) that they would appoint a design team to move forward to the next stage. Barnsley Marshall (Civil and structural engineers) and

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One Creative (architects) were appointed along with a number of additional advisors who will feed into the detailed design development and the planning application. The Trust will maintain their appointments with the Specialist Project Manager and Cost Advisors throughout the project with an additional appointment of a Clerk of Works being made before construction commences (see section 5.2).

3.3 Appraisal of contract options

3.3.1 Contract options considered

The Trust has considered the main contract options recommended for a project of this size and complexity. A formal appraisal exercise was undertaken with the conclusions summarised in table 14 below.

Table 13: Procurement options considered by the Trust

Option	Contract Option	Commentary	Score and Rank
1	Traditional Tender – design by the Trust’s consultants is completed before the contractors are invited to tender under an Official Journal European Union (OJEU) compliant tendering process	Unable to deliver in time available and weak in terms of contractual responsibilities, risk avoidance and buildability	186 (Rank 5)
2	Design and Build with a Construction Partner - detailed design and construction are both undertaken by the contractor for a lump sum price. The design will be largely prepared before the Contractor is appointed.	Design and construction give better control over the requirements for the building. Design liability rests solely with the contractor	263 (Rank 1)
3	Construction Management – Trust directly contracts with all consultants, the contract manager and all work packages.	Design liability rests with the Trust Requires considerable capacity and expertise within the Trust to manage the process	211 (Rank 4)
4	Management Contracting – Trust prepares design brief and appoints a management contractor	Design liability rests with the Trust	215 (Rank 3)
5	Design and Manage – Management responsibility for scheme handed to contractor.	Lower level of direct control over the design quality, but	224 (Rank 2)

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Option	Contract Option	Commentary	Score and Rank
		liability transferred to contractor	

Based on the evaluation undertaken against the procurement criteria it was concluded that for this scheme, the best option is Option 2 – Design and Build with a Construction Partner.

3.3.2 Approach to procurement

To ensure the timely delivery of the scheme a number of different framework options were considered for the appointment of the main contractor, with three shortlisted and appraised as set out below.

Table 14: Procurement framework options considered

	Advantages	Disadvantages	Conclusion
Direct Award Contract using SCAPE	<p>Minimise the procurement period and have a contractor on board within 2 - 4 weeks.</p> <p>The only contractor available under this framework have offices in Bristol and Cardiff and have health care experience.</p>	<p>Minimal competition to ensure best value for money.</p> <p>Only contractor available under this framework.</p>	Rejected due to lack of further VFM competition within it.
P22 Mini Competition	<p>NHSE/I preferred procurement route.</p> <p>Mini competition between 6 national contractors.</p> <p>Pre-agreed standard NEC contract, plus free VAT advice, access to standardised room models and a pre-agreed pain / gain share</p>	<p>Risk of running the mini-competition with no guarantee of interest from the national contractors due to the relatively small size of the project.</p>	Rejected due to potential low levels of interest from national players.

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	Advantages	Disadvantages	Conclusion
	% at the end of the project. 6 weeks to appoint		
Gloucestershire County Council Construction Developer Framework	Mini competition at a local rather than national framework level. Two stage process with the appointment of the main contractor through the mini-competition then competitive selection for works packages. Use of NEC 3 contract. Framework used successfully by council for a number of years. Several known contractors with healthcare experience. 4 – 6 weeks to appoint.	Lower levels of risk. Not all of the benefits of the P22 contract but still uses the same base NEC contract.	Preferred route to move forward due to localised contractor selection, ability to drive forward VFM and anticipated higher level of contractor interest.

3.4 Construction Contractor Appointment

The appointment of the Construction contractor was therefore taken forward using the Gloucestershire County Council (GCC) Developer framework.

Five contractors are on this framework. All were approached and submitted a compliant bid for consideration.

A robust assessment process was undertaken and all bidders were interviewed. The process was supported by procurement colleagues from both the Trust and Gloucestershire County Council (managers of the framework).

Speller Metcalfe were nominated as preferred bidder. They demonstrated good local knowledge and commitment to adding social value to the local economy. They have a good track record of delivering health care related projects and have recently completed the primary care health centre in Cinderford.

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Speller Metcalfe have subsequently worked with the Trust on the design development and costings to arrive at a Not-to-be-Exceeded Price (NTBEP). The table below outlines the key milestones and delivery dates that are included in the programme plan to move forward the NTBEP into a Guaranteed Maximum Price which is then included in the final construction contract.

Table 15: Milestones and delivery dates

Milestone	Start Date	End Date
NTBEP	June 2021	
Market testing	October 21	November 21
GMP	November 21	November 21
Trust Board Approval	November 21	November 21
Sign contract	December 21	December 21
Start on Site	January 22	

3.5 Contract

3.5.1 Contract Price

This Full Business Case has been completed on the basis of a “Not to Be Exceeded Price” from Construction Partner, Speller Metcalfe, plus allowances for all fees, inflation, contingency, equipment and VAT.

A Not to Be Exceeded Price (NTBEP) differs from a Guaranteed Maximum Price (GMP) in that it is a price based on market rates, soft market testing and quotations, Quantity Surveyor (QS) judgement and Subject Matter Expert input rather than formal quotations from contractors. As such a NTBEP is caveated, particularly around inflationary pressures and scope creep.

The current construction market is experiencing high volatility and there is the risk of further construction inflation in the period between NTBEP and GMP which remains a Trust risk. Additional contingency allowances have been incorporated into the Economic and Financial modelling to mitigate this. Clear terms have been agreed between the Trust and Speller Metcalfe as to where any risk sits between NTBEP and GMP.

A robust change control process is in place to manage any Trust scope creep which is acknowledged as an additional risk to contract price.

Following approval of this FBC, the Project Team will enter into a Pre-Construction Services Agreement with Speller Metcalfe to take the process through detailed design, planning approval and the tendering of work packages to arrive at a GMP. Assuming

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this is approved by Board when presented later this year, this GMP would then be set as the maximum price the Trust would have to pay the Construction Partner for the delivery of the project. The Trust would formalise a construction contract with them with a view to starting work on site in January 2022.

The work undertaken between approval of the FBC and arriving at a GMP will continue to be focused on achieving the most cost-effective solution possible (value engineering) and de-risking the scheme (risk management). In addition, when work packages are ready for tender the Trust will have an input into this process, have a right of veto on any sub-contractor, and have certainty that a minimum of three quotations have been obtained in all instances.

On this basis, the Trust has good reason to expect, especially given the detailed work undertaken to date, that virtually all opportunities to achieve cost savings will have been fully explored, evaluated and exploited. Any savings from market testing works packages after agreement of the GMP without any changes to the design or specification will accrue in entirety to the Trust.

In this arrangement, any costs over the Guaranteed Maximum Price would be the responsibility of the Construction Partner.

3.5.2 Terms of contract

This will be a single design and build contract with the Construction Partner with the architectural and structural designs the responsibility of the Construction Partner. The design will be an amalgamation of Royal Institute British Architects (RIBA) Project Stage 3 (Developed Design) and Stage 4 (Technical Design). There will be a series of work packages that will be confirmed by the Construction Partner. These work packages will be market tested with three suppliers in an open book manner by the Construction Partner.

The Trust has considered the key differences between the two main types of contracts for investments of the scale - Joint Contracts Tribunal Limited (JCT) contract and a UK Institution of Civil Engineers New Engineering and Construction Contract (NEC). The Trust believes there are many areas where, for a project of this complexity and cost, that the structure and governance support offered by NEC adds significant value and this rationale has been supported by Speller Metcalfe.

3.5.3 Working with the Construction partner and external advisers to date

The spatial and high-level design brief has continued to be revised as more information becomes available on the detail of the site conditions and site abnormalities.

The Steam Mill site has presented a range of issues which needed to be considered before a final design could be agreed. Where necessary, the Trust has engaged external advisers to report on these issues who have worked with the Design Team

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and the Construction Partner to develop practical solutions within the known financial constraints. These abnormalities are set out in the following table:

Table 16 Site abnormalities and approach taken

Nature of Abnormal Site Condition	Approach taken
The presence of old mine workings	Building placement and structural design developed to mitigate the mine shaft impact and reduce the amount of floor slab
Drainage and foul water requirements	Water attenuation systems incorporated
Ecological issues	Ecology mitigation plan developed. Landscape Architect inputting into design to ensure net biodiversity gain (planning requirement)
Highway access	Transport surveys undertaken April/May 2021 (see discussion below)
The need to minimise costly removal of soil and materials as a result of landscaping	Design solution developed to accommodate the majority of soil and materials to be retained on site as part of the levelling and landscaping solutions
Acoustic issues for nearby residents	Background noise assessment carried out

3.6 Planning permission

3.6.1 Pre-planning Engagement and Detailed Design

Positive pre-planning dialogue has been ongoing with the Forest of Dean District Council (the planning authority) since the concept for the new hospital was approved and particularly in relation to the selection of the site which was previously owned by the District Council.

In December 2020, a pre-planning application was submitted and ongoing dialogue with the Trust's Planning Consultants has demonstrated this was positively received. It provided the opportunity to receive feedback on the timing of the relocation of the recreational facilities on the site and on the Trust's approach to layout and landscape, drainage, ecology and the requirements in terms of building appearance and visual impact.

Since then, the ongoing design work has continued to consider the most economical solutions to the address site abnormalities and iterative dialogue with the planners has continued so that they remain fully apprised of the current design development, placement of the building on the site, building height and associated planning considerations. This informal dialogue has not raised any areas of concern or issues and we have a high level of confidence that our full planning application will be acceptable to the planning authority.

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There has also been engagement with the Gloucestershire County Council over the access and egress requirements to the site. Feedback from the Highways Department has now been fully incorporated into the design solution for the scheme. The Trust commissioned Cotswold Transport Planning to undertake traffic monitoring surveys for 3 weeks in April/May 2021 to validate the proposed approach to access and egress. As part of the planning for the site, the Trust commissioned a Travel Plan (Appendix 2.3) and an Ecological Report (Appendix 2.4).

Pre-planning application discussions have indicated that the transactions and reprovisions set out in section 3.10 will be included as conditions on the approval of the hospital full planning permission and must be satisfied before construction can commence.

The Trust Board approved that these are actively progressed at its meeting in May 2021.

3.6.2 Full planning permission

Following approval of this business case by the Trust Board, a full planning application will be submitted towards the end of July with an anticipated time scale of 14 weeks over the period August to October. Due to extensive pre-planning engagement, it is not foreseen that there will be major difficulties in obtaining full planning permission. An allowance for a potential s106 contribution has been made in the costed risks.

3.7 Sustainability

An underlying principle has been that the new hospital should be as energy efficient as possible, minimising or eliminating carbon and fully prescribing to the principles of sustainable environmental design. The Trust is mindful of Net Zero Carbon targets for the NHS and to deliver the Sustainability Development Unit's requirements.

The building will be built to high thermal insulation standards, employ low energy and controllable lighting and will feature all electric air exchange heating systems. Power will be generated from solar roof panels. Energy modelling has indicated that the new hospital could produce as little as 201 tonnes of CO₂ pa compared with the current emissions of the Dilke and Lydney which amount to 647 tonnes. This is a potential reduction of 446 tonnes of CO₂ pa.

In line with current NHS Sustainability Policy, the project is pursuing an Excellent rating under the Building Research Establishment Environmental Assessment Method 2018 (BREEAM) as part of the organisation's commitment to sustainability. A 75% score is required to achieve an "Excellent" rating.

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The BREEAM Assessment Fee, which is substantial is built into the current construction cost. There is a trade-off between paying this fee and additional work that could improve the sustainability status of the building.

The Construction Partner has particular expertise in developing sustainable solutions including energy modelling and diagnosing building performance. The Construction Partner works closely with their supply chain to make use of established method of building in sustainability into the design and construction. Carbon emissions are monitored during the construction phase and steps taken to reduce these where possible. Wherever possible, there will be sustainable sourcing of materials from suppliers with BES6001 Responsible Sourcing accreditation, with an intention to secure 70% of the trade supply chain within 30 miles of the project to reduce carbon emissions.

3.8 Equipment

All serviceable equipment currently in use at the Dilke and Lydney Hospitals will be transferred if required to the new hospital and fitted as part of the contract. Removal costs have been accounted for in the Economic and Financial Cases.

High level indicative capital cost estimates for new equipment or major transfers requiring specialist contractors are included in the costings both in the Economic model and in the Financial Case as set out in table below.

Table 4: Equipment costs included in the cost estimates

Equipment	Cost £000
Endoscopy suite	300
Endoscopes	300
X-ray relocation from existing site	35
Removal costs for other equipment	65

3.9 Modern methods of construction

Modern Methods of Construction (MMC) embraces a range of offsite manufacturing and onsite techniques that provide alternatives to traditional building methods. This forms part of the Government’s policy for future construction in the public sector is an important consideration for major NHS investments,

The principle is to maximise off-site factory production to a pre-agreed quality standard enabling a range of positive impacts including smaller on-site construction teams, enhanced health and safety and reduced defects are. Modern Methods of Construction lead to a reduction in overall project time.

The design for the hospital is based on NHS standardised layouts for inpatient rooms and consultant rooms which are in widespread use across many NHS trusts. This has allowed a repetition and standardisation of design across different parts of the hospital.

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The design includes:

- Using pre-assembled pods for all ensuite rooms for the inpatient bedrooms
- Offsite Manufacturing of the central Mechanical and Engineering Plant (MEP) and distribution infrastructure
- Offsite manufactured Pre-cast Concrete for floors
- Offsite manufactured Steel Frame
- Offsite Manufactured roof structure components.
- Standardised Doors
- Standardised external window sizes.

3.10 Land transfers and disposals

Ownership of the Steam Mills site has been transferred from the Cinderford Town Council to GHC as part of a deal which involves the components outlined in the following table.

Table 5: Land disposals and related requirements

Transaction	Cost/Value £000
Transfer of the Trust's health centre building at Dockham Road, Cinderford to Cinderford Town Council	agreed valuation 400
Relocating the skate park at Steam Mills site to a new site in Cinderford including the design and construction)	150
Reproviding the Multi-use Games area at Steam Mill site in Cinderford	30
Relaxing the site covenant at Steam Mills to permit its use as a health facility	30
Total land acquisition costs	600

As outlined in section 3.6.1 completion of the above transaction may be placed as conditions to the projects planning application process and therefore the Trust Board gave approval to proceed with these works at its Board meeting in May 2021.

All items are in line with the previously assumed costing allocations and with the exception of the covenant, were accounted for within the capital expenditure for 2020/21. (with funds placed in a stakeholder account with Cinderford Town Council).

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The funding strategy for the new hospital depends partly on the successful disposal of the existing sites. The Trust has worked with external consultants to develop an understanding of the anticipated outturn values for both sites.

In addition, the Trust is mindful that the sites have been registered as Assets of Community Value by the respective Town Council due to their significant political and historic value to the local communities. We are committed to exploring use by other public sector bodies and working in partnership with the local authorities, third sector organisations and local stakeholders to ensure that all disposal opportunities that offer ongoing public benefit are explored and that our disposal strategy is in line with delivering Best Value. We will market the sites on e-Pims to other public sector organisations in the first instance before progressing to offering sites through the open market.

The sales of the sites can only be completed once the sites are vacated on completion of the new hospital. The programme for taking forward the sales is shown in the project plan (insert reference). In the Economic and Financial models, sales are projected to be completed in 2023/24.

3.11 Estates and facilities management targets

The Design team have worked to minimise non-clinical space in line with the principles of the long term plan through sharing office space and hot desking, meeting space doubling up with rooms that can also be used by the public.

The strategic plan to reduce carbon footprint and energy costs is reflected in the sustainability section above.

The construction of a new building to replace the Dilke and Lydney hospitals removes a significant commitment to backlog maintenance and other essential upgrades as demonstrated in both Economic Case and Financial Case.

A full breakdown of the projected Life cycle maintenance programme and associated costs is included at Appendix 2.1. This is designed to maintain the property at Category B level for the duration of its lifetime and will inform the Trust's estates maintenance future programme.

3.12 Treatment of VAT

The Trust has worked with its tax advisers Liaison Financial to identify all areas where VAT can be recovered. The current estimate of £340,000 has been included in the analysis in the Financial Case. The Trust is continuing to work with Liaison Financial and is anticipating that the level of VAT recovery will increase once the final cost plan is agreed.

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3.13 Conclusion to the Commercial Case

The Commercial Case demonstrates that the development of a new community hospital in the Forest of Dean has been taken forward utilising a viable procurement route that has secured an experienced, local construction partner and a robust contract will be put in place between the public sector and its construction contractor and supply chain partners.

The Commercial Case demonstrates significant progress has been made to develop this scheme and deliver the requirements of this investment. There is also a clear understanding as to how risk is distributed between the Trust and its construction partner as we move from a NTBEP and GMP by the end of 2021.

4 Financial Case

4.1 Purpose of the Financial Case

The Financial Case assesses the financial impact of developing a new community hospital for the Forest of Dean. It demonstrates that the investment is affordable to the Trust and shows the impact this investment will have on the Trust's overall finances in subsequent years. It takes costs that are discussed in the Economic Case (which have demonstrated Value for Money) and treats these costs in line with the accounting principles that apply to NHS organisations.

4.2 Developments since the OBC

In 2019, after the OBC was approved, Gloucestershire Care Services NHS Trust joined with ²gether NHS Foundation Trust to form Gloucestershire Health and Care NHS Foundation Trust. Immediately following this, the pandemic had a widespread effect on health services both nationally and across Gloucestershire and amended financial regimes were put in place throughout the pandemic. The impact on Trust finances is covered in section 4.3 below.

There has been a significant increase in capital costs against the financial envelope set out at OBC stage. At OBC stage, finance was considered a key constraint of the project and costs were developed in line with this. The current position reflects the significant increase in general construction prices and the upward trend for construction inflation indices rather than a change in scope for the development of the new hospital. Although certain aspects were under-estimated at the OBC stage in terms of contingency and VAT, the scope of the scheme has not increased and careful space planning has enabled the overall area requirements to reduce slightly since the OBC work.

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The following table shows the main areas of difference since OBC with the key change being the increase in assumed cost per m² from £2,403 in the OBC to £3,687 in the FBC. The Trust has undertaken several value engineering exercises with our construction partners to review the building design, the mechanical and engineering specification and other aspects of the external works associated with the challenging site now that more detail is known. Much of this information was not available at the point of OBC as the site had not been selected at this time.

In addition, there has been an inclusion of equipment costs of c £700,000 as a more detailed review of equipment needs has now been undertaken. The bulk of the equipment needs sit within the new endoscopy service and it is assumed this space will be provided on a fully equipped basis to the main service provider (in this case GHT) in line with the arrangements in all our other community locations. This was not known at the point of OBC and costs were therefore not included. We have assessed and confirmed the viability of transferring x-ray equipment from the existing sites and have confirmed that this will offer value for money as the equipment still has circa 10 years of life expectancy.

Table 6: Changes in cost between OBC and FBC

	OBC	FBC
	Buildings 4,000m ² @£ 2,403m ²	Buildings 3,802m ² @ £3,653m ²
Construction cost	9,615	13,890
External works		2,657
Equipment (Endoscopy and re-fitting of existing)		650
Fees	1,202	1,120
Inflation		697
Site acquisition & MUGA works	400	600
Contingency	481	816
VAT	1,748	3,487
Total	13,443	23,918

4.3 Current financial position of the Trust

GHC is in a healthy financial position having delivered its portion of the Gloucestershire ICS control total in each year since its formation by merger in 2019. The merger accounting and impairments offset the surplus position and impairments and other adjustments also impacted in 2020/21 and the table below shows the adjusted position as being a small surplus.

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Table 7: Adjusted Financial Performance

Adjusted Financial Performance	2020/21 £000s
Deficit for the year	(5,913)
Before consolidation of Charity	(59)
Add back all I&E impairments / (reversals)	353
Adjust (gains) / losses on transfers by absorption	6,002
Surplus / (deficit) before impairments and transfers	383
Remove capital donations / grants I&E impact	135
Remove net impact of DHSC centrally procured inventories	(471)
Adjusted financial performance surplus	47

Of particular note, at the end of 20/21 was the cash balance, which has been built up both from prior year surpluses, the charge to Income & Expenditure (I&E) of non cash items such as depreciation and good management of working capital. This cash on the Trust balance sheet can be used for capital investment, as well as providing a buffer for working capital although an ICS Capital Delegated Expenditure Limit (CDEL) is also required for capital expenditure within current NHS guidance. The Capital funding regime is likely to change during the life of this project with the Design framework for ICS finance from 2022 stating:

Powers to ensure organisational capital spending is in line with system capital plans. A review of the NHS provider licence in light of the new legislation and policy developments and specifically to support providers to work effectively as part of ICSs to deliver system objectives.

During budget setting for 2021/22 (prior to the interim financial framework being announced) the Board approved a plan to deliver a small surplus. This has since been reduced to a breakeven for the H1 2021/22 plan. Although the plan assumes a small reduction in contract income associated with the overall bed reduction in the new hospital, the Trust is not expecting any other significant variation to contract income that would impact on the overall financial position. The position at the end of month 2 confirms this forecast as shown in the table below:

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Table 21 – Forecast position based at Month 2 2021/22

Statement of comprehensive income £000	Original Plan	YTD Actual	Full Year Forecast
Operating income from patient care activities	220,598	38,549	225,360
Other operating income	6,700	928	11,268
Other income	0	0	0
Employee expenses	(170,274)	(28,743)	(169,062)
Operating expenses excluding employee expenses	(53,533)	(10,317)	(64,908)
PDC dividends payable/refundable	(2,701)	(432)	(2,706)
Other gains/losses	0	3	0
Surplus/deficit) before impairments & transfers	790	(12)	(48)
Impairments/exceptional items*			
Remove capital donations/grants I&E impact	100	15	48
Surplus (deficit)	890	3	0
Adjust (gains)/losses on transfers by absorption/impairments			
Revised Surplus/(deficit)	890	3	0

The cash balance at the end of May 2021 was £54.4m.

The above information is sufficient to conclude that historically the Trust has a stable financial position. The impact of the new financial regime has yet to be assessed and we will continue to do so when further details are released.

Organisational analysis on the recurrent/ non recurrent position indicates that the non recurrent Covid funding and the non recurrent growth allocation have impacted adversely on the Trust's underlying position, this is thought unlikely to be permanent once the allocations for growth are made recurrent. The Trust has maintained financial discipline throughout the pandemic for example by continuing with normal budget setting and robust cost improvement planning processes.

4.4 Capital costs

Section 4.2 outlines the most significant change since OBC has been the estimated Capital Costs and the variances. The current capital costings shown below have been developed through a robust process utilising a combination of market rates, soft market testing with a range of suppliers, Quantity Surveyor judgement and Subject Matter Expert input rather than formal quotations from contractors. Further detail can be found in the FB forms at Appendix 2.2.

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Table 22: Capital Costs

Description	£'000		
	Cost	VAT	Cost Incl VAT
Construction	13,890	2,778	16,668
External Works	2,657	531	3,188
Works Cost Total	16,547	3,309	19,856
Fees	1,120	224	1,344
Non Works including land & skate park	600	0	600
Equipment Costs	650	130	780
Planning Contingency	817	163	980
VAT Reclaim		(340)	(340)
Sub Total	19,734	3,487	23,221
Inflation Adjustments	581	116	697
Total			23,919

Inflationary changes continue to be a risk to the project until GMP is secured in the latter part of 2021. The Trust has included additional headroom within the contingency figure to allow for this risk through to GMP.

The Trust has held several risk sessions with its construction partner and design team and the risk register (see Appendix 5.6) covers all known issues. The value reflects current knowledge regarding planning conditions. A number of key risks have already been mitigated and therefore removed from the risk log however, those that remain are listed below. These have been costed and an allowance of £150,000 has been included over and above the contingency sum to mitigate the risks associated with:

- S106 requirements which may get imposed as part of the full planning process
- Additional work to the culvert imposed by Severn Trent on connection
- Additional works to the entrance/road network which may get imposed by the Highways agency

As more certainty around these areas becomes known these risk allowances will be released. This allocation sits outside of the current Not to be Exceeded Price and is controlled by the Trust.

The Trust's independent cost advisor considers the level of contingency associated with these risks as robust risk.

4.5 Capital funding

The Trust is funding the scheme through its capital programmes which is funded by cash reserves and disposals including the sale of the Dilke and Lydney Hospital sites

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in the Forest of Dean. This is consistent with the assumptions contained within the OBC and despite the cost increases since the OBC scheme, this remains the preferred route. The Trust has consistently delivered surpluses over recent years and has a significant cash balance.

The table below shows the Trust's capital expenditure plan and showing capital costs for the Forest of Dean Hospital of £22.5m spread over the three years 2021/22 to 2023/24. The capital spend on the Forest of Dean up to the end of 2020/21 was £1.4m bringing the total capital spend on the hospital to £23.9m. The plan also reflects the expected capital receipts when the Trust intends to dispose of the Lydney and Dilke sites in 2023/24.

Table 23: Gloucestershire Health and Care Five Year Capital Plan

GHC Five Year Capital Plan	Final Plan	Final Plan	Final Plan	Final Plan	Final Plan	Final Plan
£000s	2021/22	2022/23	2023/24	2024/25	2025/26	Total
Land and Buildings						
Buildings	3,563	2,500	2,500	1,000	1,000	10,563
Backlog Maintenance	5,657	0	1,050	1,250	1,393	9,350
Urgent Care	750	0	0	0	0	750
LD Assessment & Treatment Unit	0	0	2,000	0	0	2,000
Cirencester Scheme	0	0	5,000	0	0	5,000
IT						
IT Device and software upgrade	200	600	600	600	600	2,600
IT Infrastructure	1,086	996	1,300	1,300	1,300	5,982
Medical Equipment	1,569	0	730	1,030	1,030	4,359
Unallocated	168	0	0	2,300	2,300	4,768
Sub Total	12,993	4,096	13,180	7,480	7,623	45,372
Forest of Dean	3,000	16,000	3,500	0	0	22,500
Total prior to proceeds/donations	15,993	20,096	16,680	7,480	7,623	67,872
Disposal Proceeds		(3,260)	(1,500)			(4,760)
Donations			(5,000)			(5,000)
Total after proceeds/donations	15,993	16,836	10,180	7,480	7,623	58,112

Nb £1.4m spent upto 31.03.21 on Forest of Dean

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4.6 The Trust's approach to affordability modelling

The affordability modelling has been evaluated over a 60-year period in line with HM Treasury guidance for large estates-related projects. A 60-year phased financial model has been developed to compare the costs operating at the Dilke and Lydney to the costs of the new Hospital. The total costs have been assessed against the available cash balance.

4.6.1 Financial Case Assumptions

Financial modelling has been based on robust assumptions, agreed from a series of workshops and discussions with clinical and service leads, subject matter experts and system partners in ambulatory care, urgent care, diagnostics and inpatient services including rehabilitation.

The financial case assumes that the new hospital will provide all the services that are currently delivered from Dilke and Lydney hospitals (except those retained locally at Lydney).

The model takes into consideration the schedule of accommodation as discussed in Section 2.

The financial case has been built using the NTBEP as referenced in the Economic and Commercial cases above.

4.6.2 Treatment of Costs in Financial Case

The costs are treated in different ways in the financial case compared with the Economic Case (see Section 2.8.7) for instance:

- Costs are expressed at in-year inflated values
- Costs/prices are not discounted
- Contingency values accounted for explicitly
- Transfers of resources (e.g. gifts, VAT, grants, subsidies, capital charges) are included in the overall estimate of financial benefit
- Income from other public bodies (e.g. in endoscopy) is a relevant income flow for the financial case
- Depreciation and loss on disposal have been assumed
- Only cash releasing benefits are incorporated into the financial case

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- The financial case includes total business case costs, including sunk costs, for example professional fees and management costs already paid.

4.6.3 Financial Modelling

The 'as is' financial modelling is based on existing operational costs of the two current Community Hospitals.

The key financial modelling assumptions are as follows:

- Year 0 of the modelling is 2021/22, with base case 2019/20 'as is' costs uplifted to a 2021/22 basis.
- Pay costs from 2021/22 base have been uplifted annually by 1.7% pay inflation (reflecting the current view of pay inflation).
- Income has similarly been uplifted by 1.7% annually. This has been deliberately linked to the pay increase to avoid any assumption differential from impacting the business case.
- Neither pay, non-pay nor income assumptions incorporate any efficiency savings, as there is currently no accurate way to forecast likely efficiency requirements in the current financial climate.
- Non pay costs have been uplifted by the GDP deflator, in line with Green Book guidance.
- Net sale proceeds of c. £1.8m from the disposal of existing sites. Timing of receipt is assumed to be in the year following that when the new hospital opens. At the same time the loss on disposal of c. £1.6M has been recognised.
- VAT payable on capital build and associated professional costs will mainly be non-recoverable. The financial case includes the estimate of £250,000 of recoverable VAT as referenced in the commercial case.
- Loss of block funding resulting from a 23-bed reduction in bed numbers in the new hospital. An indicative value has been included for this within the modelling. The reduction from existing bed stock will be managed by realising efficiencies across the Gloucestershire ICS as part of system bed modelling.
- £0.4m of annual income generation from provision of Endoscopy services at the new hospital, based on a prudent assumption of 50% utilisation, reflecting the income per list of our existing endoscopy units in Stroud and Cirencester hospitals.
- Avoided capital refurbishment / major works costs of £8m total at existing Dilke and Lydney Hospitals.

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- Avoided backlog maintenance, as identified on the backlog maintenance 6 facet survey as at March 2021, of approximately £2.1M.
- Pay costs have been derived from rotas, including headroom, designed by clinical experts, with an additional 5% optimism bias, reflecting historic actual costs being higher than budgets.
- Non pay costs are reflective of existing non pay for the services provided, with the exception of inpatients which have been reduced in line with bed numbers. The new endoscopy suite non pay is based on that of our existing endoscopy sites at Stroud and Cirencester hospitals. In addition, a 5% optimism bias has been added to all non-pay, to ensure a very prudent model.
- It is recognised that there will be workforce implications due to the changes to the operating model. All required staff reductions will be managed through redeployment and natural attrition, such that no staff redundancy costs are anticipated.
- There is an allowance for double-running and temporary excess staffing costs to reflect the likely non-recurrent transition costs associated with the move to the new hospital.

The new hospital will have general and specialist facilities for outpatient services, the majority of which will be provided by The Trust and Gloucestershire Hospitals NHSFT. All options, including the 'as is' scenario, assume there will be an approximate 30% reduction from 19/20 baseline existing outpatient activity, in line with NHS long term plan strategic direction

4.7 Average annual revenue impact

The average annual revenue impact of Business as Usual and the proposed preferred option as referenced in the economic case i.e. the establishment of a new hospital replacing two separate hospitals, will enable reductions in clinical inpatient costs, facility staffing costs and building running costs. The table shows current costs of services operating from the Dilke and Lydney Hospitals and the operating costs from 2025/26 when the full reduction/redeployment of teams will be in effect. Costs are shown at in-year inflated values.

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Table 24: Revenue Costs in financial case of 'as is' versus 'with investment' models

	Existing Annual Cost (£000s)	Existing Costs Inflated to 25/26 levels (£000s)	Annual Cost from 2025/26 (£000s)
Nursing	4,152	4,442	3,282
AHP	352	376	389
Other Clinical	312	331	289
Clinical Non Pay	433	463	527
Total Clinical Costs	5,248	5,613	4,487
Non-Clinical Costs	1,175	1,265	1,024
Building Runnings Costs	498	553	335
Rates	63	70	169
Cap charges / depn	697	815	2,024
Total Non-Clinical Costs	2,433	2,704	3,552
Total Service Costs	7,682	8,316	8,039
Directly attributable income (OPD/Endo)	(242)	(259)	(674)
Position Net of Directly Attributable Income	7,439	8,057	7,365

The changes to recurrent cost base listed above reflect all of the assumptions outlined in the financial modelling section and include the significant movement in capital charges and depreciation which must be funded as a consequence of the new hospital. The overall position demonstrates that the annual service costs in 2025/26 are more favourable following the development of the new hospital than under the existing business as usual scenario.

4.8 Impact on Trust Statement of Financial Position

The tables below are extracts from the Trust's long term financial modelling which demonstrates the balance sheet and cash flow positions each year. The Trust had a cash balances of £52.3m at 31st March 2021.

The Trust's internal cash reserves are sufficient to fund the Trust's contribution to this project. The Trust does not anticipate the need for loans to support its cash position. Working Capital in the Statement of Financial Position (SoFP) is assumed to be consistent throughout the financial model.

The Trust has a strong balance sheet that enables it to make on-going significant investment in its capital programme in future years.

The main impact on the balance sheet is an increase in building assets as a result of this capital project adding to the Trust's balance sheet as the new Hospital will be

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owned by the Trust. The Trust's cash flow projections show a reduction in cash from £52.3m in 2021 to a sustainable balance of c. £20m by 2030/31.

Table 25: The Trust's SoFP for years 1-5 and year 10

Statement of Finance Position (all figures £000s)		2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2030/31
Non-current assets	Intangible assets	488	488	488	488	488	488	488
	Property, plant and equipment: other	110,388	119,681	130,167	133,847	134,726	135,548	134,697
	Total non-current assets	110,876	120,169	130,655	134,335	135,214	136,036	135,185
Current assets	Inventories	718	418	218	218	218	218	218
	NHS receivables	6,077	5,877	5,827	5,777	5,777	5,777	5,777
	Non-NHS receivables	5,928	5,928	5,428	5,328	5,328	5,328	5,328
	Cash and cash equivalents	52,333	40,695	30,959	27,429	24,907	24,085	24,936
	Property held for Sale	0	0	0	0	0	0	0
	Total current assets	65,056	52,918	42,432	38,752	36,230	35,408	36,259
Current liabilities	Trade and other payables : capital	(5,108)	(5,108)	(5,108)	(5,108)	(5,108)	(5,108)	(5,108)
	Trade and other payables: non-capital	(23,762)	(20,262)	(20,262)	(20,262)	(20,262)	(20,262)	(20,262)
	Borrowings	(107)	(107)	(107)	(107)	(107)	(107)	(107)
	Provisions	(3,526)	(1,526)	(1,026)	(1,026)	(1,026)	(1,026)	(1,026)
	Other liabilities: incl. deferred income	(2,273)	(773)	(773)	(773)	(773)	(773)	(773)
	Total current liabilities	(34,776)	(27,776)	(27,276)	(27,276)	(27,276)	(27,276)	(27,276)
Non-current liabilities	Borrowings	(1,363)	(1,363)	(1,363)	(1,363)	(1,363)	(1,363)	(1,363)
	Provisions	(1,423)	(1,423)	(1,423)	(1,423)	(1,423)	(1,423)	(1,423)
	Total net assets employed	138,370	142,525	143,025	143,025	141,382	141,382	141,382
Taxpayers Equity	Public dividend capital	126,578	126,733	126,733	126,733	126,733	126,733	126,733
	Revaluation reserve	6,826	6,826	6,826	6,826	6,826	6,826	6,826
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	(1,241)	(1,241)	(1,241)
	Donation reserve	0	0	0	0	0	0	0
	Income and expenditure reserve	6,207	10,207	10,707	10,707	9,064	9,064	9,064
	Total Taxpayers' and other equity	138,370	142,525	143,025	143,025	141,382	141,382	141,382

4.9 Impact on Trust Cash Flow

As can be seen above, the Trust has carefully assessed its five-year capital requirements. The table below demonstrates that taking account of the current cash

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balance, future year's depreciation, anticipated disposals and predicted balance sheet movement, this five-year capital plan can be securely funded.

We have assumed that the Trust will not generate a surplus in future years. Our assessment demonstrates that we would have sufficient cash available each year through to 2025/26 to fund the capital programme, including the FoD scheme at a cost of £23.9m.

Our forecast has indicated this level of expenditure would enable the Trust to continue to operate a significant operational cash buffer which we believe is sufficient to cover all contingencies.

Table 8: Impact on Trust Cash flow

Statement of Cash Flow £000	21/22	22/23	23/24	24/25	25/26	30/31
Cash and cash equivalents at start of period	52,333	40,695	30,959	27,429	24,907	24,736
Cash flows from operating activities						
Operating surplus/(deficit)	2,300	2,300	2,300	657	2,300	2,300
Add back: Depreciation on donated assets	0	0	0	0	0	0
Adjusted Operating surplus/(deficit) per I&E	2,300	2,300	2,300	657	2,300	2,300
Add back: Depreciation on owned assets	6,700	6,350	6,500	6,601	6,801	7,200
Add back: Impairment	0	0	0	0	0	0
(Increase)/Decrease in inventories	300	200	0	0	0	0
(Increase)/Decrease in trade & other receivables	200	550	150	0	0	0
Increase/(Decrease) in provisions	(1,500)	0	0	0	0	0
Increase/(Decrease) in trade and other payables	(1,500)	0	0	0	0	0
Increase/(Decrease) in other liabilities	0	0	0	0	0	0
Net cash generated from / (used in) operations	6,500	9,400	8,950	7,258	9,101	9,500
Cash flows from investing activities						
Interest received	0	0	0	0	0	0
Purchase of property, plant and equipment	(15,993)	(20,096)	(16,680)	(7,480)	(7,623)	(7,000)
Sale of Property	0	3,260	6,500	0	0	0
Net cash generated / (used) in investing activities	(15,993)	(16,836)	(10,180)	(7,480)	(7,623)	(7,000)
Cash flows from financing activities						
PDC Dividend Received	0	0	0	0	0	0
PDC Dividend (Paid)	(2,145)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)
Finance Lease Rental Payments	0	0	0	0	0	0
Net cash generated / (used) in financing activities	(2,145)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)
Cash and cash equivalents at end of period	40,695	30,959	27,429	24,907	24,085	24,936

4.10 Sensitivities, Downsides and Mitigations

The Trust has approached the financial modelling in a very prudent way, as demonstrated by our capital contingency, alongside introducing an optimism bias into our operating cost model.

The Trust has utilised a 'not to be exceeded' price, with an additional c. £0.8M contingency, which will be superseded by a 'guaranteed maximum price' arrangement. Therefore, a sensitivity analysis on capital cost has not been completed at this stage.

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The model is, however, sensitive to assumptions around pay and income inflation rates. The table below identifies some of the key sensitivities and their effect on the overall financial benefit over 60 years.

4.10.1 Income Growth %

The business case has assumed an income growth of 1.7%. Income growth is a key variable for the business case. A higher income growth means a greater value will be lost due to the reduction in bed numbers. Conversely, a lower rate of income growth reduces the value lost. The table below shows the effect of reduced rates of income growth.

Table 9: Impact of income growth

Variable	Variable value	Total Benefits Case (£000s)	Net Benefit (£000s)
Income Growth %			
Business Case Assumption	1.7%	69,717	45,817
Bus Case minus 0.1%	1.6%	72,376	48,476
Bus Case minus 0.2%	1.5%	74,963	51,063
Bus Case minus 0.3%	1.4%	77,408	53,508
Bus Case minus 0.4%	1.3%	79,738	55,838

4.10.2 Pay Inflation %

Pay inflation, linked to Agenda for Change inflation, drives part of the potential staff cost saving in the financial case and thereby is a key assumption. The table below shows the sensitivity of the financial case to changes in this assumption.

Table 28: Impact of pay growth

Variable	Variable value	Total Benefits Case (£000s)	Net Benefit (£000s)
Pay Growth %			
Business Case Assumption	1.7%	69,717	45,817
Bus Case plus 0.1%	1.8%	73,905	50,005
Bus Case plus 0.2%	1.9%	78,180	54,280
Bus Case minus 0.1%	1.6%	65,937	42,037
Bus Case minus 0.2%	1.5%	62,029	38,129

4.10.3 Non- Pay Inflation % (based on GDP Deflator)

In line with HM Treasury guidance, non-pay is inflated at the same rate as the published GDP Deflator (March 2021). The GDP deflator for years 2025/26 onwards utilises the 2025/26 GDP deflator rate which may be subject to variability in the current economic climate.

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The table below highlights the model’s sensitivity to movement in this assumption. A higher pay inflation means a greater value saved through the reduction in staff numbers as a result of bringing team together in one hospital.

Table 29: Impact of changes in the GDP deflator

Variable	Variable value	Total Benefits Case (£000s)	Net Benefit (£000s)
GDP Deflator %			
Business Case Assumption	2.14%	69,717	45,817
Bus Case plus 0.1%	2.24%	68,180	44,280
Bus Case plus 0.2%	2.34%	66,918	43,018
Bus Case minus 0.1%	2.04%	70,728	46,828
Bus Case minus 0.2%	1.94%	71,785	47,885

The variables outlined above are not within the control of the Trust and therefore there is no reasonable mitigation against any downside impact of unfavourable movements in their rates.

4.11 Conclusion of Affordability

The finance section demonstrates that the preferred option is affordable to the Trust and continues to offer a significant reduction in risk associated with backlog maintenance and risk of service failure. This scheme results in cost efficiencies from bringing services onto a single site which outweigh the additional capital charges of the new hospital so the scheme is affordable from a revenue perspective.

The increase in capital costs against the financial envelope set at the OBC stage reflects the increase in general construction prices and the upward trend for construction inflation indices rather than a change in the scope of the scheme. This has resulted in the Trust rigorously reassessing its affordability position and funding strategy and the £23.9m capital cost for this project, along with the remaining schemes in the Trust’s capital plan can be securely funded. The case demonstrates that the Trust remains financially viable with a sufficient cash buffer to meet all operating and contingency requirements.

The NTBEP will form the basis of this business case approval and has been developed utilising a range of market intelligence and market testing and it is expected that the Construction Partner will provide us with a GMP by November 2021. Assuming acceptance, this would enable the contract to be signed by December 2021.

The preferred funding route for the capital programme remains the utilisation of the Trust’s cash reserves and disposal proceeds.

Forest of Dean Hospital FBC Management Case

5 Management Case

5.1 Purpose of the Management Case

This section of the FBC explains the governance and management arrangements and the actions required to ensure the successful delivery of the project in accordance with best practice. These include the project and programme management arrangements, the management of risks and the planning to ensure the benefits of this investment are realised.

5.2 Project governance arrangements, roles and responsibilities

The planning for a new community hospital for the Forest of Dean has been integral to the strategic planning for the One Gloucestershire ICS and the investment is part of the ICS Estates strategy. As shown in the Strategic Case, the Trust and its predecessors have worked closely with system partners on designing the composition of services for the new hospital and how these support the models of care being implemented. The Trust will continue to work with system partners, including primary care to explore how it can best align with the developing Forest Healthcare facility at Cinderford, the new primary care hub at Coleford and with a potential primary care hub at Lydney.

The Trust has established a robust project management structure that is accountable to the Trust Board but will also continue to maintain important liaison and joint working with other groups within the ICS. The Trust will continue to work with Gloucestershire CCG around ongoing public engagement although developing local community involvement with the new hospital will be led by the Trust's Communication and Engagement Team.

The governance structure is set out in the following figure which shows accountability lines, and key internal and external relationships.

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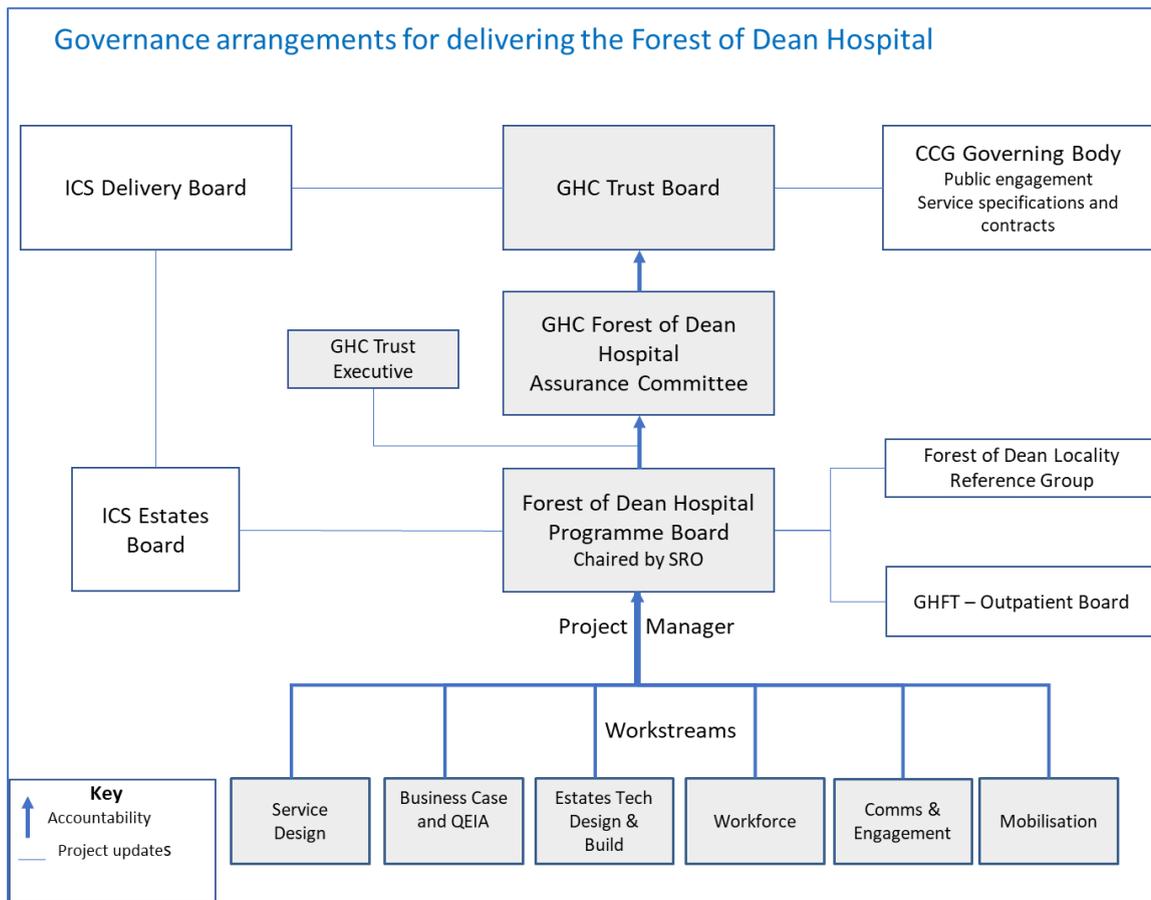


Figure 10: Governance arrangements for delivering the Forest of Dean Hospital

The Trust Board will have overall accountability for the programme and on the basis of this viable and affordable business case, will ensure delivery of the agreed investment objectives and the successful completion of the new hospital for the Forest of Dean.

The Senior Responsible Officer (SRO) is the Executive level Director of Strategy and Partnerships who chairs the Programme Board.

PRINCE 2 and other recognised project methodology, as appropriate, have been and will continue to be followed to ensure project planning and monitoring are carried out with rigour.

5.2.1 The Forest of Dean Hospital Programme Board

The Programme Board comprises key internal stakeholders and operational decision makers (see Appendix 5.1 for Terms of Reference and membership). The Programme Board which reports to the GHC Forest of Dean Assurance Committee meets monthly to provide oversight and scrutiny to all the contributing work streams ensuring key dependencies are clearly identified and understood. It will continue to operate until the project is handed to operational management oversight (January 2024, the equivalent of the final stage of the Office Government Commerce (OGC) Gateway 5).

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The Programme Board:

- Receives regular highlight reports from work streams.
- Maintains oversight of the programme risk and issue registers and ensures appropriate mitigations are in place.
- Escalates issues and risks to the Trust Executive Team or the FoD Assurance Committee as appropriate.
- Ensures there is timely internal and external communication and stakeholder engagement planning within the programme and ensures response to any Freedom of Information (FOI) requests.
- Allocates resources to the work streams as agreed within the financial parameters of the overall programme and monitors capacity in order to deliver key outcomes.
- Monitors the delivery of the programme within the agreed financial context.
- Establishes links across community, partner and voluntary organisations to ensure community involvement in the design of the new hospital. This includes the Forest of Dean Locality Reference Group, the Forest of Dean Health Forum and the Forest of Dean Integrated Locality Partnership (ILP).
- Ensures that innovation and transformation is at the forefront of the new hospital development.
- Oversees the benefits realisation plan up to the point the project is handed over to operational management (see 5.6 below).

Throughout the construction phase of the project, the technical, design and build workstream will continue to oversee the development of the hospital and work with our appointed external Project Manager and Quantity Surveyors to ensure quality of build, timeline and cost estimates are appropriately reviewed and ratified at each stage of the development and that clear gateways for progression are in place and adhered to. The Trust will appoint a Clerk of Works to support the quality assurance and sign-off process associated with the actual construction stages.

A robust change control process is in place to monitor service design and ensure that a thorough confirm and challenge process is in place to prevent design creep or cost impacts following design freeze. The SRO is responsible for the sign off of any service change requests following the design freeze stage.

A number of workstreams will be key to planning the detail of the transition, benefits realisation and commissioning of services in the new building along with the ongoing engagement with stakeholders including neighbours, colleagues and wider interested parties. These include the:

- Workforce workstream
- Engagement and Communication workstream
- Mobilisation workstream

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All workstreams will provide regular update and escalation reports to the Programme Board.

5.2.2 Forest of Dean Hospital Assurance Committee

The Assurance Committee is a Committee of the Trust Board chaired by a Non-Executive Director and comprising three Non-Executive Directors (including the Chair) and three Executive Directors – The Director of Finance, Director of Human Resources & Organisational Development and Director of Strategy and Partnerships (who chairs the Programme Board). The Committee currently meets monthly to provide a level of scrutiny that would not be possible at a Trust Board meeting. The Terms of Reference and membership are detailed at Appendix 5.2.

The purpose of the Assurance Committee is to receive and provide assurance to the Trust Board on the overarching delivery of the FoD Hospital programme, ensuring that the programme is delivered on time, to the agreed budget, and to a satisfactory quality.

The FoD Assurance Committee updates the Trust Board after each meeting on its activity, highlighting decisions made, issues being progressed and issues requiring further consideration or decision by the Board. During the early stages of the programme, the Resources Committee received reports on the development of the financial elements of the scheme.

The Committee will:

- Receive regular progress assurance reports from the FoD Programme Board.
- Provide an oversight and assurance function on the delivery of the new hospital.
- Have oversight of the costing plan and will review and consider any significant variations.

5.2.3 Expertise engaged in the project

The members of the Programme Board listed below will take lead responsibilities for the areas listed.

Table 10: Programme team experience

Role	Function	Experience
Director of Strategy & Partnerships (Angela Potter)	SRO	SRO on a number of public sector funded FBCs including a child & adolescent mental health unit and Community Hospitals. 5 years as Programme Director for Southern Derbyshire LIFT

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Associate Director of Estates, Facilities and Medical Devices (Kevin Adams)	Technical Lead	Estates lead on numerous schemes with ten years' experience in role including New Builds, Acquisition and fit outs, Backlog Programmes, Sustainability Programmes and Refurbishments.
Trust Project Manager (Fiona Smith)	Project Management Support to the Programme Board	Project Manager of 3 previous new Community Hospitals schemes for Gloucestershire including transition and mobilisation planning. Project Manager for this scheme over 4 years.
Service Director Hospitals (Julie Goodenough)	Operational oversight	Senior operational manager with experience of providing an operational lead role in the design, transition and mobilisation of a new Community Hospital and a number of large refurbishment schemes across the Community Hospital estate in Gloucestershire.
Service Director Urgent Care (Helen Mee)	Lead for Urgent Care	Operational Leader with system wide experience in community services including transformation of MIU and urgent care models following organisational mergers and redesign. Skilled in using data analysis to develop models of care designed to meet local population needs.
Deputy Director of Human Resources (HR) & OD (Lesley Maiden)	Workforce lead	Wide ranging HR experience across the public and private sectors. Involved in the TUPE transfer of a Community Unit into a District hospital and large-scale projects.
Matron Lydney & Dilke Hospitals (Cheryl Haswell)	Lead for inpatient and outpatient services	Matron at Dilke and Lydney hospitals. Previous experience as Matron IP&C in an acute Trust with experience of involvement in new inpatient ward design and refurbishments, endoscopy and outpatient departments.
Comms & Engagement (Matt Blackman)	Lead for internal and external comms and engagement	Extensive experience on a wide-range of public sector internal and external communications with a background in journalism. Long-standing involvement with this scheme over 4 years.
Information Technology (IT) (Kevin Booth)	IT Lead	Worked on numerous IT deployment Projects including IT and infrastructure requirements for Clinical Systems, Trust Wide secure follow-me Printing and the migration to NHSmail. Also involved in assessing and preparing new sites for IT requirements i.e. Pullman Place, Gloucester.

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The Trust will continue to work with the following advisers:

Table 11: Specialist advisers engaged by the Trust

Function	Specialists and advisers appointed
Cost advisers	Gleeds
Specialist Project Manager	Arcus (formerly employed through Gleeds)
Planning Advisers	Avison Young
VAT advisers	Liaison Financial
Clerk of Works	To be appointed
Other specialist advice as required	To be appointed (if required)

The Trust will continue to engage the Specialist Project Manager who has worked with the project over the past two years to maintain continuity. In addition, the Trust will engage a Clerk of Works to monitor the work and progress of the Construction Partner.

The Specialist Project Manager (Alison Halmshaw) has over 20 years' experience in project management with 17 of those being in healthcare. She has worked on several different community hospital projects including Minehead and Bridgwater. She is also an NEC 3 & 4 accredited Project manager and is currently delivering Devizes Health Centre on site under a P22 contract.

The Construction Partner will engage advisers as required to deliver the building and conduct the market testing. These will be in addition to those below who have been engaged in the final stages of planning.

Table 12: Specialists and advisers to be engaged in the construction and implementation phases

Function	Specialists & Advisers appointed
Architects	One Creative (from April 2021)
Civil & Structural Engineers	Barnsley Marshall (from April 2021)

5.3 Contract management and change

During construction, monthly reports will be provided by the Contractor and Cost Manager and these will then be summarised in an overall Project Management report.

The Contract change control procedure is set out at Appendix 5.3 and governs changes to the Construction Contract throughout the Construction period. The Change Control Procedure encompasses the five activities shown in the diagram below and establishes how 'Changes' will be monitored and controlled, how they will be proposed, accepted or rejected, authorised and instructed.

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Figure 11: Contract Change Control procedure

The Change Control Register is a live Project Document and will be maintained by the Technical Lead throughout the Construction Stage to Practical Completion.

Completed *Early Warning Notices*, *Instructions* and *Compensation events* will be retained as a record and stored in the appropriate Project file to provide a complete audit of changes throughout the project.

5.4 Project plan

A Construction Project Plan has been developed to progress the scheme to commencement on site in the 2nd week of February 2022. (See Appendix 5.4).

A number of key milestones exist across the lifespan of the project as outlined below.

Table 13: Key milestones for the investment

Key Milestones	Start date	End date	Key assumptions
Trust Board approves FBC	7 July 21	15 July 21	
RIBA 3 design for planning	14 June 21	13 August 21	
Submission of Full Planning Application	23 July 21	End of October 21	Assuming maximum of 14 weeks and that Pre-planning expectations correctly inform application
RIBA 4 Design	19 August 21	29 October 21	
Tender of packages	1 November 21	10 December 21	Assuming Full Planning Permission is granted

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Key Milestones	Start date	End date	Key assumptions
Finalised costs	13 December 21	23 December 21	Assuming tender programme proceeds to plan
Trust Board agrees Guaranteed Maximum Price	12 January 22	12 January 22	
Contractors appointment and mobilisation	12 January 22	8 February 22	Ability to mobilise in given period
Construction starts	8 February 22		
Construction period (70 weeks)	7 Feb 22	12 June 23	
Commissioning of new building and transfer of services from Dilke and Lydney	June 2023	June 2023	Dependent on construction timescale /unforeseen delays
Closure of Dilke and Lydney and availability for disposal	July 2023		

5.4.1 Project assurance and internal gateways

Progress on the project will be continually monitored by the Programme Board, assured as appropriate by the Assurance Committee and reported to Trust Board at regular meetings (see section above).

The following internal gateways have been agreed to enable progression to the next stage. Gateways will be overseen by the Trust Board, delegated as appropriate to the Assurance Committee.

Table 34: Internal gateways

Internal Gateways	Date in line with Project plan
Approval of Full Business Case	Trust Board 15 July 2021
End of Design Phase - completion of technical design (RIBA Stage 4)	Assurance Committee October 2021
Confirmation of any NHSEI approvals	November 2021

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Final GMP cost and entering into the Construction Contract	Trust Board January 2022
End of construction phase (RIBA Stage 5)	Assurance Committee May 2023
End of Commissioning of new building (RIBA Stage 6)	Assurance Committee June 2023
End of initial operation (RIBA Stage 7)	Assurance Committee Sept 2023
End of Post Project Evaluation	Assurance Committee December 2023
Final sign off and Project Closure (equivalent to OGC Gateway 5)	Trust Board January 2024

5.5 Service development and transition

The move from two hospital sites requires detailed preparation and careful management, supported by the ongoing work of the Workforce, Communications and Engagement, and Mobilisation workstreams reporting to the Programme Board.

Key changes include:

- Forming new teams from pre-existing separate teams and in the case of endoscopy forming a completely new team.
- Significant changes in staff numbers in Inpatients, Facilities and Endoscopy.
- A change in ward operations from predominantly bedded bays in two units to entirely single rooms in one location.
- A strengthening of therapy services to enable 7 day a week therapy to be maintained on the ward.
- New opportunities for joint working with Rapid Response, MIU and Out of Hours services.
- Outpatient clinics at one site instead of split between two sites.
- Exploiting the opportunities arising from having a consistent imaging service across the week.
- A major relocation exercise in which equipment and furniture will be transported over a weekend to facilitate the minimum possible break in service moving from the existing hospitals to the new hospital in June 2023.
- Preparations to minimise the adverse effects of moving inpatients.
- Ensuring the public are kept fully informed and understand what to expect when services change location.
- New ways of working to capitalise on the new facilities provided e.g. making better use of new adjacencies to develop one-stop approaches and multi-disciplinary working.

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5.5.1 Contingency planning and business continuity

A draft comprehensive transition and implementation project plan has been developed (see Appendix 5.5) to cover the period leading up to the opening of the new hospital and the initial operational phase. This sets out broad level tasks for each of the service areas, based on requirements for the move and informed by the extensive experience gained through similar community hospital commissioning exercises.

The plan covers three phases;

- Preparation phase from July 2021 to November 2022;
- Mobilisation phase from December 2022 to June 2023;
- Initial Delivery Phase from July 2023 to January 2024 when the project is scheduled to be handed over to Trust Operational Management.

Development of the plan will be a regular reporting feature of the Programme Board and will continue to be refined as the scheme progresses.

5.5.2 Workforce

Detail of the planned changes in staffing structures are set out at Appendix 5.9. In summary these will involve:

- A reduction of facilities staff of 8.8 wte.
- An overall reduction of ward staff of 35 wte (after conversion of nursing posts to additional therapy posts).
- A reduction in MIU staff of 2.6 wte.
- An increase in staffing of 9.5 wte for endoscopy.

The management of change requires close attention to supporting staff, communicating openly and in a timely manner, engaging with staff where possible in the decision-making process ensuring staff views are taken into account. Transition will be underpinned by the GHC Management of Change Policy which aims to ensure that the organisation has the right level of appropriately skilled colleagues organised in the right way to deliver a modern, responsive and efficient service to achieve improved patient care.

The Workforce workstream has a comprehensive plan to deliver the required changes within the two-year period assumed to achieve the planned staff reductions. It is anticipated that the endoscopy staffing requirement will largely be met through re-training of existing nursing staff.

There are a range of subsidiary workforce workstreams highlighted in the following table.

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Table 14: *Subsidiary workstreams contributing to the Workforce workstream*

	Workstream and lead	Objective
1	Management of change – Lead Faye Lynch	To ensure that the Trust follows our management of change policy appropriately and supports the workforce in the transition to the new hospital whilst limiting any employment risks.
2	Training – Lead Lucy Blandford	To ensure that Staff are able to transition to their new roles effectively
3	Recruitment and retention – Lead Faye Lynch + senior recruitment lead	To ensure that the new hospital is staffed as effectively as possible maximising the use of existing staff and limiting any redundancies and temporary staffing costs
4	Communications (internal) – Lead Matt Blackman	To support the timely and transparent communication with the affected workforce.
5	OD/Wellbeing support – Leads Linda Gabaldoni/Alison James	To ensure that staff who transition to the new hospital are given appropriate support prior to and after the move.
6	Workforce – Lead Andy Mills	To provide data to support the workforce planning process and ensure new structures and roles are on the Electronic Staff Record (ESR) and the 'e' rostering systems

Actions, target dates and responsibilities for each of these workstreams are set out below.

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Table 15: Workstream actions and target date

	Workstream	Action	Target date
1	Management of change	Review workforce plans Review of management of change policy Policy sub group Joint Negotiation and Consultative Forum (JNCF) Review Management of Change (MoC) policy and processes Plan MoC process for each area Implement MoC processes in a timely fashion	Quarterly June June/August 21 July/September 21 By December 21 Jan- March 22 June 22 onwards
2	Training	Review of workforce plans Analysis of new skills/technology needs Design new internal courses Agree/Contract external provision Courses on Care to Learn	December 21 February 22 March 22 March 22 August 22
3	Recruitment and retention	Review workforce plans Identify issues Design and agree retention packages Get job descriptions for new roles Evaluate Job descriptions Advertise new roles Recruitment of staff to bank	December 21 January 22 February 22 February 22 By June 22 Nov 22 – March 23 From Sept 22
4	Communications (internal)	Develop Frequently Asked Questions (FAQs) to align with Full Business case Develop internal Communications plan Delivery against Communications plan	June/July 21 July 21 August 21- June 23
5	OD/Wellbeing support	Agree orientation plans Agree team building plans Agree Wellbeing initiatives Implement plans	Sept 22 Sept 22 Sept 22 March – June 23

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6	Workforce	Provide up to date workforce data – review age profiles/LoS Set up new rosters Close old rosters Amend organisational structures in ESR and cost centres Process starters and leavers Process assignment changes	On-going/Quarterly Jan 23 As appropriate Jan 23 As appropriate As appropriate
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5.5.3 Communications and Engagement

Engagement around health provision in the Forest of Dean began in 2015, and the first formal consultation on the future of community hospital provision started in September 2017. Engagement and consultation have been predominately led by Gloucestershire Clinical Commissioning Group, with the Trust Communications and Engagement team and the Partnership and Inclusion teams working alongside to ensure a true partnership approach to the proposals. The Trust announced the new site for the hospital in October 2019 and the subsequent engagement with residents of Springfield Drive and the owners of other neighbouring properties is led by the Trust teams.

GCCG teams continue to lead ongoing work with the local community to review urgent care service options in the Lydney / South Forest area with the Trust now leading all elements of engagement associated with the new hospital development.

The aims of the Communications and Engagement workstream are to:

- Ensure a dialogue with service users, residents, stakeholders and colleagues to enable input and support in the design and development of the new hospital
- Maintain trust with colleagues, the community and stakeholders
- Maintain the reputation of the Trust,
- Ensure timely and factual updates on progress.

To support these goals, regular briefings with Forest colleagues and stakeholders will take place to ensure they are aware of significant developments in advance and to provide assurance and respond to any questions. The Trust has formed a working group with residents of Springfield Drive, on one boundary of the site, and liaises with owners on the other boundary.

We have engaged with the Forest of Dean Locality Reference Group which includes in its membership representatives from key patient and public groups including the Forest of Dean Health Forum, local Primary Care Practice Participation Groups and Healthwatch Gloucestershire. The group includes service specific representation, including Great Oaks Hospice, Dilke League of Friends, Friends of Lydney Hospital; Forest Voluntary Action Forum, Crossroads Care Forest of Dean; Forest Sensory Services and Gloucestershire Care Providers Association.

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The Communications and Engagement workstream reports to the Programme Management Board, and the Communications Plan is updated regularly.

Engagement undertaken during the development of the Full Business Case

A stakeholder mapping exercise was completed by the Communications and Engagement workstream in January 2021. This identifies stakeholders, risk around non-engagement, methods of engagement and planned frequency of contact and assigns responsibility to a specific lead for maintaining contact. This is being regularly monitored and updated.

Following the GCCG Governing Body meeting on Thursday 28 January 2021, a statement was released across the Trust and externally confirming the services to be commissioned at the new hospital.

In January and February 2021, engagement meetings were held with local neighbouring residents who might be affected by the construction work and the subsequent operation of the hospital. Recent communication activities have included:

- Internal Communications / stakeholder Communications / media release on the timeline for the FBC & July board meeting
- Skatepark update with Cinderford Town Council / Forest Urban Sports Experience (FUSE)
- Progress update for GHC Foundation Trust members via the Membership Newsletter
- Residents engagement meeting planned
- Presentation at the Forest of Dean Health Forum

Ongoing communication and engagement requirements

The Communications and Engagement Teams have responsibility for a number of key audiences including:

- GHC colleagues
- Other NHS providers (including GHFT, SWAST and Primary Care)
- Site neighbours
- Patients
- Forest residents

The team will be supporting Estates colleagues and wider planning team with engagement to fulfil the need for a statement of community involvement as part of the planning application for the new hospital, with that work anticipated in July 2021 and throughout the planning application process.

Significant ongoing activity is anticipated to maintaining regular updates on progress, provide key information internally and externally on future arrangements and ensure

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regular engagement with stakeholders throughout the build, including the transfer of services to the new site and engagement after the hospital is open.

5.6 Benefits realisation

The Benefits to be achieved by this investment can be categorised as follows:

- Benefits that will be realised through the agreed design and the satisfactory completion of the building – these will have been achieved in June 2023 when the building is commissioned.
- Benefits enabled by the building but requiring specific action to fully realise. Realisation will be over a period June 2023 to the end of 2025 (beyond the period of Programme Board oversight).
- Benefits as perceived by patients and staff using the building (these will be assessed by the end of the initial operational phase (September 2023 and again before project closure (January 2024).

Of these benefits, six contribute non-cash releasing or societal benefits in the economic model as set out in Section 2. Carbon saving and improved running costs will be immediately realised through the construction of the new hospital and the decommissioning of the existing hospitals as will the ability to isolate inpatients in their own rooms if required, leading to better infection control. Others depend on the service changes that will be enabled by the new building and the combined operation on one site. Some are within direct control of the Trust. Others (the establishment of endoscopy and the staffing of a sustainable x-ray service) rely on leadership from GHT.

All benefits are set out at Appendix 5.8 which aligns benefits to the Strategic Objectives (section 1.4). Key dates and actions are integrated into the Transition and Implementation Project Plan and risks recorded in the Transition and Implementation Risk Register (Appendix 5.7).

Benefits realisation will become a key responsibility of the Programme Board in the period leading up to the completion of construction, the transfer of services into the new facility and the initial period of operations (up to January 2024). Some benefits (e.g. the non-cash releasing benefits derived from the 7-day therapy on the wards) may not be fully realised (through changes in staffing structure and embedding of practice) until after the project comes under the governance of operational management in 2024.

The Programme Board will:

- Receive regular reports on the status of the inpatient, urgent care and estates staff teams as they prepare to merge and operate on one site through the regular reporting of the workstreams.
- Ensure that any relevant training needs have been identified for all staff who will operate from the new hospital and where appropriate training has

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commenced to ensure effective operation from the date of occupation of the new wards and building.

- Ensure that the integration of nursing and therapy on the wards will enable a 7/7 therapy input from an agreed time at or after occupation to ensure the benefit of effective discharge is quickly realised.
- Pass on to operational managers at the end of the Programme Board's life (January 2024) clear evidence of the realisation of benefits to date and a clear programme for ongoing realisation and maintaining the benefits already achieved.

Assessing the realisation of benefits is closely linked with post project evaluation (see 5.8 below). Built into the Transition and Implementation Project Plan are scheduled surveys to assess patient and user satisfaction relating to the bringing together of services in one place and the provisions for privacy, dignity and a dementia friendly environment. These will take place in September 2023 and in January 2024. Staff satisfaction in relation to the working environment, clinical space and adjacencies etc will also be assessed at the same time.

The Trust has an active engagement programme and demonstrates innovative ways of working with patients and carers including Experts by Experience. The exact form of survey or engagement will be agreed nearer the time and will be informed by the ongoing engagement of the Trust with the people of the Forest.

5.7 Project risks, mitigation and management

The Trust has a well-established approach to risk management which is set out in the Trust's Operation Risk Management Policy. The Trust has a Risk Management Framework in place to steer the way we identify, prioritise, manage and mitigate any risks we face. It ensures that the Trust tackles risk in a consistent way, with robust internal controls, and that every colleague understands their personal and collective risk-related responsibilities. This approach has been applied throughout the planning process for the Forest of Dean Hospital

The Programme Board will review programme risk registers on a monthly basis to ensure that all risks have appropriate mitigation strategies and that actions are completed to reduce the risks in a timely manner. Any new risks identified will be appropriately risk rated and assigned a senior risk owner and where appropriate escalated to the Assurance Committee for detailed review.

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5.7.1 Building design and construction risk register and mitigations

The Construction partner working closely with the Trust Associate Director of Estates, Facilities & Medical Equipment and Specialist Project Manager will pro-actively identify and manage additional risks as these emerge. The risks for **building design and construction** up to start of construction are set out at Appendix 5.6. complete with mitigation. The Programme Board will regularly review this risk register, making decisions as required and reporting to the Assurance Committee as and when this is necessary.

5.7.2 Transition and implementation risk register and mitigations

The Programme Board will be directly responsible for the **Transition and implementation risk register** and its mitigations, making decisions as required and reporting to the Assurance Committee where this is necessary (Appendix 5.7).

This is a live document that will be considered at every Programme Board meeting. Therefore, assessments of likelihood and impact will evolve over the course of the next two years. Currently the greatest risks include those at the point of transfer and commencement of new services. As preparations progress, these are likely to be downgraded. The Programme Board will also consider carefully risks associated with the delivery of services in the longer term including the realisation of benefits. The Programme Board will take into account systems developments and the overall environment for health and social care locally and nationally and will engage proactively with systems partners especially Gloucestershire Hospitals NHS FT and NHS Gloucestershire CCG.

5.8 Post project evaluation

The Trust is committed to evaluating both the project processes and the success of the investment created through this programme. The Trust has demonstrated its capacity to learn lessons from its previous investments in community hospitals in Gloucestershire.

The programme has already been engaged in the Design Quality Indicator Process (DQI). The process focuses on functionality, build quality and impact for healthcare buildings and is undertaken at various stages over a project's lifecycle.

On 15 January 2021, an externally facilitated session enabled a wide range of participants to complete the Concept Design Questionnaire stage of the DQI process. This informed the design at that stage of development. Although the design has changed since the DQI exercise, valuable feedback has informed the subsequent design. The Developed Design DQI will take place well before the end of RIBA Stage 4 in early August 2021 enabling feedback to be incorporated in the final design.

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It is anticipated that further stages of the DQI process will be undertaken including *Ready for Occupation* stage (around June 2023) and the *In-Use* stage DQI Process around November 2023. These are included in the implementation and transition project plan.

5.8.1 Project Implementation Review

The Project Implementation Review will be undertaken within two months of the completion of the building, its commissioning and the transfer of services to the new site in order to capture the lessons learnt. The process will be overseen by the Programme Board but where necessary independently facilitated.

Areas of focus will include:

- Effectiveness of the project structure, its ability to monitor progress and make the necessary decisions.
- Effectiveness of reporting, anticipating issues and identifying the impact of decisions.
- Distribution of work between workstreams and the capacity to undertake the work.
- Arrangements with the constructing partner and the effectiveness of the contract.
- Immediate lessons on cost and quality control.

5.8.2 The Post-Evaluation Review

A Post-Evaluation Review (PER) for reviewing how well the service is running and delivering its anticipated benefits will take place in a number of stages:

- At mid-point of the initial operational phase (September 2023).
- At the handover from the Programme Board to Operational management – January 2024.
- At additional stages beyond this, as required by the Benefits Realisation plan.

These reviews are included in the transition and implementation project plan.

Reviews of service implementation will also include assessment of any changes in patient use, flows and outcomes and will be informed by patient/user/carer surveys undertaken as part of the Benefits Realisation plan. The results of all reviews will be reported to the Assurance Committee and Trust Board.

5.9 Equality Impact assessment

As explained in the Strategic Case (see Section 1.6) Equality Impact Assessments were undertaken by or on behalf of NHS Gloucestershire and Gloucestershire Care Services as part of the planning and engagement process for the new hospital.

Forest of Dean Hospital FBC Conclusion

The independently produced *Equality Impact Analysis (EIA) for the location of a new community hospital in the Forest of Dean (2017)* recommended that the EIA process be developed further with the evolution of the project and this was reflected in further work undertaken by the CCG.

With the development of the new hospital, the Trust now takes responsibility for the ongoing Equality Assessment. This means continuing a process of “relevancy testing” with members of the Protected Characteristics as things change or as service operational design is finalised in the lead up to moving from the existing sites and occupying the new building. The Trust accepts that it cannot be assumed that it is always known who will be affected, in what way and why.

As an integral part of workforce development for the new services, The Trust HR and OD team will monitor the impact of changes on staff with relevance to staff characteristics, protected or otherwise and report to the Programme Board.

The Trust will engage with its range of users including members of Protected Characteristics in the development of Standard Operational Procedures for each service operating out of the new hospital in the 6-month period leading up to the opening of the hospital. The Trust will review operations with the same stakeholders in the period 6-12 months after opening to evaluate the impact and assess where changes to services may be required.

5.10 Conclusion to the Management Case

The Trust has robust programme and project management structures in place to ensure the appropriate levels of governance and assurance to be in place through the next stage of the design process through to construction and commissioning of the new hospital. The programme is led by a skilled and experience team and has appropriate oversight arrangements in place at both a Programme Board and Committee level to ensure delivery on time and within budget.

Conclusion

This FBC represents the culmination of over five years of planning and preparation and is a significant step change in the ability to provide a modern, fit for purpose environment and enhanced service facilities for the people of the Forest of Dean and beyond.

Investment in this new facility will enable the re-provision of services, and subsequent closure of the existing two community hospitals, namely Lydney & District Hospital and the Dilke Memorial Hospital

Forest of Dean Hospital FBC Conclusion

The new hospital is considered a key part of the wider investment proposed in the Forest of Dean to address primary and community infrastructure needs. And will deliver the services as set out in Gloucestershire Clinical Commissioning Group service strategy which was confirmed in January 2021.

This FBC demonstrates that the preferred option being taken forward from the OBC delivers a viable and affordable solution to meeting the requirements laid out in the case for change. The Trust has been presented a NTBEP price from its construction partner, Speller Metcalfe and has confirmed that these costs are affordable from a capital and revenue perspective. The economic modelling demonstrates that the scheme offers good VFM when compared to business as usual.

This FBC is therefore commended to the Trust Board for approval to enable the progression of developing a new community hospital in the Forest of Dean.

Forest of Dean Hospital FBC Glossary

Glossary

ABBREVIATION	MEANING
ARU	Assessment and Rehabilitation Unit
BAME	Black and Minority Ethnic
BREEAM	Building Research Establishment Environmental Assessment Method
CIA	Comprehensive Investment Appraisal
CIC	Community Interest Company
CDEL	Capital Delegated Expenditure Limit
COVID	Coronavirus Disease (COVID-19)
CQC	Care Quality Commission
DCF	Discounted Cash Flow
DDA	Disability Discrimination Act
DQI	Design Quality Indicator
ED	Emergency Department
EIA	Equality Impact Assessment
ESR	Electronic Staff Record
EV	Electric vehicle
FAQ	Frequently Asked Questions
FBC	Full Business Case
FB Forms	Full Business Case Forms
FF&E	Furniture, Fittings and Equipment
FoD	Forest of Dean
FoI	Freedom of Information
FM	Facilities Management
GCCG	Gloucestershire Clinical Commissioning Group
GCG	Gloucestershire County Council
GCS	Gloucestershire Care Services NHS Trust
GDP	Gross Domestic Product
GHC	Gloucestershire Health & Care NHS Foundation Trust
GHT	Gloucestershire Hospitals NHS Foundation Trust
GIFA	Gross Internal Floor Area
GMP	Guaranteed Maximum Price
GP	General Practice
H1	Half Year 1
HBN	Health Building Note

Forest of Dean Hospital FBC Glossary

ABBREVIATION	MEANING
HOLD	Hands off Lydney and Dilke
HR	Human Resources
HTM	Health Technical Memorandum
I&E	Income & Expenditure
ICS	Integrated Care System
ICT	Integrated Care Team
ILP	Integrated Locality Partnership
IPC	Infection Prevention & Control
IT	Information Technology
JAG	Joint Advisory Group for GI Endoscopy
JCT	Joint Contracts Tribunal Limited Contract
JNCF	Joint Negotiation and Consultative Forum
LoS	Length of Stay
MEP	Mechanical & Electrical Plant
M&E	Mechanical & Electrical
MIIU	Minor Injury and Illness Unit
MMC	Modern Methods of Construction
MoC	Management of Change
NEC	New Engineering and Construction Contract
NCRB	Non Cash Releasing Benefit
NHS	National Health Service
NHSEI	NHS England/Improvement
NPSV	Net Present Social Value
NTBEP	Not To Be Exceeded Price
OBC	Outline Business Case
OGC	Office Government Commerce
OJEU	Official Journal of the European Union
PCN	Primary Care Network
P22	Procure 22 Framework
PER	Post Evaluation Review
QALY	Quality Adjusted Life Year
QS	Quantity Surveyor
RIBA	Royal Institute of British Architects
S106	Section 106 Planning Condition
SOC	Strategic Outline Case
SoFP	Statement of Financial Position
SRO	Senior Responsible Owner

Forest of Dean Hospital FBC Glossary

ABBREVIATION	MEANING
SWAST	South Western Ambulance Services NHS Trust
VAT	Value Added Tax
VFM	Value for Money

FOREST OF DEAN ASSURANCE COMMITTEE SUMMARY REPORT

DATE OF MEETING 23 June 2021

COMMITTEE GOVERNANCE	<ul style="list-style-type: none"> • Committee Chair – Steve Brittan, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes
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KEY POINTS TO DRAW TO THE BOARD’S ATTENTION

DESIGN UPDATE

The Committee received an update on the proposed design of the Forest of Dean (FoD) hospital, which included an artist’s impressions of what the hospital would look like. The final designs developed in consultation with key stakeholders including services leads, hospital matrons and clinical staff. The Committee was assured the ground floor designs satisfied the requirement for therapies to have access to outside/external space and that the proposals for the first floor of the hospital were as optimal as possible, and guaranteed each of the bedrooms would have an external window. The decked area would provide accessible outdoor space - ensuring safe access for dementia patients.

The Committee noted the update provided.

CONSTRUCTION COST UPDATE

The Committee received a presentation providing an update on the Construction Cost to date. It was reported that the overarching construction cost of the project was £23.3m which were slightly higher than was originally anticipated in May. This increase was largely due to inflation costs within the construction industry and the rise in the cost of steel. An additional risk allowance of £150k had been added to the costings.

The Committee considered the predicted cashflow and profile over the next three years. It was noted that the position had slightly improved for the 22/23 from the previous estimation. The Committee was informed of the work being undertaken by the Estates Team and Speller Metcalfe on the pre-construction agreement and was assured that the Guaranteed Maximum Price (GMP) remained in the Trust’s financial envelope.

The Committee **noted** the update.

APPROACH TO SUSTAINABILITY

The Committee received the Approach to Sustainability Report, which provided an overview of discussions which had taken place with Speller Metcalfe in relation to the project’s approach to sustainability and the approach to BREEAM accreditation.

It was recognised that the BREEAM accreditation standards significantly predate current best practice in low-carbon building design and operation. Nevertheless, BREEAM accreditation is currently a mandatory requirement by NHS England for all new building projects, and therefore the Trust is obliged to incur the costs of BREEAM accreditation.

It was reported that the criteria for each BREEAM credit had been reviewed and assessed for sustainability and the report compared best practice for the design against the process for BREEAM accreditation to “excellent” level.

The Committee **agreed** that the current approach to BREEAM accreditation was appropriate but would be kept under continuous review.

HEAD OF TERMS – NOT TO BE EXCEEDED PRICE AND INFLATION RISKS

The Committee received and noted the Head of Terms – *Not to be Exceeded Price* providing an overview of the current discussions that had taken place with Speller Metcalfe on the development and associated terms for *not to be exceeded price* which would be included in the FBC.

The Committee received an overview of discussions with Speller Metcalfe in relation to inflation risk and the impact on the current construction market. The Committee considered whether an additional level of contingency should be included within the costings to allow mitigation to any further inflation due to material uncertainty. The paper included an overview of inflation allocation within the costings and associated risks in terms of current market volatility.

The Committee agreed that taking a cautious approach to inflationary pressures would be advisable.

DRAFT FULL BUSINESS CASE

The Committee received the Draft Full Business Case (FBC), noting the progress made in developing the FBC to date.

The Committee **noted** the version of the Full Business Case and provided feedback.

OTHER ITEMS RECEIVED:

- The Committee **received** and **noted** the risk register.
- The Committee **received** the Critical Path Timeline and **noted** the proposed timeline and ongoing activities to develop the programme of works.
- The Committee **received** the FoD Programme Board update report.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	TBC
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**Development of a New Community Hospital for the Forest of Dean
Full Business Case
Table of Appendices**

Appendix Reference:	Title
0.1	Outcome of Consultation January 2021
0.2	FoD Service Strategy Update
0.3	Support from System Partners
1.1	Bed Modelling for Gloucestershire
1.2	EIA Report for FoD
2.1	Life Cycle Costs
2.2	FB Forms
2.3	Draft Travel Plan
2.4	Ecological Report
2.5	Schedule of Accommodation
5.1	Terms of Reference for the Programme Board
5.2	Terms of Reference for the FoD Assurance Committee
5.3	Change Control Procedure
5.4	Construction Project Plan
5.5	Transition and Implementation Project
5.6	Building and Design Risk Register
5.7	Transition and Implementation Risk Register
5.8	Summary of Benefits
5.9	Planned Changes to Staff Structure



Output of Consultation Report: January 2021

A new hospital for the Forest of Dean



Fit for the Future: A new hospital for the Forest of Dean Consultation

1. Executive Summary

The *A new hospital for the Forest of Dean* Output of Consultation Report is intended to be used as a practical resource for NHS Gloucestershire Clinical Commissioning Group (CCG) and Gloucestershire Health and Care NHS Foundation Trust (GHC); to provide them with information about how the public, community partners and staff feel about the range of services proposed for the new hospital, in order to inform their decision making in 2021.

The new hospital in the Forest of Dean is part of the wider ambitions of One Gloucestershire; a partnership between the county's NHS and care organisations to help keep people healthy, support active communities and ensure high quality, joined up care when needed. The NHS partners of One Gloucestershire are:

- NHS Gloucestershire Clinical Commissioning Group (CCG)
- Primary care (GP) providers
- Gloucestershire Health and Care NHS Foundation Trust
- Gloucestershire Hospitals NHS Foundation Trust
- South Western Ambulance Services NHS Foundation Trust

This Report will be shared widely across the local health and care community and is available to all on the Forest of Dean health website www.fodhealth.nhs.uk and on the new online participation platform Get Involved in Gloucestershire <https://getinvolved.glos.nhs.net>

We would like to thank everyone who has taken the time to share their views and ideas.

'Consultation: The dynamic process of dialogue between individuals or groups, based upon a genuine exchange of views and, with the objective of influencing decisions, policies or programmes of action'.

The Consultation Institute (2004)¹

The Governing Body of **NHS Glos CCG** and Board of **GHC** are invited to consider the feedback from the Consultation and indicate how it has influenced their decision making. Full details of the next steps for the development of the new hospital can be found in Section 2.3.

This Report has been prepared by the One Gloucestershire Communications and Engagement Group. This report is produced in both print and on-line (searchable PDF) formats. For details of how to obtain copies in other formats please turn to the back cover of this Report.

¹ The Consultation Institute: <https://www.consultationinstitute.org/beware-wholly-inadequate-definition-consultation/#:~:text=Since%202004%2C%20the%20Institute%20has,policies%20or%20programmes%20of%20action>

1.2 Consultation key facts

- 3,400 Consultation booklets distributed, 495 requests for information following door-to-door leaflet distribution.
- 20 consultation events.
- More than 250 socially distanced contacts with members of the public & community partners and over 100 with staff.
- 10 Facebook posts with a reach of over 56,000 and 200 'engagements'.
- 8 tweets generated over 7,000 impressions and 100 'engagements'.
- 554 consultation surveys completed, plus additional written responses.

1.3 Summary of feedback

The summary of feedback uses the following sources of consultation feedback:

- Analysis of 554 completed surveys
- Themes from other forms of responses including: correspondence (including formal responses), events, social media and responses to an alternative survey developed by a local campaign organisation
- Themes from face-to-face Information Bus Tour visits
- Themes from targeted consultation activities, taking account of groups identified through the Equality Impact Assessment
- Detailed feedback from all of these consultation activities can be found in Section 5.2

Based on quantitative analysis the feedback to the consultation is less supportive of the proposals for inpatient care and urgent care and more supportive of the proposals for diagnostic and outpatient services. The strength of support across all services is dependent upon the individual respondent's or groups of respondents' geographical partiality. Respondents from the south of the district are less supportive of the proposed services for the new hospital than those in the central and northern parts of the Forest of Dean.

Qualitative feedback notes the benefit of providing services from an improved facility in the Forest of Dean, rather than having to travel to Gloucester or Cheltenham. Concern is voiced about access to the new hospital from Lydney and the south of the Forest, and the ability to provide services from a single site, whilst the population in the Forest of Dean is continuing to increase. Many of the comments made focussed on issues outside of the Consultation;

- the decision to provide one new hospital which would result in the closure of the existing hospitals; and
- the agreed location for the new hospital.

In terms of the reach of the consultation, demographic information is known about those survey respondents who chose to provide 'About You' information in their survey responses; approximately 27% of respondents did not complete the 'About You' information.

Targeted activities aimed to extend the reach of the Consultation and collect data on all protected groups, as recommended in earlier Equality Impact Assessments. Analysis of the survey responses shows there is a broad representation of most groups. Further analysis of responses by various demographics, e.g. age, gender, health and care professionals, does not show any significant variation when compared with the overall themes.

During the consultation participants also took the opportunity to access information, ask questions and comment on the national and local response to the coronavirus pandemic. Many people expressed their gratitude to NHS and care staff and recognised Gloucestershire's diverse communities' mutual acts of support for colleagues, friends, families and neighbours.

A detailed summary of feedback received can be found in Section 5.2. All feedback received can be found in the Appendices to this Report.

1.4 Making the best use the information provided in this Report

There are elements of feedback which will be relevant and of interest to all readers; these can be easily found in the main body of the report. The theming of the qualitative feedback presented in this report has been undertaken by members of the One Gloucestershire Communications and Engagement Group.

All feedback relating to the specific services can be found in a series of online Appendices. These Appendices include all comments collected including copies of individual submissions received in addition to the FFTF survey responses.

Some respondents may have answered the formal consultation survey as well as giving feedback in other ways, such as sending a letter, participating in a discussion event. All feedback received has been read and summarised and had been coded into themes such as: 'access', 'capacity' and 'quality'. Please note that individuals comments may cover more than one theme.

We acknowledge that such an exercise includes a subjective element and we recognise that others may have chosen to place items of feedback under alternative themes. To provide assurance, all qualitative written feedback from both survey respondents, comments and individual correspondence received and collated by representatives of **One Gloucestershire** partners during the consultation period is included within this report and/or the online Appendices.

1.4 Appendices

All appendices are available at: www.fodhealth.nhs.uk

Appendix 1: Survey analysis

- i) Full survey
- ii) Easy Read
- iii) Responses by geography: Central, North, South
- iv) Response by other demographics:
 - a. age,
 - b. carer,
 - c. disability,
 - d. ethnicity,
 - e. gender,
 - f. health or care professional
 - g. members of the public & community partners,

Appendix 2: Other feedback/correspondence:

- i) public responses;
- ii) responses from elected representatives and political parties
- iii) Primary Care Network
- iv) Forest of Dean District Council

Appendix 3: Equality and Engagement Impact Assessment

2 Introduction

2.1 A new hospital for the Forest of Dean

Following a period of Consultation in 2017, the Board of Gloucestershire Care Services NHS Trust (now Gloucestershire Health and Care NHS Foundation Trust; GHC) and the Governing Body of NHS Gloucestershire Clinical Commissioning Group (CCG) approved the option to build a new community hospital in the Forest of Dean. This new hospital will replace The Dilke Memorial Hospital and Lydney and District Hospital.

A Citizens' Jury, made up of local people, met over four days in August 2018. Having reviewed extensive information, they recommended that the new hospital should be located in Cinderford. This recommendation was formally approved by the CCG and GHC.

Further engagement with local people and staff during 2019 has informed the services for the new hospital as proposed through this Consultation. The site for the new hospital was announced in December 2019 as the Collingwood Skatepark and Lower High Street Playing Field in Steam Mills Road, Cinderford.

2.2 Public and staff consultation programme

What the Consultation is about

The public and staff consultation programme started on 22 October 2020 and ran until 17 December 2020. The purpose of the consultation is to seek views on the range of services provided at the new hospital for the Forest of Dean:

- Inpatient care
- Urgent care
- Diagnostic services
- Outpatient services

All feedback received is collated into this comprehensive Output of Consultation Report and online appendices and will be used to inform the decisions about the future of local NHS services.

During the last phase of engagement, concerns were raised around the availability of urgent care in the southern areas of the Forest and the challenge for residents in terms of distance and accessibility to the new hospital in Cinderford. Alongside this Consultation, there is a public commitment to explore if it might be possible to develop other options for the provision of additional urgent care services in the Lydney area. Comments regarding this are also included in the Output of Consultation Report.

What the Consultation is not about

This Consultation is not about the decision to move to a single community hospital for the Forest of Dean. Nor is it a consultation on the location of the new hospital, which was approved following a recommendation by a Citizens' Jury in August 2018. However, people completing the survey have taken the opportunity to comment on both of these decisions and this is noted in the Sections 5.2 and 5.3 of this Report

Consultation process

There have been a number of innovative ways the NHS has involved local people and staff over the past few months from online events, to a 'socially distanced' Information Bus Tour to a door-to-door mail-drop to all households in Gloucestershire. Full details of the consultation process can be found in Section 3.

This Consultation is the latest element of the review of health and care services in the Forest of Dean², which began in September 2015.

2.3 Next Steps: What happens next?

Consultation review period

There will be a consultation review period, where NHS Gloucestershire CCG and GHC will carefully consider all of the feedback received at their Governing Body and Board meetings in January and March 2021 respectively.

Decision

The feedback will be used to inform the CCG in commissioning future hospital services in the Forest of Dean, as set out in this Consultation. If the proposals are supported by the CCG Governing Body i.e. the services that will be provided will be confirmed within a commissioning specification, GHC will finalise a formal business case setting out the benefits, the design specification and financial plan for the building and ongoing operation of the new hospital.

The final business case will need approval from the Board of GHC. It is anticipated that this approval will be considered at the Trust's board meeting in March 2021.

Process of implementation

Following approval of the business case, GHC will need to seek full planning permission before construction can begin. Services will remain at The Dilke Memorial Hospital and Lydney and District Hospital until the new hospital is opened.

² **Previous engagement:** <https://www.fodhealth.nhs.uk/consultation/>

Providing feedback to you on the consultation and decisions

The feedback from the consultation and the final decisions made by the CCG Governing Body and Board of GHC will be published at: <https://www.fodhealth.nhs.uk/consultation/> and shared on the online participation platform Get Involved in Gloucestershire <https://getinvolved.glos.nhs.uk>

3 Our approach to communications and consultation

3.1 Working with others

Planning and delivery of the consultation has been supported by many external groups:

- Forest of Dean Locality Reference Group: helped refine our plans for Consultation and raise awareness of the Consultation with their local networks.
- The Consultation Institute: The Consultation Institute provides advice and guidance in relation to all aspects of consultation planning and activity.
- Gloucestershire Health and Care NHS Foundation Trust (GHC) : Assisted with the development of Easy Read materials.
- Healthwatch Gloucestershire (HWG): HWG Readers Panel reviewed an early draft of the full consultation booklet and made suggestions for changes, which were incorporated into the final version.
- Community Connectors³: This forum allowed us to share information at their online meeting during November to promote the Consultation.
- District/Town Council and Retail partners: Supported the 'socially distanced' visits of the Information Bus (outside of Lockdown 2) to locations with maximum footfall across the Forest of Dean.
- Others: Many other groups and individuals have helped to raise awareness of the consultation.

Thank you to everyone who has supported this consultation.

³ Community Connectors: Facilitated by Forest Voluntary Action Forum, this group of community partners was established as a response to the current pandemic.

3.2 Covid 19: Socially distanced consultation

In order to maximise opportunities to raise awareness of the consultation and opportunities to get involved the following methods were used:

Door to Door mailer

The NHS commissioned the Royal Mail to deliver a mailer to all households in Gloucestershire. The mailer gave brief information about the Forest of Dean Community Hospital consultation and the Fit For the Future consultation, which has been running concurrently. The mailer included a freepost reply slip to request information in a range of formats, or ask for a telephone call.

- 833 mailers were returned in total (before the Consultation closed)
- 1,743 requests for information (1,286 items posted)
 - FoD CH (495)
 - Full booklet 308 (239 sent by post)
 - Easy Read 187 (145 sent by post)
 - FFTF (1248)
 - Long 226 (162 sent by post)
 - Short 587 (415 sent by post)
 - Easy Read 256 (193 sent by post)
 - Pre-Consultation Business Case 180 (132 sent by post)
- 116 requests for telephone call backs
 - FOD CH (33)
 - FFTF (83)

In addition, households in Springfield Drive, Cinderford, (which neighbours the site for the new hospital) received a letter from Gloucestershire Health and Care NHS Foundation Trust, updating them on the consultation.

3.3 Developing understanding and supporting the consultation

This section describes the wide ranging approach taken to promote the Consultation and the range of involvement opportunities. In summary:

Media releases and stakeholder briefings

This included:

- launch materials – media release and stakeholder briefing
- media statements reinforcing key messages and involvement opportunities
- materials sent by post to 334 GHC Foundation Trust Members living in the Forest of Dean and emailed to all 6095 Members across the county.

Hardcopy engagement booklets

3,400 booklets were widely distributed to a range of public places including community pharmacies, GP surgeries, hospitals and libraries. The booklets included the survey and information detailing the ways people could get involved.

‘Consultation’ area on the FODhealth website and Get Involved in Gloucestershire online participation platform

All consultation materials can be found at: <https://www.fodhealth.nhs.uk/>

Get Involved in Gloucestershire is an online participation space where anyone can share views, experiences and ideas about local health and care services. Information about the consultation including activities can be found at <https://getinvolved.glos.nhs.uk/fit-for-the-future11>

Social media

Social media was used to support the consultation and planned activity covered topics such as promotion of how people could get involved, Information Bus Tour and Cuppa and Chat events and promotion of the booklet and survey.

Facebook

During the engagement there were 7 Facebook posts (non-paid for activity), with a total reach of 30,077. There were 177 ‘engagements’ with these posts (i.e. actions such as comments, likes or shares) of which 72 were shares. There were also three paid-for adverts that linked to the Consultation section on the FOD health website. They achieved a reach of 26,280 with 23 shares.

Twitter

During the Consultation period there were 8 tweets, with a total of 7,198 impressions. There were 109 ‘engagements’ with these tweets (i.e. actions such as link clicks, retweets, likes, or comments) of which 17 were retweets and 55 were clicks through to the FOD health website.

3.4 Staff communication and engagement

Gloucestershire Health and Care NHS Foundation Trust

Information regarding the Consultation was shared with all Trust staff. In addition, four online Teamtalk sessions were held for staff working in the Forest of Dean. These were attended by 83 members of staff in total.

Primary care (GP practices) and NHS Gloucestershire Clinical Commissioning Group (CCG)

The Forest of Dean hospital and Fit for the Future consultations have been regularly promoted to all staff working at NHS Gloucestershire Clinical Commissioning Group and in GP

practices, Primary Care Networks and the Local Medical Committee via the Primary Care Bulletin. The Primary Care Network have submitted a response to the consultation, which is detailed in Section 6.

3.5 Elected Representatives

Members of Parliament

Regular MP briefings have taken place prior to and during the Consultation period.

Gloucestershire County Council (GCC)

Gloucestershire County Council Health Overview and Scrutiny Committee Members have received regular updates on the Consultation. Consultation materials have been available to elected members and staff.

Forest of Dean District Council

An online Members Seminar was held on 1st December and attended by 14 representatives. Following a presentation, members had the opportunity to participate in a Question and Answer session.

The Council has submitted a motion regarding hospital and primary care facilities in the Forest of Dean to the CCG; *This Council fundamentally believes that the entire future of Forest Hospitals and indeed Primary Care facilities needs to be revisited in light of the Covid emergency and mindful that the greater proportion of new build expansion is destined for the South Forest Area.* The full submission is included in Appendix 2

3.6 Other community stakeholders and the public

Surveys

Two surveys (standard and Easy Read) were developed by the NHS to support the Consultation. These were available as print, FREEPOST return copies in the Consultation booklets and also on line at: <https://www.fodhealth.nhs.uk/consultation/> and <https://getinvolved.glos.nhs.uk/fit-for-the-future11>

- A total of 554 completed surveys have been received; 497 full surveys and 57 Easy Read. Most of these were completed online, but 45 full surveys and 20 Easy Read surveys were received as paper versions.
- 45 individuals who responded to the survey identified themselves as health or care professionals.

Other surveys and petitions

HOLD (Hands off Lydney and Dilke hospitals)

What is HOLD?

The HOLD (Hands off Lydney and Dilke hospitals) campaign was launched during an earlier Consultation. In the 'About' section of their Facebook page, the group note they are:

"Campaigning to retain at least two community hospitals in the Forest of Dean, against the sell-off and closure of the Dilke and Lydney hospital sites and demanding investment, not a single, smaller, new hospital".

A letter to Gloucestershire Health and Care NHS Foundation Trust is available for download on the HOLD Facebook page. HOLD are asking people to sign and send the letter to the Trust. A copy of the letter is included in Appendix 2. 20 adapted versions of the HOLD letter, have been received by the Trust.

Petitions

At the time of writing no petitions relating to the new hospital in the Forest of Dean have been received by either the CCG or GHC.

Other correspondence

Additional emails and letters have been received during the consultation.

- 3 letter responses were received.
- 10 email responses were received.

These are collated (redacted as appropriate) in full at Appendix 2.

Events

NHS Information Bus Tour

The Information Bus aims to facilitate partnership working, offering information and activities which support self-care, health and wellbeing and self-management across the communities of Gloucestershire. The Bus is also used a consultation resource to support engagement with the public to inform service planning and design.

An Information Bus Tour to raise awareness of the new hospital in the Forest of Dean and the Fit for the Future consultations commenced on 2 November 2020. Unfortunately due to new Covid-19 restrictions introduced from 5 November 2020, planned Information Bus Dates originally planned for November 2020 were cancelled. Three events had been held prior to lockdown.

Additional Information Bus Tour dates were planned for after 2 December 2020, when lockdown in England ended. The Bus recommenced its Tour on 1 December 2020 in Chepstow, Monmouthshire (where lockdown was not in place) and in Cheltenham on 3 December 2020.

See Section 3.7 for details of all Information Bus Tour dates. 92 people visited the Bus during events in the Forest of Dean.

Cuppa and Chats

When the Information Bus Tour was paused in November 2020, locality and countywide online 'Cuppa and Chats' were set up to replace the socially distanced face-to-face visits planned. These took the form of a short presentation (including showing of a promotional film) followed by a shared discussion.

The sessions were initially organised at Microsoft Teams meetings, in response to feedback from public participants, the sessions were moved to an alternative platform, Zoom, which is more frequently used by community partners.

Two Cuppa and Chats specifically relating to the new hospital Forest of Dean Consultation were hosted reaching 12 participants.

Targeted activities

In addition to the main consultation activities, the consultation sought feedback via community partners and groups identified in the Equality Impact Assessment. Further analysis of responses by various demographics, e.g. age, gender, health and care professionals, does not show any significant variation when compared with the overall themes.

3.7 Consultation events activity timeline

Week	Engagement activity	Number engaged with
15 October	Gloucestershire Health & Care NHSFT - online awareness raising session for staff based in Forest	15
22 –28 October	Health Overview and Scrutiny Committee (HOSC)	15
29 October – 4 November	Information bus – Cinderford, Co-Op (Forest of Dean)	22
5 – 11 November	Gloucestershire Health & Care NHSFT – Staff Teamtalk session	25
	PPG Network	25
	Gloucestershire Health & Care NHSFT – Staff Teamtalk session	19
12 – 18 November	Health Overview and Scrutiny Committee (HOSC)	15
	Forest of Dean Locality Reference Group	13
	Forest of Dean Community Connectors/KYP	17
19 – 25 November	Cuppa and Chat - Forest of Dean (using Zoom)	10
26 November – 2 December	Information bus - Chepstow	17
	BAME C19 Task and Finish Group	12 attendees – info circulated to full membership
	Forest of Dean District Council briefing	14
3 – 9 December	Information bus – Lydney, Newerne Street car park (Forest of Dean)	32
	Cuppa and Chat - Forest of Dean	2
	Forest of Dean Primary Care Network	19
10 - 17 December	Gloucestershire Health & Care NHSFT - online Q&A session for staff based in Forest	10
	Gloucestershire Health & Care NHSFT – Staff Teamtalk session	28
	Information bus - Coleford Clock Tower (Forest of Dean)	38
	Gloucestershire Health & Care NHSFT – Staff Teamtalk session	11

4. Equality and Engagement Impact Assessment (EEIA)

Equality, diversity, Human Rights and inclusion are at the heart of delivering personal, fair and diverse health and social care services. All commissioners and providers of health and social care services have legal obligations under equality legislation to ensure that people with one or more protected characteristics⁴ are not barred from access to services and decision making processes

The consultation has been informed by the experiencing of managing earlier extensive engagement activities. During earlier engagement relating to the location of the new hospital, an independent Equality Impact Assessment was commissioned. The plan for the consultation was informed by the feedback from these engagement activities, including feedback from NHSE/I Assurance process.

Extract from NHSE/I Assurance Process feedback in relation to communications and engagement:

- The engagement output report shows that the team have really given people every opportunity to take part in the engagement programme and the resulting output report is very extensive. Full credit for openness and transparency
- In response to COVID-19 restrictions the Strategy and Plan has been designed to support a 'socially distanced' consultation. It includes an Appendix/Briefing which summarises recent advice and guidance regarding online consultation, sets out assumptions and considerations and makes the following observations and conclusions, which will be taken into account during the consultation:
- Consideration to be paid to online deliberation and engagement are those you should pay attention to regardless of whether engagement is face to face or online. Things such as feeling safe, ensuring transparency and that participants have the facts to be able to make an informed decision would apply regardless of how you engage.
- Online consultations prove to be most successful when used in conjunction with offline methods such as telephone structured interviews/market research techniques/managed exhibitions.
- Two-way direct communication is crucial in creating meaningful dialogue – video conferencing software (Zoom, Microsoft Teams etc.) can facilitate this.
- Online forums should be moderated to keep discussion topics organised and to keep participants safe.
- Think about varying the times of online events – avoid excluding working age participants.

⁴ It is against the law to discriminate against someone because of: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex, sexual orientation. These are called protected characteristics. <https://www.equalityhumanrights.com/en/equality-act/protected-characteristics>

- Online events should be no longer than 2 hours and comfort breaks should be scheduled.
- Use creative and interactive dialogue methods for online and offline activities.
- Paper surveys should be replicated as online surveys.
- Some individuals or groups feel more comfortable sharing their thoughts on their own platforms, rather than official channels designed explicitly for themed discussions.
- Different marketing messages required to encourage online participation for ‘always’ (compete with other opportunities), ‘seldom’ (relevance, links to pandemic interests) and ‘never’ online (other opportunities or assistance required).

4.1 Consulting people with protected characteristics and others identified in the Equality and Engagement Impact Assessment

The consultation took two main routes to reach, gather and record views from people with protected characteristics and others identified in the EEIA:

- promoting the formal consultation routes and encouraging participation. The consultation survey asks for respondents to provide demographic information (see Section 5.1) We have extended these questions in response to the recommendations of the independent Equality Impact Assessment undertaken in 2018.
- proactive consultation with targeted groups. The consultation team contacted groups across Gloucestershire using existing well established networks, Community Connectors and Your Circle <https://www.yourcircle.org.uk/>, (an online directory to help you find your way around care and support and connect with people, places and activities in Gloucestershire).

The Consultation was open to all and consultation activities were designed to facilitate feedback from as wide a cross-section of the local community as possible. The full Equality and Engagement Impact Assessment (EEIA) of the planned consultation activities is available at <https://www.fodhealth.nhs.uk/wp-content/uploads/2020/10/Equality-and-Engagement-Impact-Assessment-FOD.pdf>

Groups potentially impacted, issues identified and actions taken

Our aim with this consultation was to reach a good representation of the local population, whilst making sure we hear from those groups who might be most affected by the proposed changes. We will seek out the views of people from the groups set out below, to gain a better understanding of the potential impact on them and to identify ways to lessen any potential negative impacts:

- Over 65s who are more likely to have long term conditions such as cardiovascular disease, obesity or diabetes and are higher users of community hospital services.
- People from BAME communities

- People living with a disability (includes physical impairments; learning disability; sensory impairment; mental health conditions; longterm medical conditions).
- Adult Carers/Young Carers
- People living in low income areas.
- LGBTQ+ people

Issues identified and action taken (as noted in the EEIA)

Less information, less jargon and easy read

The Consultation booklet has been reviewed by the Healthwatch Gloucestershire Lay Readers Panel. An Easy Read version of the consultation booklet and survey has been produced by Gloucestershire Health and Care NHS Foundation Trust.

Further engagement to address the homogeneity of participants

Targeted opportunities for consultation with protected characteristic groups identified through the EEIA e.g. via Voluntary Sector organisations, Carers Forum, etc. Alternative formats of all consultation materials available on request. Contract in place with telephone (and face to face) interpreters, incl. BSL and for written translation. An introduction to the Consultation, with information about support to enable people to participate, was sent to the Forest of Dean Talking Newspaper.

Paper surveys should be replicated as online surveys

Surveys made available on line in regular and easy read formats. People have also been offered assistance to complete surveys over the telephone.

Different marketing messages required to encourage online participation for ‘always’ (compete with other opportunities), ‘seldom’ (relevance, links to pandemic interests) and ‘never’ online (other opportunities or assistance required).

A variety of forms of media, print, broadcast, and social media platforms were used. A ‘mailer’ has been delivered to all households in Gloucestershire telling them about the two consultations and how they can get involved.

Liaise with community leaders to encourage participation from the BAME communities, providing support for interpreters

Working through community partners, including BAME communities, we aimed to promote opportunities for participation in the consultation. Consultation materials were available in alternative languages on request.

Use creative and interactive dialogue methods

We used a range of communication and consultation methods: Online, face-to-face (socially distanced), telephone, written.

Online consultations prove to be most successful when used in conjunction with offline methods such as telephone structured interviews/market research techniques/managed exhibitions.

We hosted a range of online activities and chat forums via Zoom and our Get Involved in Gloucestershire platform. We invited people to request a booked telephone interview. Although restricted due to Covid19 lockdown measures, we were able to use our Information Bus across the county, visiting three of the market towns in the Forest of Dean.

Online forums should be moderated

The Forum function of the Get Involved in Gloucestershire online participation platform is independently moderated.

Varying the times of online events

Events were held at different times of day and different days of the week.

Events, e.g. workshops, no longer than 2 hours

All scheduled online events were no longer than 90 minutes. Online events were informal and participants encouraged to take a comfort/refreshment break as required.

Some individuals or groups feel more comfortable sharing their thoughts on their own platforms, rather than official channels designed explicitly for themed discussions.

We were able to offer a range of platforms, to ensure they worked best for the individual or group: Zoom, Face Time, Microsoft Teams, Webex. Following feedback from participants, our Cuppa and Chat sessions were switched to Zoom. We were also able to offer more traditional methods such as telephone calls: we successfully followed up 33 requests for telephone calls.

Target groups identified through the EIA

We promoted the Consultation to representatives from the groups identified through the EEIA process and in conjunction with the Fit for the Future Consultation that was being undertaken simultaneously, sought advice to encourage participation, eg. Advice from the Homeless Healthcare Team, Carers Hub, Age Uk and other community partners.

5. A new hospital for the Forest of Dean: Survey Responses

All written feedback received via the two Consultation surveys (redacted for personally identifiable information e.g. names) can be found in Appendix 1.

5.1 Respondents to the survey

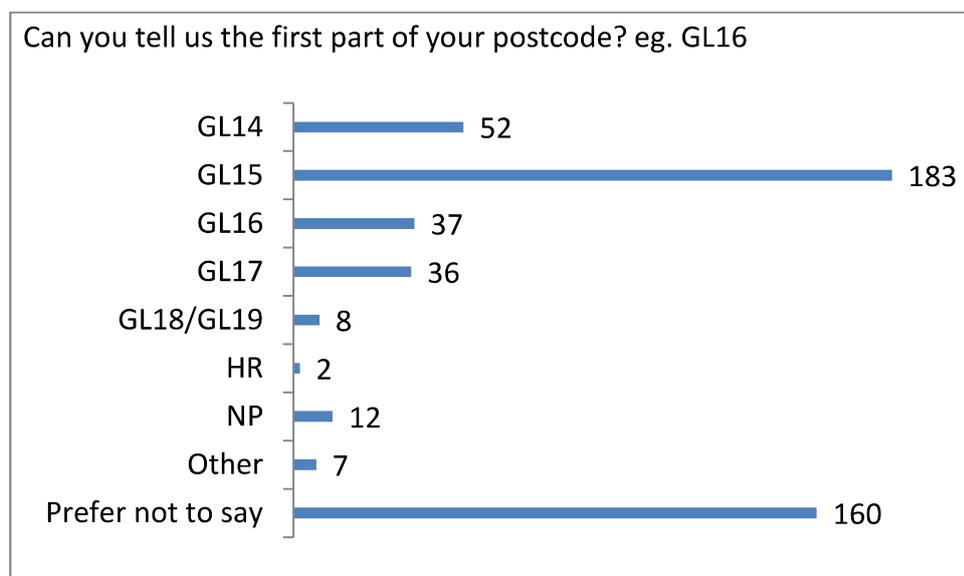
Demographic information about respondents was collected through the survey. Monitoring of equality data requires a two-stage process: data collection and analysis. Gathering good equality data supports legislative requirements in that it aids prevention of discrimination. This is why it is really important to provide an explanation that the process is worthwhile and necessary.

The survey included the following statement:

About You: Completing the “About You” section [of the survey] is optional, but the information you give helps to show that people with a wide range of experiences and circumstances have been involved. Your support with this is really appreciated.

Not everyone who responded to the survey completed any/all of the demographic questions. However, the data presented below indicates that a diverse range of respondents, including those groups identified in the Equality and Engagement Impact Assessment, have provided feedback to the consultation.

Demographics: Full survey



Where analysis has been undertaken based on respondents geographical location, the above postcodes have been grouped into Central (GL14, GL17, GL17 & HR), North (GL18 & GL19) and South (GL15, NP).

Which age group are you?

			Response Percent	Response Total
1	Under 18		0.00%	0
2	18-25		3.23%	12
3	26-35		10.24%	38
4	36-45		16.17%	60
5	46-55		15.90%	59
6	56-65		22.91%	85
7	66-75		20.49%	76
8	Over 75		10.51%	39
9	Prefer not to say		0.54%	2
			answered	371
			skipped	126

Are you:

			Response Percent	Response Total
1	A health or social care professional		12.97%	45
2	A community partner/member of the public		80.40%	279
3	Prefer not to say		6.63%	23
			answered	347
			skipped	150

Do you consider yourself to have a disability? (Tick all that apply)

			Response Percent	Response Total
1	No		67.49%	247
2	Mental health problem		7.65%	28
3	Visual Impairment		3.01%	11
4	Learning difficulties		1.09%	4
5	Hearing impairment		4.37%	16
6	Long term condition		15.57%	57
7	Physical disability		10.38%	38
8	Prefer not to say		2.19%	8

Do you consider yourself to have a disability? (Tick all that apply)

			Response Percent	Response Total
9	Other (please specify):		4.92%	18
			answered	366
			skipped	131

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.

			Response Percent	Response Total
1	Yes		47.27%	173
2	No		47.27%	173
3	Prefer not to say		5.46%	20
			answered	366
			skipped	131

Which best describes your ethnicity?

			Response Percent	Response Total
1	White British		93.01%	346
2	White Other		0.54%	2
3	Asian or Asian British		0.00%	0
4	Black or Black British		0.27%	1
5	Chinese		0.00%	0
6	Mixed		0.00%	0
7	Prefer not to say		4.30%	16
8	Other (please specify):		1.88%	7
			answered	372
			skipped	125

Which, if any, of the following best describes your religion or belief?

			Response Percent	Response Total
1	No religion		32.43%	119
2	Buddhist		0.00%	0
3	Christian (including Church of England, Catholic, Methodist and other denominations)		59.13%	217
4	Hindu		0.00%	0
5	Jewish		0.00%	0
6	Muslim		0.00%	0
7	Sikh		0.00%	0
8	Prefer not to say		7.90%	29
9	Other (please specify):		0.54%	2
			answered	367
			skipped	130

Are you:

			Response Percent	Response Total
1	Male		30.56%	114
2	Female		66.76%	249
3	Other		0.00%	0
4	Prefer not to say		2.68%	10
			answered	373
			skipped	124

Do you identify with your gender as registered at birth?

			Response Percent	Response Total
1	Yes		96.19%	353
2	No		0.27%	1
3	Prefer not to say		3.54%	13
			answered	367
			skipped	130

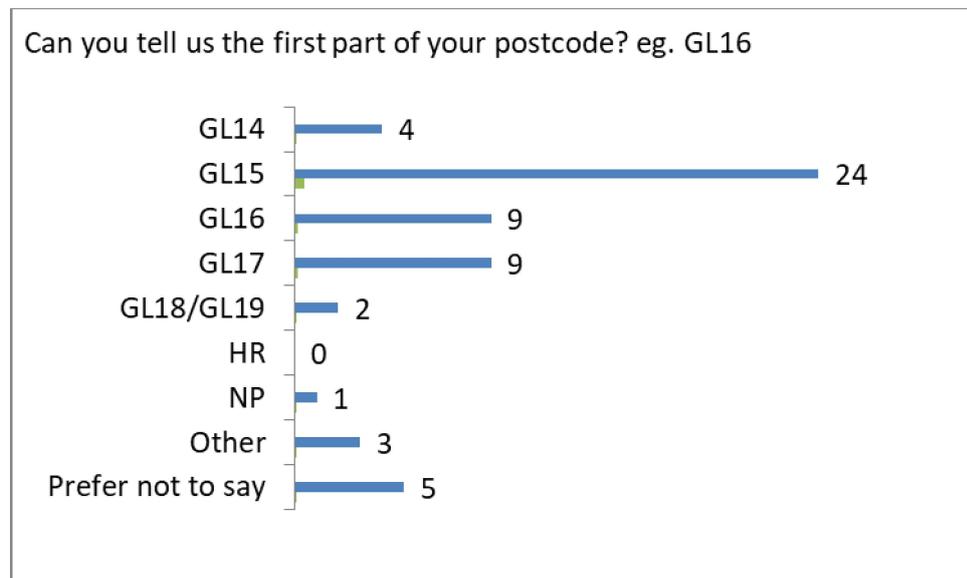
Which of the following best describes how you think of yourself?

			Response Percent	Response Total
1	Heterosexual or straight		87.05%	316
2	Gay or lesbian		0.28%	1
3	Bisexual		1.65%	6
4	Other		1.10%	4
5	Prefer not to say		9.92%	36
			answered	363
			skipped	134

Are you currently pregnant or have given birth in the last year?

			Response Percent	Response Total
1	Yes		3.81%	14
2	No		78.20%	287
3	Prefer not to say		2.18%	8
4	Not applicable		15.80%	58
			answered	367
			skipped	130

Demographics: Easy Read



Where analysis has been undertaken based on respondents geographical location, the above postcodes have been grouped into Central (GL14, GL17, GL17 & HR), North (GL18 & GL19) and South (GL15, NP).

Which age group are you:			
		Response Percent	Response Total
1	0 - 18	0.00%	0
2	18-25	0.00%	0
3	26-35	11.76%	6
4	36-45	3.92%	2
5	46-55	17.65%	9
6	56-65	19.61%	10
7	66-75	25.49%	13
8	75+	21.57%	11
9	Not saying	0.00%	0
		answered	51
		skipped	6

Are you:

			Response Percent	Response Total
1	Someone who works in health or social care		7.55%	4
2	A member of the public		92.45%	49
3	Not saying		0.00%	0
			answered	53
			skipped	4

Do you have a disability - tick the ones that describe you.

			Response Percent	Response Total
1	No		46.15%	24
2	Mental health problem		7.69%	4
3	Problems with your sight		9.62%	5
4	Learning difficulties		0.00%	0
5	Problems with your hearing		0.00%	0
6	A health problem you have had for a long time like asthma, diabetes, or something else		34.62%	18
7	Physical disability		13.46%	7
8	Not saying		3.85%	2
			answered	52
			skipped	5

Do you look after, or give any help and support that you don't get paid for, to other people because they are ill or older?

			Response Percent	Response Total
1	No, I don't		59.62%	31
2	Yes, I do		38.46%	20
3	Not saying		1.92%	1
			answered	52
			skipped	5

Please can you tell us which o the groups in our list best describes you? This is called ethnicity.

		Response Percent	Response Total
1	White British		96.23% 51
2	White Other		0.00% 0
3	Asian or Asian British		0.00% 0
4	Black or Black British		0.00% 0
5	Chinese		0.00% 0
6	Mixed		0.00% 0
7	Not saying		3.77% 2
		answered	53
		skipped	4

Please tick if you have any of these religions or beliefs

		Response Percent	Response Total
1	None		23.08% 12
2	Buddhist		0.00% 0
3	Christian		65.38% 34
4	Hindu		0.00% 0
5	Jewish		0.00% 0
6	Muslim		0.00% 0
7	Sikh		0.00% 0
8	Other		0.00% 0
9	Not saying		11.54% 6
		answered	52
		skipped	5

Can you say about your gender? Tick the one that describes you.

			Response Percent	Response Total
1	Male		26.42%	14
2	Female		71.70%	38
3	Transgender		0.00%	0
4	Non-binary		0.00%	0
5	Not saying		1.89%	1
			answered	53
			skipped	4

Are you the same gender you were born with?

			Response Percent	Response Total
1	Yes		98.11%	52
2	No		0.00%	0
3	Not saying		1.89%	1
			answered	53
			skipped	4

Can you say how you think of yourself?

			Response Percent	Response Total
1	Heterosexual or straight		88.46%	46
2	Gay or lesbian		1.92%	1
3	Bisexual		1.92%	1
4	Other		0.00%	0
5	Not saying		7.69%	4
			answered	52
			skipped	5

Are you pregnant or had a baby in the last year?

			Response Percent	Response Total
1	Yes		1.89%	1
2	No		73.58%	39
3	Not saying		3.77%	2
4	This question doesn't apply to me		20.75%	11
			answered	53
			skipped	4

5.2 Survey Feedback

This section sets out the survey feedback received about each of proposed services; Inpatient care; Urgent care; Diagnostic services; and Outpatient services.

The survey included two types of questions:

- Quantitative questions, which offer a choice for the respondent e.g.

We think that the range of services proposed in this Consultation will meet the needs of local people. Please tell us whether you agree with this statement, for each of the following: Inpatient care, Urgent care, Diagnostic and Outpatient services.

- Strongly agree*
 - Agree*
 - Disagree*
 - Strongly disagree*
 - No opinion*
- and Qualitative questions which invite the respondent to write a comment

Please tell us why you think this, e.g. the information you would like us to consider:

Quantitative feedback is shown in a series of charts, whereas qualitative feedback is summarised, noting key themes. Some people did not reply to every question. A full report, including all feedback received in the survey is included in Appendix 1.

Further analysis was undertaken to identify any variation in responses across a number of demographics; age, gender, disability and geographical location. Responses from members of the public/community partners and members of the staff were also separately reviewed.

Data for each of these groups is included in Appendix 1, with any significant variations noted in the summary of feedback below. It is important to note, however, that approx. 25% of respondents did not complete the 'About you' section of the survey and are therefore not included in these demographic analyses.

Inpatient care

We think that the range of services proposed in this Consultation will meet the needs of local people. Please tell us whether you agree with this statement, for:

1. Inpatient care:			Response Percent	Response Total
1	Strongly agree		21.9%	105
2	Agree		21.9%	105
3	Disagree		19.8%	95
4	Strongly disagree		32.6%	156
5	No opinion		3.8%	18
			answered	479

The strength of support is dependent upon the individual respondent's or groups of respondents' geographical partiality. Respondents from the south of the district are less supportive of the proposed services for inpatient care, compared with those in the central and northern parts of the Forest of Dean.

	Central (124 responses)	North (7 responses)	South (192 responses)
Strongly agree	33.3%	42.9%	10.4%
Agree	24.2%	42.9 %	18.8%
Disagree	16.1%	0.0%	24.0%
Strongly disagree	21.8%	14.3%	43.8%
No opinion	4.8%	0.0%	3.1%

Analysis of other demographics, e.g. disability, age, ethnicity, health care professionals did not show any notable variation in responses between those who shared a certain characteristic and those who did not.

Qualitative feedback noted that those who agreed with the proposals for inpatient care thought the new hospital would reduce the need for travelling out of the Forest of Dean, but recognised the need to provide high quality care in the community.

A local hospital which we can get access to inpatient and outpatient services will be good and the travelling will be less than having to go out to Gloucester or Cheltenham

Keeping the number of beds to 24 in the light of a growing and aging populations will require excellent community care and home based end of life care.

The analysis undertaken seems to meet the population needs of people living in the area

As a staff nurse who currently works at the dilke the resources we are having to work with, or lack of inhibits our ability to care for our inpatients to the standard at which everyone should expect from a modern NHS.

Feedback from those who disagreed with the proposals asked for consideration of an increase in the local population and questioned whether the 24 beds provided sufficient capacity to support the needs of people in the Forest of Dean. There were comments about a lack of capacity across the county and the need for end of life care to be provided.

The number of beds proposed is inadequate. Although based on the current number of inpatients at both Lydney and The Dilke, it fails to account for an aging population and an increase in population in the area.

There are numerous patients from the forest area in hospitals outside the area atm, with all these new houses being built throughout the forest there is no way 24 beds will cover the 'locals' needs.

Need to be able to provide end of life care in a hospital - not all patients wish to die at home and no hospice inpatient facility in forest Concerned about reduction in beds. Beds currently occupied by many Glos and Chelt patients as they do not have a community hospital. This will not change.

I feel that consideration should be given to reviewing the bed provision, if there is insufficient capacity achieved elsewhere in the county forest residents could find the reduced number of beds unavailable to them if otherwise occupied.

Single rooms

There was a mixed response to the proposals for the provision of single ensuite rooms, with some concerns that patients may feel isolated.

Single en suite rooms probably best.

Better facilities in the single rooms would be more beneficial

My main concern is that although single rooms are wonderful they are isolating and make observation difficult.

Will there be communal spaces and or dining area to support people to interact when appropriate?

I think individual rooms whilst helpful to a degree with infection control do not overall aid care or recovery.

Urgent care

We think that the range of services proposed in this Consultation will meet the needs of local people. Please tell us whether you agree with this statement, for:

2. Urgent care:		Response Percent	Response Total
1	Strongly agree		23.4% 112
2	Agree		19.2% 92
3	Disagree		20.3% 97
4	Strongly disagree		34.3% 164
5	No opinion		2.7% 13
		answered	478

The strength of support is dependent upon the individual respondent's or groups of respondents' geographical partiality. Respondents from the south of the district are much less supportive of the proposed services for urgent care, compared with those in the central and northern parts of the Forest of Dean.

	Central (123 responses)	North (7 responses)	South (193 responses)
Strongly agree	35.0%	28.6%	11.4%
Agree	26.8%	57.1 %	15.0%
Disagree	17.9%	0.0%	20.7%
Strongly disagree	18.7%	14.3%	50.8%
No opinion	1.6%	0.0%	2.1%

Analysis of other demographics, e.g. disability, age, ethnicity, health care professionals did not show any notable variation in responses between those who shared a certain characteristic and those who did not.

Main concerns that people asked us to consider related to poor access and the proposed opening hours for urgent care in the Forest.

Urgent care - locating all MIU services in one area, namely Cinderford, severely disadvantages people who live in the south of the Forest. Access to local GPs is becoming increasingly difficult and being able to call in at a local 'urgent care centre for reassurance is most important.

Easy access to urgent care services for Lydney and surrounding areas will be key.

The distance to travel to the new hospital from Lydney and its surrounding villages is too great for "Urgent" care

With hours being 8 am to 8 pm it means for urgent care (A&E) you will have to go to Glos which can cause delay to treatment.

Concerned at the lack of emergency cover in the forest between 8.00 pm and 8.00 am

The urgent care should be open for longer hours. Our child had an accident that required treatment this happened late into an evening but luckily the Dilke was open past 10pm

Urgent care support for the south of the Forest of Dean

During earlier engagement about the new hospital, concerns were raised about people accessing a single urgent care facility located in Cinderford. A commitment to undertake a further review of urgent care services in the south of the Forest has therefore been made and, through this Consultation, people were offered the opportunity to be involved in this work. Almost 100 people have expressed an interest in participating in further discussions.

People's suggestions for how urgent care could be made more accessible for people living in the south of the Forest included an additional facility; working with local GP services; and improved transport links. Feedback received will be used to inform the planned review.

Diagnostic services

We think that the range of services proposed in this Consultation will meet the needs of local people. Please tell us whether you agree with this statement, for:

3. Diagnostic services:			Response Percent	Response Total
1	Strongly agree		24.1%	115
2	Agree		31.4%	150
3	Disagree		15.1%	72
4	Strongly disagree		24.5%	117
5	No opinion		4.8%	23
			answered	477

The strength of support is dependent upon the individual respondent's or groups of respondents' geographical partiality. Respondents from the south of the district are less supportive of the proposed diagnostic services, compared with those in the central and northern parts of the Forest of Dean.

	Central (124 responses)	North (7 responses)	South (192 responses)
Strongly agree	38.7%	42.9%	11.5%
Agree	36.3%	42.9%	28.6%
Disagree	8.1%	0.0%	19.3%
Strongly disagree	14.5%	14.3%	35.4%
No opinion	2.4%	0.0%	5.2%

Analysis of other demographics, e.g. disability, age, ethnicity, health care professionals did not show any notable variation in responses between those who shared a certain characteristic and those who did not.

Qualitative feedback noted support for the proposals which would result in a reduced need to travel outside the Forest of Dean, but also reflected on the overall difficulty in accessing services for those living in the south of the Forest.

Good that diagnostic services will be there, so that people in the forest don't have to travel to Gloucester or Bristol.

More diagnostics and minor surgical procedures would be welcome to save the trips to Gloucester or Cheltenham.

I welcome the additional diagnostic services over the weekend, but you need to ensure that staff are sufficiently competent to provide the right level of care

I like the sound of more diagnostic and outpatient services

Diagnostic services in one place should not preclude x ray in Lydney which needs ready access and already has a state of the art facility funded by local people.

Lydney hospital is super important for people like me, I can't drive and I have 4 children. The buses to anywhere are practically impossible and I can't afford a taxi to Cinderford or Gloucester for a hospital visit. It would be detrimental to the health of myself and my children.

Outpatient services

We think that the range of services proposed in this Consultation will meet the needs of local people. Please tell us whether you agree with this statement, for:

4. Outpatient services:			Response Percent	Response Total
1	Strongly agree		25.9%	124
2	Agree		28.5%	136
3	Disagree		15.1%	72
4	Strongly disagree		26.4%	126
5	No opinion		4.2%	20
			answered	478

The strength of support is dependent upon the individual respondent's or groups of respondents' geographical partiality. Respondents from the south of the district are much less supportive of the proposed outpatient services, compared with those in the central and northern parts of the Forest of Dean.

	Central (124 responses)	North (7 responses)	South (192 responses)
Strongly agree	37.9%	42.9%	13.0%
Agree	35.5%	42.9 %	24.5%
Disagree	9.7%	0.0%	19.8%
Strongly disagree	13.7%	14.3%	39.6%
No opinion	3.2%	0.0%	3.1%

Analysis of other demographics, e.g. disability, age, ethnicity, health care professionals did not show any notable variation in responses between those who shared a certain characteristic and those who did not.

Qualitative feedback noted support for the proposals which would result in a reduced need to travel outside the Forest of Dean, but also reflected on the overall difficulty in accessing services for those living in the south of the Forest.

I think it would be great to also consider outpatient services with the availability to connect with consultants digitally/ remotely rather than driving to Gloucester /Cheltenham.

Ortho and Neuro and Respiratory O/P appointments would be REALLY useful if the hospital was to have an effective REHAB role.

We need as many outpatient clinics as possible because getting to Gloucester/Cheltenham by car is bad enough, (time, traffic, parking) but without a car can mean several buses and a whole day taken. I question the statement on page 21 about the range of outpatient clinics provided by Gloucester hospital. Recently I have had to visit orthopaedics several times for follow up consultations. I was told neither of these clinics were available at the Dilke or

This once in a life time opportunity to get it right – don't combine services assuming they will work it out. Space is a necessity when providing rehabilitation for complex people with multiple disabilities. Having all community services within the hospital space will enhance the holistic management of patients and the patients journey. That is why investing in multidisciplinary teams is the gold standard approach.

Other comments

Many of the comments made in the initial section of the survey focussed on issues outside of the Consultation; the decision to provide one new hospital in the Forest of Dean, which would result in the closure of the existing hospitals; and the agreed location for the new hospital. These issues also provided the main theme for the following questions on potential impact of the proposals and suggestions on how we could limit any negative impacts.

Please tell us about any impact, either positive or negative, that you think any of our proposals could have on you and/or your family?

The positive impact of receiving care in new modern facilities was noted, as was the opportunity to access services more locally within the Forest of Dean.

Having access to better, more up-to-date services has to be a good thing.

I think having single rooms will be nicer for people, I think people want to die at home and not in hospital if they can so I agree with this.

I think this is a wonderful opportunity to innovate and transform services for the Forest of Dean. thing.

I think that having a new hospital with more facilities would be more beneficial for myself and my parents as it would reduce the amount of time it would take to get to the local hospital rather than have the stress of having to get to Gloucester or Cheltenham.

Positive impact on our family, but only if you can deliver a real choice of the local hospital for outpatient services. In my experience you only get an appointment at one of the current hospitals if you ask for it - the default is always Gloucester.

The themes in relation to negative impact of the proposals focussed on a loss of services in Lydney and the south of the Forest and the difficulty of travelling to Cinderford for care. There was also concern about the proposed reduction in hours for urgent care.

We feel our needs in the south of the Forest are being ignored and that proposals to base all services in Cinderford will make them inaccessible to us as we get older.

We will be deprived of having services locally and MIU will be hugely missed. I would go to Gloucester rather than Cinderford not knowing if it was open or not or being referred on to there anyway.

I am worried about getting emergency care when I need it and quickly, as well as reassurance or advice eg head bump. I am worried we wouldn't be able to get help over night. There are no positives. The location, reduced hours and beds will be catastrophic.

Urgent care only being available between 8am-8pm means outside of these times a long journey to an already over pressured service in Gloucester. Considering the size of the county of Gloucestershire, 1 A&E is always going to be under pressure and in escalation for the majority of the time - causing long delays and waits for potentially very poorly patients and worrying times for family.

I believe it would have a negative impact on my family and the general populace due to lack of access to care. Cinderford is closer to Gloucester and should not have investment where as Lydney is more accessible and further to any other hospital.

The journey to Cinderford even by car is harder than just driving straight to Gloucester A&E which is what many from the south of the Forest will do or they will drive direct to Southmead.

If you think any of our proposals could have a negative impact on you and/or your family, how should we try to limit this?

Responses to this question may be drawn into three main themes:

- Improvements in public transport and infrastructure;
- Retention of existing facilities, or the provision of a new facility in the south of the Forest;
- Extension of the services proposed, i.e. additional inpatient care, extended hours for urgent care

Need to work with people on transport links, as bus may not be suitable and limited taxi services in the forest.

With regard to transport you should negotiate and ensure through the appropriate bodies a more frequent and reliable bus service to serve the southern area, otherwise it will prove a real problem.

I believe we still need two hospitals so the forest area is covered properly and Lydney is not disadvantaged. The provision should be growing not shrinking. It will have a massive impact on the local community and lives will be lost. . .

By leaving our existing hospitals to continue their great work and provide this new one as an extra to accommodate the increase in population..simple..

Try to introduce longer opening hours for MIU

By providing a new centre in Lydney for Urgent care and community services.

I am very much in favour of a new hospital but worry about no end of life care for people to die in hospital. A lot of people who cannot have this at home would hate to go into a care home to die.

At least the equivalent number of inpatient beds as Lydney & Dilke combined for the status quo, .. if you actually want to improve the existing service increase beds by at least 25%

5.3 Easy Read survey

The Easy Read version of the survey asked three questions:

- What is good about our plans?
- What is bad about our plans?
- What else would you like to tell us?

Themes from the qualitative feedback

The themes from the Easy Read survey reflect those in the full survey with people reporting the opportunity to receive care in new modern facilities and the reduction in travel outside the Forest of Dean as “good”. The closure of facilities in Lydney and difficulties for people travelling to Cinderford from the south of the Forest is noted. Concern is also expressed about the reduction in the number of beds available for inpatient care.

What is good about our plans?

Really welcome the plan for new hospital in cinderford - makes financial sense to have services and access to them in once centralised place - up to date services, accessibility to all in forest of dean, less stress for patients and families having to travel to gloucester etc

A new hospital with appropriate equipment and layout, which is conducive to staff and patients alike is needed, and this plan meets the criteria.

Providing services where they are needed without long journeys for treatment. Better for environment as well as convenience for patients and staff. Also good for patients' visitors

Keeping significant services within the Forest area. Travelling to GRH can be a nightmare.

Good that diagnostic services will be there, so that people in the Forest don't have to travel to Gloucester or Bristol

What is bad about our plans?

Inpatients Plans: How is reducing the beds available from 47 to 24? It means a significant reduction of nearly 50% (half of what we have now!)

Urgent Care: How is closing the current 2 existing hospitals Lydney and the Cinderford going to help urgent Care.

The plans for a new hospital in Cinderford with reduced bed capacity does not appear practical as the population has and is increasing, especially in Lydney which has been hit the hardest.

With more and more houses being developed in and around the Lydney hospital we will all have further to go when our hospital is needed!

If people do not drive they don't have the local hospital
The population is growing and I don't feel one hospital could cope with the demand.

6. Other feedback received

The survey is not the only mechanism for receiving feedback. The following section summarises other feedback received during the Consultation. All written feedback, redacted to maintain individual's confidentiality, i.e. names and contact information removed, are included in Appendix 2.

Members of the public

In total, 28 emails and letters were received from members of the public. This included 20 adapted versions of the HOLD letter that were sent to GHC.

Responses reflect comments made in the survey responses:

- Increased travel to the new hospital for residents in the south of the Forest and lack of public transport in the district.
- The new hospital will not have sufficient capacity to meet the needs of the Forest of Dean residents, in particular given the increase in population.
- The number of beds proposed does not take account of the increase in population.

The HOLD letter notes the environmental impact of additional travel for some in accessing one new site and calls for the decision to close the two existing hospitals to be reversed.

Elected representatives

In addition to the motion from the Forest of Dean District Council, correspondence was received from four town/parish councils, and the Green Party.

Responses raised similar concerns to the survey responses:

- Increased travel to the new hospital for residents in the south of the Forest and lack of public transport in the district.
- The new hospital will not have sufficient capacity to meet the needs of the Forest of Dean residents, in particular given the increase in population.

Additional suggestions relating to the hospital design and scope of specific services were also included.

Primary Care Network

The Forest of Dean Primary Care Network (PCN), which has membership of GP practices from across the district, submitted a response to the Consultation. The PCN welcomes a new community hospital in the Forest of Dean, but is not supportive of all of the proposals set out in the Consultation. The full response is included in Appendix 2.

7. Questions and Answers

Throughout the consultation a range of questions have been received from a variety of sources e.g. online discussion groups, Information Bus Tour, survey free text responses. The following questions (and responses) are representative of frequently asked questions.

Question	Response
<p>Why won't there be a maternity unit?</p>	<p>Guidance by the National Institute for Health and Care Excellence (NICE) on the care of healthy women and their babies during childbirth, recommends that women thought to have a low risk of pregnancy complications would be better served by giving birth at home or at a midwife-led unit. Recognising the unique attributes of the Forest of Dean, careful consideration has therefore been given to the inclusion of a midwife-led birthing unit at the new hospital.</p> <p>Having reviewed the clinical guidance, the average number of births per annum in the Forest of Dean district and the rights of women to choose the place in which they give birth, the option of a midwife-led unit has been discounted on the basis that a clinically safe and sustainable service could not be provided. We will however, continue to promote home births for women where it is clinically safe and appropriate to do so.</p>
<p>Why are you proposing all single ensuite rooms?</p>	<p>Our older hospitals have a number of challenges in terms of providing modern health care services and are particularly difficult around infection prevention and control, privacy and dignity, impact of mixed sex accommodation and noise and disturbance at night for those in multiple bedded areas.</p> <p>Gloucestershire Health and Care Services are considering providing all of the inpatient beds in single rooms with ensuite facilities:</p> <ul style="list-style-type: none"> • Learning from Covid-19 has clearly demonstrated that single rooms are a much safer option from an infection

	<p>prevention and control perspective.</p> <ul style="list-style-type: none"> • Increased privacy and dignity for people if they have their own room with their own en-suite bathroom. • People often feel more confident to move around their own room and use the bathroom rather than a commode by the bedside which helps them to keep mobile. • There is now a greater use of digital technology which enables patients to keep in touch with their loved ones via virtual means outside of normal visiting hours which they can do without disturbing others. • The new hospital will have good social space on the ward where patients will be able to gather including a dining room and activity/therapy room to reduce risk of isolation or loneliness.
<p>Given the rising population in the Forest of Dean, how can 24 beds be enough?</p>	<p>Based on our evolving approach to care:</p> <ul style="list-style-type: none"> • inpatient rehabilitation provided 7 days a week, • care focused on the needs of people who live in the district; and • only keeping people in a hospital bed when they will benefit from a continued hospital stay; <p>we are confident that our proposal to provide 24 beds in the new hospital will provide appropriate capacity now and in the foreseeable future.</p> <p>Our analysis shows that compared with five years ago, the number of residents of the Forest of Dean who have needed a community hospital bed has reduced, due to the introduction of more community services. Where Forest residents have needed hospital care they have been admitted to a bed in one of the Forest hospitals 92% - 97% of the time.</p> <p>Our bed data also shows that at any given time, almost half of the beds in the Forest of Dean are occupied by people from other localities, most typically Gloucester.</p>

	<p>Our continued emphasis on community-based services, and introduction of:</p> <ul style="list-style-type: none"> • a specialist stroke rehabilitation in a countywide unit; • alternative provision of End of Life care (in line with countywide strategy); and • additional bed capacity in Gloucester and Cheltenham <p>will ensure the 24 beds proposed for the new hospital in the Forest of Dean will be sufficient.</p>
<p>Please can I ask 1 straight forward question when the 1 new hospital is built and the other 2 have closed, when we have the next pandemic where are the people what have not got the illness going to go too for treatment.</p> <p>I think you will realise that this time we where very fortunate to have 1 hospital that could treat people with the virus and 1 where the other people with injuries and illnesses could attend.</p>	<p>Throughout the current pandemic the two hospitals in the Forest of Dean have taken a mix of both COVID positive and negative patients. This has been in line with the way we have utilised all seven of our community hospitals and we have implemented a programme of internal zoning to ensure segregation of patients to prevent cross infection. We have also had to take a number of the inpatient beds out of action to ensure a COVID secure environment. The current environment has a number of the beds within bays rather than single rooms and thus it is harder to prevent cross infection so it has been necessary to take the additional measures of reducing capacity. We have also kept the Minor Injuries Unit at the Dilke closed as we could not ensure a safe COVID environment due to the size of the facility and access and exit routes.</p> <p>In planning the new single hospital, our aspiration is that we will incorporate 100% single rooms that will enable us to ensure safe infection control practices which means that we do not have to zone by hospital site but will continue as we have done currently, to manage patients within their own safe zone of their individual bedroom. In this way, we can safely respond to a future pandemic without the need to reduce hospital capacity at the time of greatest need.</p>

	<p>This is different to the way in which services within our acute hospitals in Gloucester and Cheltenham have been managed throughout the pandemic in that they have zoned by site as far as they can – this reflects the more different and more complex range of services that they provide and the greater levels of activity and therefore movement that they need to deal with. The majority of people who are admitted to our community hospitals do so after an episode of care at one of our acute hospitals, as such anybody who needs to be discharged into one of our community hospital sites are swabbed before admission so that we are aware of whether they are COVID positive or not and can therefore place them into an appropriate zoned location.</p>
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8. Evaluation and next steps

Considerations and learning points for future engagement and communication activities

Our approach to evaluating the effectiveness of our consultation activities locally is to apply a well-known quality improvement methodology, using an iterative process: Plan, Do, Study, Act (PDSA cycle) <https://improvement.nhs.uk/documents/2142/plan-do-study-act.pdf>

We have applied the following evaluation framework.

Engagement (and Consultation), Experience and Inclusion Evaluation Framework developed by The Science and Technologies Facilities Council has developed a useful engagement evaluation framework, https://stfc.ukri.org/files/corporate-publications/public-engagement-evaluation-framework/ We have adapted this to support the STUDY element in our Engagement, Experience and Inclusion PDSA Cycle		
Dimension	Definition	Response
Inputs	Engagement (and Consultation), experience and inclusion inputs include the time, skills and money that are invested into delivering engagement activities.	A comprehensive communications and consultation plan was developed to support the consultation activity. This plan, assured by NHS England/Improvement, set out the approach to communications and consultation. In response to pandemic restrictions, the plan was developed to support a socially distanced consultation. This included the development of more online methods such as the new Get Involved in Gloucestershire online participation platform; The plan was evaluated using an Engagement and Equality Impact Assessment https://www.fodhealth.nhs.uk/wp-content/uploads/2020/10/Equality-and-Engagement-Impact-Assessment-FOD.pdf
Outputs	Engagement (and consultation), experience and inclusion outputs are the activities we undertake and the resources that we create.	A number of events were held on line. The Information Bus Tour provided three socially distanced face to face events. 3,400 information booklets were distributed in local communities. A door to door leaflet drop delivered information about both the new hospital in the Forest of Dean and the Fit for the Future consultations to 297,000 households in Gloucestershire. This resulted in over 1,700 requests for information; 495 of which related to the Forest of Dean consultation. Feedback received included comments on the communications and consultation process itself. Feedback received was a mixture of positive and negative comments.

<p>Reach</p>	<p>Reach has two main elements: The number of people engaged, this includes attendance at events, completion of surveys, social media interaction etc. The types or diversity of people engaged.</p>	<p>Total face-to-face (online and bus tour) contacts was more than 200 (public/community partners) and more than 80 staff. 554 surveys were completed. There were 10 Facebook posts with a reach of over 56,000. 8 tweets generated over 7,000 impressions and over 100 engagements.</p> <p>We do not routinely collect demographic information about individuals participating in events/drop-ins etc.</p> <p>Demographic information was collected through our survey, but these questions were optional and consequently were not always completed. However, demography is considered during consultation planning and events/meetings targeted to reach a wide range of communities of interest and those groups identified through the Equality and Engagement Impact Assessment.</p>
<p>Processes</p>	<p>Processes are the way we work to plan, develop and deliver our engagement, experience and inclusion activities. They include our approaches to quality assurance and following good practice.</p>	<p>A comprehensive communications and consultation plan was developed to support the consultation activity. This plan is assured by NHS England/Improvement.</p> <p>Gloucestershire Health and Care NHS Foundation Trust: developed Easy Read materials.</p> <p>Gloucestershire County Council's Digital Innovation Fund Forum: Informed early planning for online activities and assisted with awareness raising of the consultation to potentially digitally excluded groups.</p> <p>Forest of Dean Locality Reference Group: Supported awareness raising and survey completion within their communities.</p> <p>Healthwatch Gloucestershire (HWG): HWG Readers Panel reviewed a draft of the consultation booklet.</p> <p>Community Connectors (KYP Coordinators): allowed us space on agendas to share information at online meetings during November 2020 to promote the consultation.</p> <p>District/Town Councils and Retail partners: Supported the 'socially distanced' visits of the Information Bus (outside of Lockdown 2) to locations with maximum footfall across the district. The Forest of Dean District Council also hosted a</p>

		<p>members' seminars to discuss the consultations.</p> <p>Others: Many other groups and individuals have helped to raise awareness of the consultation such as Trust members, staff representatives and community and voluntary sector organisations.</p>
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Act (following earlier engagement)

The following actions were undertaken following feedback received during earlier engagement:

- Less information, less jargon and easy read copies of all information.
- Mailer produced to promote the Consultation and ways to request information and contribute to the Consultation via telephone, survey, letter.

Act (during and following Consultation)

The following actions have been/will be undertaken following feedback received during the Consultation to support future communications and engagement:

- Information regarding the Consultation was sent to the Forest of Dean Talking Newspaper. Future consultations will endeavour to reach more people with Visual Impairment by:
 - Placing adverts in Talking newspapers
 - Using BBC local radio
 - Focussing on promotion of telephone line and ability to order large print copies of the booklet
 - Focussing on voice based/telephone based contact as most of people with visual impairment don't use desktops/laptops and rely on mobile phones.
- The consultation used more **online participation methods** than ever before. These proved to be very popular with groups who may not have engaged with consultations before and facilitated easier access to more people who may not have previously been willing or able to attend face to face events. The One Gloucestershire Communications and Engagement Sub Group will review the current online methods available and consider opportunities for maximising their use for future engagement and consultation activities.

9. Copies of this report

This report is available on the FODhealth website at: www.fodhealth.nhs.uk
and on the online participation platform Get Involved in Gloucestershire
<https://getinvolved.glos.nhs.uk>

Print copies of the report can be obtained from the Engagement and Experience Team by calling Freephone 0800 0151 548 or email: GLCCG.participation@nhs.net For information in alternative formats please see back cover.



To discuss receiving this information in large print or Braille,
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Forest of Dean Consultation

5220 Valiant Court, Gloucester Business Park, Brockworth,

A NEW HOSPITAL FOR THE FOREST OF DEAN

Proposed next steps for the Forest Community Hospitals Review

Document Control

Author:	Ellen Rule, Director of Transformation and Service Redesign / ICS Programme Director & Angela Potter, Director of Strategy, Gloucestershire Health and Care
Status:	Draft v 0.9

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0.1	22/06/20	Ellen Rule	v 0.1 first draft of document developed, source material includes previous Forest of Dean CCG Commissioning Strategy, and GHC Board papers on the Forest Review from June / July 2019
0.2	23/07/20	Angela Potter	Update case for change, bed configuration and associated narrative changes
0.3	8/8/20	Angela Potter	Removed track changes and ongoing editing Completed best practice checklist
0.4	11/08/20	Angela Potter	Updates following check-in meeting 10/8
0.5	19/08/20	Angela Potter	Updates to community bed numbers and EOL
0.6	26/08/20	Angela Potter	Updates to Endoscopy and urgent care
0.7	27/08/20	Ellen Rule	Updates to urgent care narrative
0.8	18/09/20	Angela Potter	Updates in response to NHSE/I initial feedback
0.9	18/09/20	Ellen Rule	Review and additions as above

Document Distribution:

Forum/Audience	Date	Doc	Comments
NHSE/I	27/8	V0.7	Submitted to NHSE/I as draft for feedback
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1. Introduction

This document sets out an overview of service provision in the Forest of Dean locality, with a specific focus on the service proposals specific to the planned building of a single new community hospital for the district, which following previous phases of engagement and consultation will be built in Cinderford. The service proposals in this document are consistent with the aims and objectives of the Gloucestershire Integrated Care system and are planned to meet the needs of the population now and into the future. The business case to build a new community hospital is primarily concerned with ensuring the 'right' infrastructure can be developed with sufficient flexibility to allow for the continuous evolution of service delivery models in the NHS. The Gloucestershire Integrated Care System is confident that the proposals set out in this strategy will ensure that the Forest of Dean gets a bright, modern facility that is flexible and forward looking – one that is Fit for the Future of our local NHS.

1.1 One Gloucestershire Integrated Care System

The One Gloucestershire Integrated Care System (ICS), a partnership between local NHS and care organisations, is committed to turning the NHS Long Term Plan into action for the benefit of local people and our dedicated workforce. Our expectations of healthcare, the demands on health services and the incredible progress made in development of staff, skills and technology mean that we continue to adapt to support healthy lives and transform care to meet the needs of people into the future.

Our Integrated Care System priorities are to:

- Place a far greater emphasis on personal responsibility, prevention and self-care, supported by additional investment in helping people to help themselves
- Place a greater emphasis on joined up community based care and support, provided in patients' own homes and in the right number of community centres, supported by specialist staff and teams when needed
- Continue to bring together specialist services and resources in to centres of excellence that deliver a greater separation of emergency and planned care and, where possible reduce the reliance on inpatient care (and consequently the need for bed based services) across our system by repurposing the facilities we have in order to use them more efficiently and effectively in future
- Develop new roles and ways of working across our system to make best use of the workforce we have, and bring new people and skills into our delivery system to deliver patient care
- Have a continued focus on ensuring Parity of Esteem for Mental health.

1.2 Inter-relationship with Fit for the Future

The Forest of Dean Community Services review has been running since the summer of 2015. Through this period we have gathered a wealth of evidence to support future

thinking around a services model for community services in the district and the wider strategic context has been evolving, as Gloucestershire continues to develop as an Integrated Care System and take forward the ambitions outlined in the NHS Long Term Plan.

There has been considerable complexity in navigating the political landscape of effecting service change in the NHS, and the Forest review has found itself inexorably linked to the wider context of the evolving services review for the county – known as Fit for the Future. This major change programme will equally benefit the residents of the Forest of Dean and at stages during the development of the Forest of Dean Community Services review, the inter-relationship has been considered and the two programmes have been brought together. The current inter-relationship between the two programmes of work has been fully considered and in light of the current proposals within the Fit for the Future programme, the development of the new hospital in the forest of Dean (which is primarily an infrastructure business case) will be developed in tandem but no longer inter-connected with the wider Fit for the Future work plan.

Through most of 2020 we have been engaged in responding to the COVID-19 major incident and global pandemic, which has meant that the Forest Hospitals review has been on hold. It is now the right time for the review to get back on track and come to a conclusion; to enable the plans for the new hospital to be finalised and building to begin.

2. Strategic Context

Our proposals for the Forest of Dean Hospital are shaped by our vision and fundamental aim, which is that by all working together in a joined up way as '*One Gloucestershire*', we can build stronger, healthier and happier communities and transform the quality of care and support we provide to all local people. Our long term ambition is to have a Gloucestershire population that is:

- Healthy and well – taking personal responsibility for their health and care, reshaping the personal benefits that this can bring.
- Living in healthy, active communities and benefitting from strong networks of community services and support.
- Able to access consistently high quality, safe care when needed in the right place, at the right time

Locally, a new Integrated Locality Partnership has formed and in the future this body, along with the associated Primary Care Networks will take a key role in leading the delivery of future community based services for the district. Our challenge now is to ensure that our proposals and local plans for the hospital are aligned to both national and local strategies, and meet the need to commit to detailed plans for the hospital and associated health centre infrastructure in the district, whilst also remaining flexible enough to accommodate evolving future service models.

The updated proposals set out in this document have been developed through extensive feedback and engagement with local communities and clinicians across the

locality over a number of years. Our last period of engagement highlighted some key issues that were of particular interest to the local population, as follows:

- Proposed bed capacity in the new hospital
- Urgent Care provision for the district, and in particular for Lydney now that we have confirmation that the new hospital will be based in Cinderford
- End of Life care provision
- Travel and Access

This updated paper will describe our proposals and response to each of these areas of interest, provide an overview of the historic activities and timeline and the proposed next steps for the programme.

2.1 Case for change

The review into the future of health and social care services within the Forest of Dean was established in 2015. The vision of this review was to:

develop a plan for delivering high quality and affordable community health and care services to the people of the Forest of Dean which meet their needs now and, in the future, and is developed with patients, the public and our key partners. The review will encompass all community services in the Forest of Dean, including those within the community hospitals

The review was undertaken by GCCG, overseen by the Forest of Dean Locality Reference Group between September 2015 and June 2016. Following extensive engagement throughout the lifetime of the Forest Health and Care Review, and with the support of the wider One Gloucestershire Sustainability and Transformation Partnership (STP), the Case for Change received support from the respective organisational Boards in July 2017.

The case for change specifically relating to the community hospital service provision in the Forest of Dean identified the following challenges and outcomes:

Case for Change Summary – Community Hospital Services

Challenges:

In developing and delivering high quality services for the future, the following **Challenges** have been identified:

- the two existing community hospitals are reaching the stage where it is becoming increasingly difficult to provide modern, efficient, effective, high-quality care;
- the ability to maintain some essential services across two community hospital sites is becoming increasingly difficult with healthcare professionals working across different sites and the challenge of recruiting and retaining enough staff with the right skills;
- there are significant issues relating to cost of maintenance of the existing hospitals and restricted space for services;
- the current physical environment within the hospitals makes it increasingly difficult to ensure privacy and dignity for all patients and manage infection control;
- too many people from the Forest of Dean are having to travel outside the local area to receive care that should be provided more locally, such as endoscopy;
- the current healthcare system can be fragmented and disjointed from both a patient and professional perspective;
- healthcare needs within the Forest of Dean are not always being met effectively.

Outcomes:

The following **outcomes** were proposed for patients, health and care staff and the Forest of Dean community:

- more consistent, reliable and sustainable community hospital services, e.g. staffing levels, opening hours;
- a wide range of community hospital services, including beds, accommodation to support outpatient services and urgent care services;
- significantly improved facilities and space for patients and staff;
- services and teams working more closely together;
- better working conditions for staff and greater opportunities for training and development to recruit and retain the best health and care professionals in the Forest of Dean.

The above outcomes informed the development and consideration of the strategic investment objectives for the future delivery of community hospital services. These have been reviewed and continue to apply.

Strategic Investment objectives:

Investment objective
<p>Facilitate the delivery of the new models of care</p> <p>To provide accommodation that will support the delivery of integrated primary and community based services in the Forest of Dean.</p>
<p>Improve local access to services</p> <p>To have extended access to a high quality primary and community based services in the Forest of Dean.</p>
<p>Provide appropriate service capacity</p> <p>To provide accommodation that will at least meet the needs associated with planned population growth in the Forest of Dean and across Gloucestershire more generally.</p>
<p>Provide a high quality flexible facilities and infrastructure</p> <p>To have co-designed and delivered appropriate facilities to meet the needs of the Forest of Dean</p>

Benefits from investment into a new community facility;

The key benefits were identified specifically in relation to the investment in a new community hospital in the locality. These have been reviewed and updated as follows:

Investment Objective	Benefit Title	Benefit Description	Stakeholder
Facilitate the delivery of the new models of care	Improved patient experience	<ul style="list-style-type: none"> - Improved access to current service provision across the system, in an improved environment - Improved care pathway through health and social care - Improved co-ordination of local healthcare - Improved patient dignity and privacy 	<ul style="list-style-type: none"> - Patients - Community - Staff - Trust
Improve local access to services	Improved quality & accessibility of services	<ul style="list-style-type: none"> - Equity of service delivery through co-location of services - Multiple hook-ups - Improved environment with DDA compliance - Continuous CQC compliance 	<ul style="list-style-type: none"> - Patients - Community - Staff - Trust
Provide appropriate service capacity	Improved Quality & Performance	<ul style="list-style-type: none"> - Improved functional suitability of accommodation 	<ul style="list-style-type: none"> - Patients - Community - Staff

		<ul style="list-style-type: none"> - Separate children and adult waiting areas - Increased and flexible capacity for new equipment - Flexible space to accommodate growing/changing needs of local population - Improve staff retention and recruitment, more development opportunities 	<ul style="list-style-type: none"> - Trust
Provide high quality flexible facilities and infrastructure	Improved Building Design	<ul style="list-style-type: none"> - Robust infrastructure to meet the needs of the local population - Adaptability of rooms to accommodate changes in technology /new models of care - Flexible/multi-functional space to grow and/or change services - Corporate social responsibility; environmental factors e.g. reduced emissions 	<ul style="list-style-type: none"> - Patients - Community - Staff - Trust

3. Timeline and Governance Activities to Date

A number of periods of engagement and consultation have already been conducted on the Forest of Dean hospital. Firstly to consider the proposal to build one hospital to replace the existing two ageing facilities and then subsequently to determine the location of the hospital - which was decided ultimately by an independent citizen's jury. This final phase will focus on the confirmation of the service model that the new hospital will provide.

A Forest of Dean website has been set up by the CCG and GCS (now GHC), providing a repository of all information that has supported our public conversations regarding the proposal to build a new hospital in the Forest of Dean <https://www.fodhealth.nhs.uk/>. This site includes dates for current and previous engagement and consultation events, Frequently Asked Questions and documents that have supported the process.

Below is a timeline outlining the programme, engagement and consultation activities that have been conducted between 2015-2020:

Date	Details
September 2015	Programme working group and Locality Reference Group - established by the CCG and GCS working in partnership
Nov 2015 – June 2016	Targeted engagement with a broad range of stakeholders – asking people about their experience of local health and care services, including services at home, in the community and in hospital. Included staff engagement.
July 2016	Interim report produced by CCG
July 2017	Case for Change published
September 2017 – Dec 2017	Formal consultation –Views on our preferred option to replace the two existing community hospitals, Dilke Memorial Hospital and Lydney & District Hospital, with a newly built hospital in the Forest of Dean - 52 public events, 1,218 face to face contacts, 3,344 surveys completed).Link to summary presentation, including Overview and Scrutiny comments 9Jan18: https://www.fodhealth.nhs.uk/wp-content/uploads/2018/02/FoD-Health-Outcome-of-Consultation-Powerpoint-Presentation.pdf
25 January 2018	Board Decision – GCS and CCG unanimously approved the option of a new community hospital in the Forest of Dean to replace Dilke Memorial hospital and Lydney District Hospital. Site criteria were agreed (https://www.fodhealth.nhs.uk/wp-content/uploads/2018/05/FoD-Health-Location-Site-Criteria.pdf), with a recommendation to carry out further public engagement on the location.
May – July 2018	Engagement on location of future hospital – 6 weeks from 21 st May to 1 st July 2018.
July/August 2018	Citizens’ Jury to recommend a location for a new community hospital in the Forest of Dean. Recommendation of the Jury: Cinderford
August 2018	Board Decision – GCS and CCG agreed the recommendation to locate the future hospital in Cinderford (GCS and GCCG), supporting the Citizens’ Jury recommendation.
August 2019 – Oct 2019	Fit for the Future engagement – focus on services to be included in a future hospital (alongside wider county discussion on Community urgent care and Centres of Excellence) 9 drop in events; meetings with District Council and Town Council; workshop with Integrated Locality Partnership members, members

153 FoD responses received	of the public, staff and other stakeholders; workshop with Reference Group. Report drafted and presented to HOSC in January 2020 and to GHC Trust Board, programme then on hold due to COVID-19 incident.
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Informal engagement activities have continued throughout and include connections through the health forum, the ILP, through the residents committee established for those properties against to the proposed site and informally with stakeholders and wider community partners. One such example was a workshop held in February 2020 to engage with stakeholders and the local voluntary community organisations to maintain an understanding of what they feel is important from the new facility to ensure it adds real value to the health and well-being of the community and be more than ‘just a hospital’.

The workshop generated some excellent discussion in terms of how the generic space could be used to offer something back to the community, especially when not being used for clinical services and provided thoughts on what additional (non-statutory) services would add value. Some of the key themes that emerged included;

- Space for exercise classes / group activities e.g. falls prevention / weight management
- Outdoor space – community garden – outdoor gym – walking trails and hosting walking groups around the site for patients, carers and visitors
- Space for social clubs/ café with healthy food as well as cake – local produce
- Public health info / health promotion / access to computers for health info
- Use of partitioning so space can be used as a community hub, available for talks and support groups
- Information hub – signposting and one stop info hub with a Forest Directory of Services

Our plan is that this type of informal and local engagement and feedback continues throughout the lifespan of the programme and that these interactions help inform the evolving design regarding the ethos and aesthetics of how we want the hospital to feel and enable it to be a key community asset once open.

4. Assurance and Oversight

All programmes that involve service change need to fulfil the assurance requirements that apply to all significant service changes. These can be found in the national guidance document from NHS England, Planning, Assuring and Delivering Service Change: <https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf>. In summary the requirements are to:

- Meet the Governments’ four tests for service change, which are:

- Strong public and patient engagement
 - Consistency with current and prospective need for patient choice
 - Clear, clinical evidence base
 - Support for proposals from clinical commissioners
- NHS England's test for proposed bed closures (where appropriate)
 - Be guided by the best practice checks, where applicable
 - Demonstrate that the scheme is affordable in capital and revenue terms

The NHS England bed test was introduced from the 1 April 2017. This requires that in any proposal including plans to significantly reduce hospital bed numbers NHS England will expect commissioners to be able to evidence that they can meet one of the following three conditions:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

The Forest of Dean project was subject to a Stage 2 Assurance review by NHS England in August 2017. The assurance letter received at the time confirmed the following:

“We recognise that the condition of the Forest of Dean Estate and the principle of the proposed build of a new community hospital for the Forest of Dean is linked to the wider Gloucestershire STP transformation scheme, but that there is a local desire to consult on the principle of the new build ahead of the ‘One Gloucestershire’ scheme which is proposed for full public consultation in early 2018.

Statement of assurance

Following consideration of the evidence presented and the discussion at the assurance meeting and subsequently, it has concluded that this scheme is assured against the four key tests of service change:

- *strong public and patient engagement;*
- *consistency with current and prospective need for patient choice;*
- *clear clinical evidence base;*
- *support for proposals from clinical commissioners.*

Partial assurance is provided regarding the NHSE Beds / Patient Care test, as introduced in April 2017, this is in part due to the clinical model assessment and review being part of the larger ‘One Gloucestershire’ consultation. The current proposal is a reduction in community beds, and verbal assurances have been given that the

associated clinical models and evidence will be provided at the planned stage 2 for the 'One Gloucestershire' scheme currently planned for November 2017."

Subsequent to this assurance statement being received, the planned timeline for the One Gloucestershire (now known as Fit for the Future Programme (FFTF)) has subsequently been severely delayed a number of times. First due to an inability for the pre consultation business case to meet financial governance requirements, then strategic changes leading to a change of approach for urgent care and the range of specialities in scope for the Centres of Excellence proposals and finally by the impact of the COVID-19 pandemic.

The consultation on the single hospital and the decision making regarding the location of that hospital involving a citizen's jury did proceed as planned and this has been completed as outlined above.

Feedback received to this point and during the subsequent engagement on services has highlighted a number of areas of interest to local stakeholders (see Annex 3), that will be addressed in the final stage of consultation to be undertaken in Autumn 2020. Given the partial assurance received from NHS England in 2017 our expectation is that the assurance regarding the four tests would remain valid, with the partial assurance on the bed test needing to move to full assurance prior to approval to move to consultation being received.

The key components of the service model have not changed since the outset of this project in 2015 and there have been no significant service changes since the Stage 2 Assurance meeting that took place in 2017. Broadly speaking the service components are as follows;

Service Component	Model of care and changes since 2017 Assurance meeting
Inpatient bed provision	<p>No change since 2017 assumptions</p> <p>Beds in the locality are proposed to reduce from 47 to 24 based on meeting the needs of the FoD population with a range of alternative community based provision for the non-resident populations.</p> <p>Demonstrable increases in community based alternatives have been achieved.</p>
Urgent care in the Community	<p>Single urgent care facility was proposed in the new facility</p> <p>As a consequence of public feedback the feasibility of a hub and spoke model is being explored with the feasibility of a satellite service in the south of the Forest in conjunction with primary care being explored</p>
Ambulatory care	No significant change since 2017 assumptions

	<p>A full range of outpatients and diagnostics will be integrated from the two existing facilities with the option of an additional endoscopy services being explored.</p> <p>Post COVID we will continue to explore the new models of delivery and ensure technology is appropriately integrated specifically in terms of outpatient and the ongoing use of digital solutions</p>
Elective theatres, maternity provision and core mental health services	<p>No changes since 2017 assumptions</p> <p>No proposed changes to existing service delivery which are currently out with the existing community hospital sites</p>

In essence, the case for change is one of consolidation and rationalisation of the community hospital estate. There are no novel or new service models proposed within the business case which is essentially an infrastructure case concerned with the capital build of a new community hospital. All community based alternatives are in place, and the direction of travel (to care for people in their own homes wherever possible, rather than in hospital beds) is well evidenced at a national level as to the benefits that they offer in terms of supporting people to continue to live independently in their usual place of residence.

Recognising the decision taken to separate the continued progression of the FoD from the wider Fit for the Future programme the system has considered the ongoing inter-relationships in terms of service delivery and models of care. The main interfaces would be in the range and nature of ambulatory care, and particularly outpatient provision in each locality.

For the Forest of Dean we will ensure that the detailed design phase of the new facility has multi-purpose outpatient facilities that will allow most specialities to be delivered therefore future proofing the facility should the models of care across the system change the range of specialities currently being considered.

Our detailed proposals regarding the beds are set out at section 3.1 of this paper and in section 7 of the updated commissioning strategy attached at Annex 1. A summary of our response to the bed test requirements is set out in the following table:

Bed Test Requirement	Evidence
Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new	<p>Significant alternative provision in both beds and 'bed alternatives' has been provided: This includes:</p> <ul style="list-style-type: none"> • Complex Care at home service • Rapid Response Service • End of life hospice care arrangement • Stroke rehabilitation at the Vale

workforce will be there to deliver it; and/or	<ul style="list-style-type: none"> Rehab beds in Gloucester purchased as part of EIO offer
Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or	Not applicable to this case, although it should be noted that our alternative provision for stroke rehab at the Vale and the new end of life care model spot purchase arrangement will reduce admissions to the Forest hospitals for both of these categories
Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).	Our developing new model of care for rehabilitation will improve length of stay in the community hospitals and improve efficiency. This has not been factored into our model and therefore we believe this provides a 'buffer' regarding the number of beds proposed. Our planning proposals have assumed that we will no longer have 'super stranded' patients with a length of stay over 50 days as this does not represent a good quality experience or care outcome for our patients.

Our own internal assurance and governance will also need to be completed, and we have tested our proposals against the best practice checklist – a summary of which is included at Annex 4.

5. Service Models and Response to Engagement Feedback

Our last period of engagement highlighted some key issues that were of particular interest to the local population. Our updated proposals for each of these are set out below. These proposals will form the basis of a final consultation period focused on the services to be provided in the new Forest Hospital which will be conducted in the Autumn of 2020.

5.1 Bed Capacity in the New Hospital

Our proposal for the new hospital is that it should provide a bed capacity that aligns to the needs of the local population of the Forest of Dean. The current number of beds in the hospitals are an artefact of history (where the hospitals were originally built) and do not relate to the needs of the population. The result of this is that at any given time, approximately half of the beds are occupied by people who are travelling from other localities in our county (most typically Gloucester). This is demonstrated in Figure 5.1 below;

	Resident FoD	Non Resident FoD	Postcode not recorded
2017/18	56.32%	39.80%	3.88%
2018/19	54.89%	42.11%	3.00%

2019/20	53.95%	42.43%	3.62%
Grand Total	55.04%	41.47%	3.49%

Figure 5.1 – Admission analysis by Postcode

Whilst length of stay can often be significantly impacted when a patient is not cared for in their immediate locality, in this instance, there is no significant difference for those patients who live within or outside of the Forest. However, to ensure we deliver community services that are as ‘close to home as possible’ in line with our vision, our future plans are to ensure that Gloucester residents no longer have to travel to where the beds have been historically located but are instead able to receive care closer to their home.

The Commissioning Intentions document attached as Annex 1 clearly outlines in section 7 the detailed bed modelling that has been undertaken to develop the proposed bed numbers within the new facility. This is then supported by the ongoing development of community based models of care across the county but specifically into Gloucester and Cheltenham. There is a clear preference in the engagement and consultation responses for people to receive care close to home where possible, and we are aware that patients and families travelling to a Forest hospital when they live in Gloucester or Cheltenham does not represent care close to home for these people.

Figure 5.2 below shows the pattern of admissions to both the Dilke and Lydney Hospitals since 2017 to June 2020. This continues to show a steady downward trend which correlates with the increased activity in community-based alternatives as shown in Section 5.2.

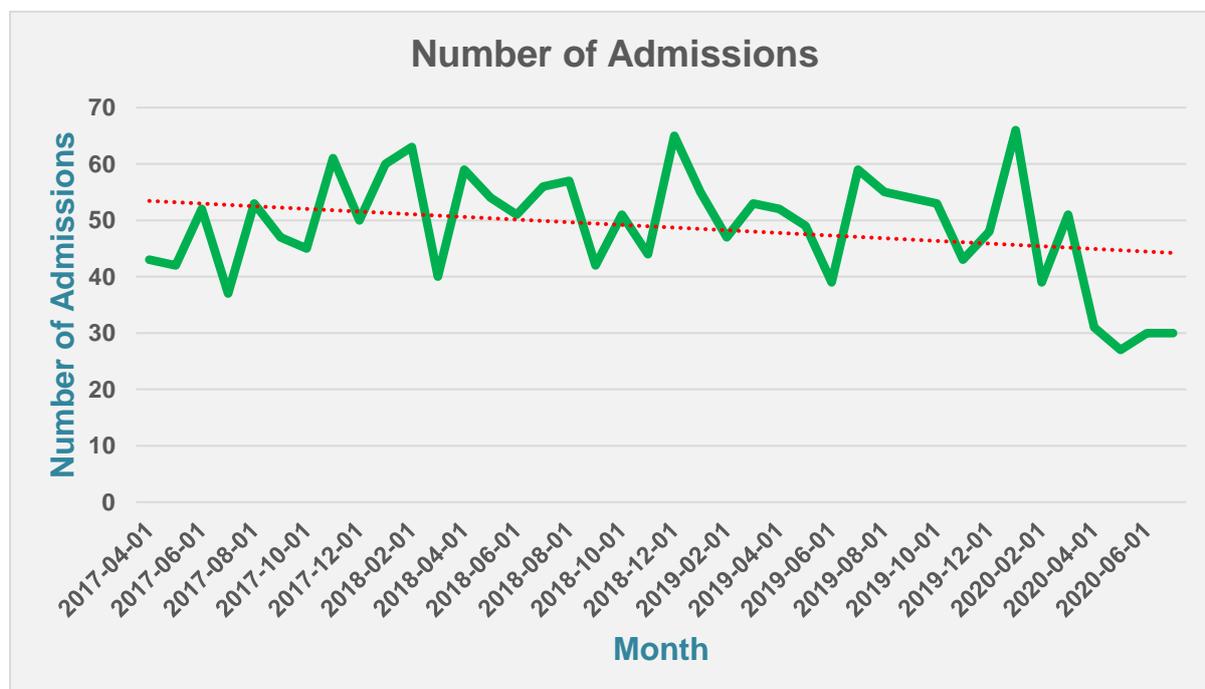


Figure 5.2 – Number of Admissions

Occupancy across all community hospitals has reduced since-Covid (period from 23rd March 2020 onwards) compared to pre-Covid (see Figure 5.3 below).

As can be seen, from the table below occupancy levels since Covid have been at an average of c80% across the county for community hospital beds which also takes into account a reduction in beds at Dilke and Lydney (and other hospitals with bays) as a consequence of introducing zoning arrangements to enable us to safely manage patient flow and the introduction of 2m spacing between beds.

For Dilke and Lydney this has reduced the overall bed capacity by an average of 10 beds over the period since 23rd March, which is a decrease in overall bed capacity of 20% in the Forest of Dean.

Hospitals	Bed Occupancy %		
	Pre-Covid	Since-Covid*	% Change
Cirencester	95.7%	75.7%	-20.9%
Dilke	91.1%	74.4%	-18.4%
Lydney	91.3%	77.7%	-14.9%
North Cotswold	97.0%	91.7%	-5.5%
Stroud	93.3%	78.4%	-15.9%
Tewkesbury	97.6%	82.5%	-15.5%
The Vale	97.0%	91.6%	-5.5%
Grand Total	94.6%	80.9%	-14.5%

Figure 5.3 – Community Hospital Occupancy Percentages

*Given the difficulties of ensuring the estate of Dilke and Lydney in meeting infection prevention and control requirements of managing in a COVID pandemic only 30 beds have been open since March 2020, with this occupancy it means the average beds utilised have been 22.4 through this period in total across the two sites, with no impact on system flow. With the caveat that patient activity levels have been affected by the impact of COVID, it can be seen that the community hospitals, including Dilke and Lydney, have managed patient flow well to ensure more than sufficient community bed capacity has been available to the system to manage demand.

The model of care within all of our Community Hospitals is for sub-acute, general rehabilitation and to support those who may have complex discharge needs. There is no change proposed in this model of care from the existing utilisation of beds at the Dilke or Lydney Hospital to that proposed within the new facility. Predominately these beds are therefore used for patients stepping down from an episode of acute hospital care and in need of a period of intense rehabilitation to maximise their independence

and outcomes. Additionally, the units will admit people directly from the community and therefore help prevent an acute hospital admission.

The impact of COVID has not resulted in an overall change in the admission criteria or rehabilitation offer made from the Community Hospitals. However, we acknowledge that throughout COVID there has been an enhanced focus on the rapid discharge model and the accelerated implementation of a 'Home First' approach.

As a consequence, we anticipate that we will see an impact in that more people will be going directly to their usual place of residence from an acute hospital admission and therefore there should be less people requiring a community bed. Implementation of the Home First model would suggest that only 4% of patients in an acute hospital will then require a community hospital admission which again will be a consideration in the bed modelling in terms of the proposed bed reduction. Similarly, the community hospitals should be able to use the home first model to discharge patients in a timely manner which will help to reduce LOS and increase capacity.

5.2 Community Based Models of Care

Our vision for our county is that we expect to have less reliance on inpatient beds, including community beds over time, as we have invested extensively in community-based alternatives such as Rapid Response (a service providing care in people's own homes and minimising delayed transfers of care) and Complex Care at Home. To support reduced length of stay, a new bed-based rehabilitation care model is being developed to improve patient outcomes and reduce length of stay over time through more intensive, multi-disciplinary team support.

Our community teams are now operating in a relatively stable state. Whilst we are continuing to implement an Enhanced Independence Model in conjunction with primary care our core integrated community teams and rapid response services are now stable. Our Current funded establishment for our Forest & Tewkesbury Integrated Community Team locality is 94.29 WTE. In addition, we have 5.7 WTE in our Complex Care at Home team and the EIO/Reablement service which is a Gloucester County Council service managed by GHC and supporting the community services has 37 wte across the Forest and Tewksbury locality.

5.2.1 Complex Care at Home

The Complex Care at Home (CC@H) service is a preventative, proactive model of care provision that aims to support people at home using a Case Management approach. The service was specifically started in Cheltenham and Gloucester and runs weekdays from 8am to 6pm. We are now starting to expand the model out into other localities.

The team consists of Community Matrons / Case Managers, Dementia Matrons with a RMN qualification, Physiotherapists, Occupational Therapists, a Dietitian, Social Care Practitioners and Wellbeing Coordinators.

The CC@H service accepts referrals from GPs, Integrated Community Teams, Rapid Response, Specialist Services, the Enhanced Discharge Service, the Integrated Assessment Team and its voluntary partners.

Aims of the service

The CC@H service aims to proactively manage patients with complex health needs, in the community, who may previously have been high users of primary care and/or urgent care services. Using a case managed proactive approach to care, there will be a reduction in unplanned admissions to the acute services and/or a delay in escalation of their health and social care needs. The principles of the service include;

- Proactive management of patients in the community who may have been previously high users of primary and urgent care services
- Patients will be seen within 10 working days of referral being received
- Use of a case managed coordinated approach to care
- Person centred approach using the tool “My Life, My Plan”
- Support the person to improve their health and wellbeing by developing a patient centred partnership
- Put the person and their family/carer at the centre of their treatment/care plans
- Improve patient and carer experience
- Reduction or delay in escalation to a care home placement, or nursing home bed
- Better use of assistive technology, such as Telecare and Telehealth to support more patients at home

Figure 5.3 and 5.4 below demonstrate the increased referral pattern and number of contacts since the service commenced in 2018/19.

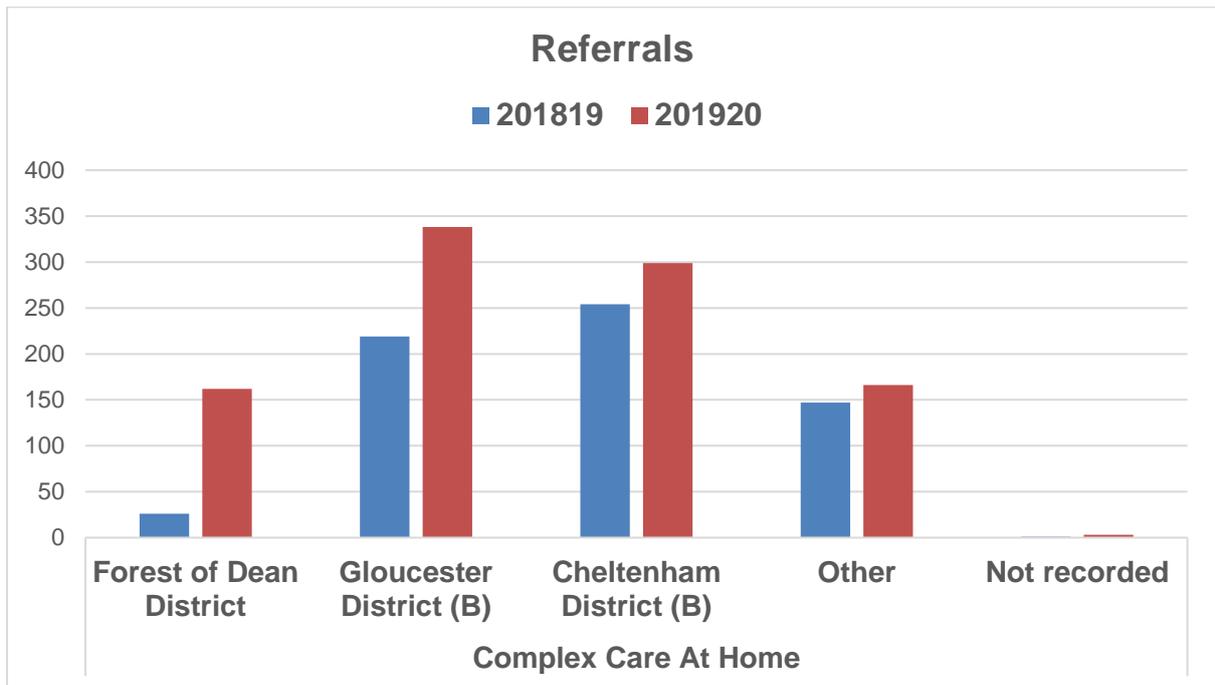


Figure 5.3 – Referrals to Complex Care at Home Service

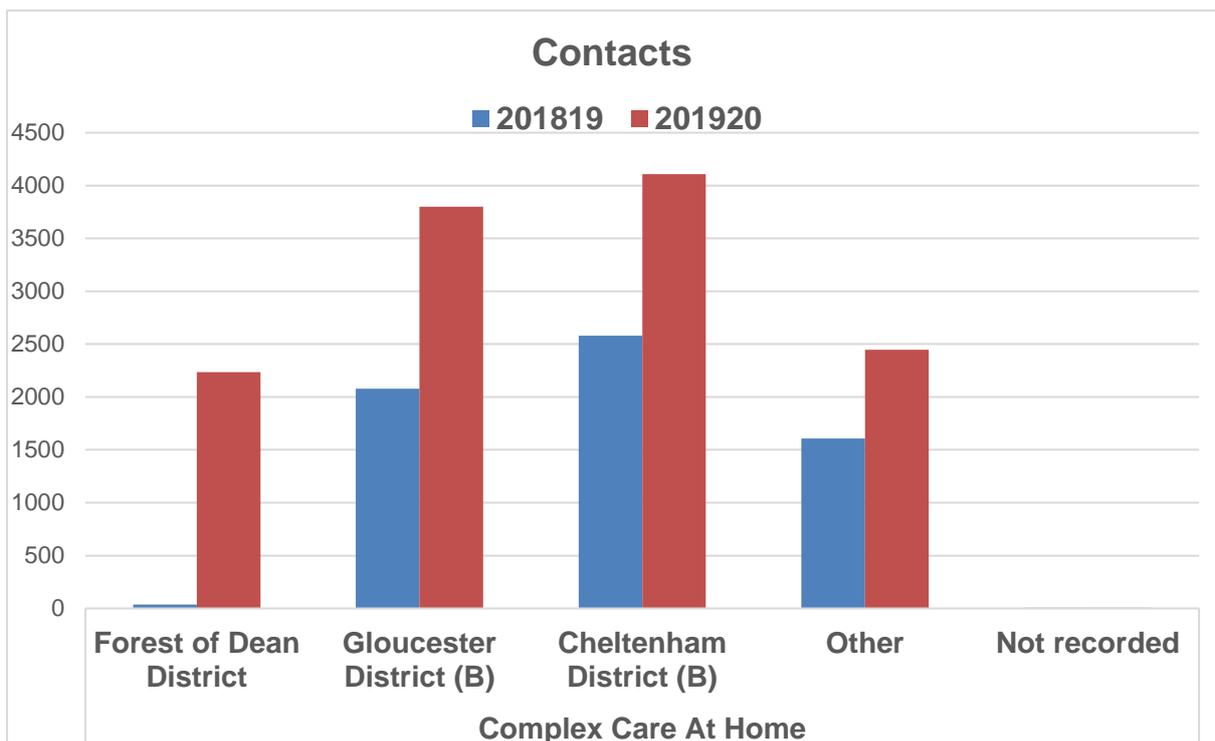


Figure 5.4 – Contacts undertaken by locality by the complex care at home team

5.2.2. Rapid Response

The rapid response service is a dedicated team of professionals who support older people and adults with complex health needs who have a very urgent care need, including a risk of being hospitalised. Response can be accessed within 2-4 hours to provide a range of support that will enable a person to stay independent and remain

at home whilst recovering from any exacerbation in a health condition or equally will help them restore their independence and confidence on discharge from hospital.

Whilst this model of care is still evolving Figures 5.5 and 5.6 below show that there is now a steady and stable service offered in both Gloucester and Cheltenham since it commenced in 2017/18.

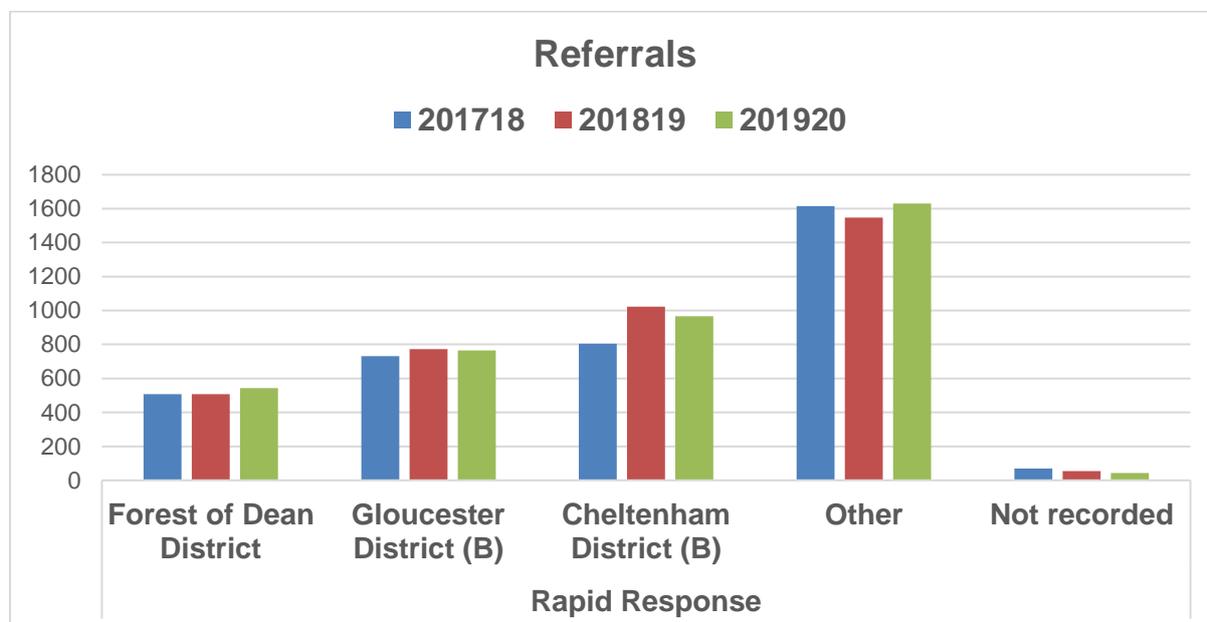


Figure 5.5 – Number of Referrals to Rapid Response – 2017/18 – 2019/20

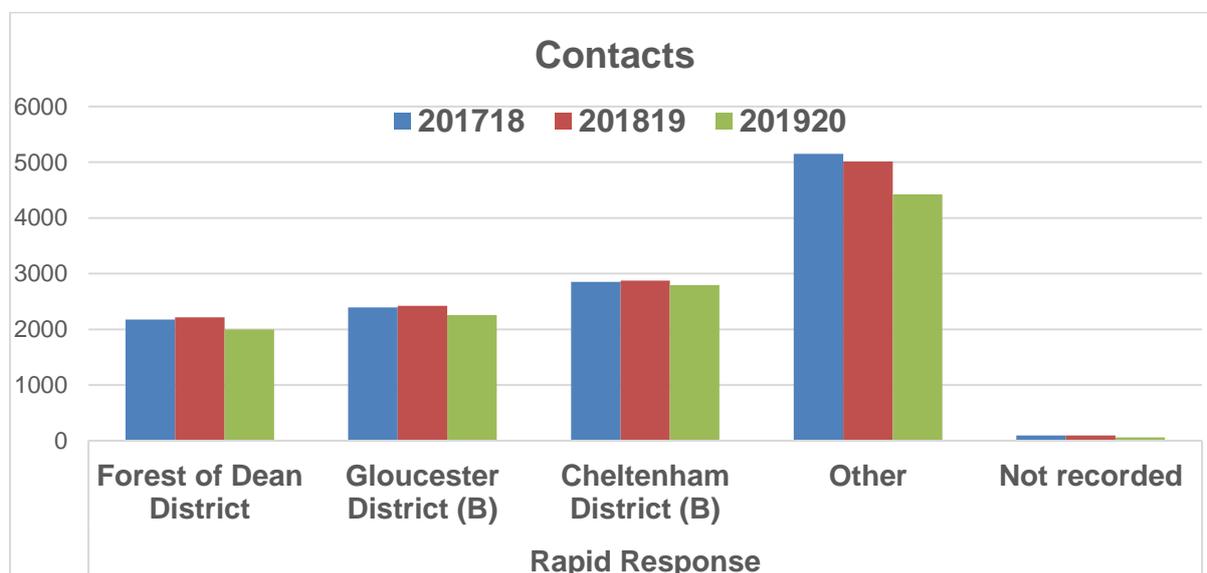


Figure 5.6 – Number of Contacts undertaken within the Rapid Response Team – 2017/18 – 2019/20

5.2.3 Integrated Community Teams and Reablement

The reablement staff work as part of our integrated community teams with a specific focus on supporting people to lead independent lives in their own home, safely and appropriately, for as long as possible by enabling them to do things for themselves instead of relying on others to do things for them.

Typically, reablement support is given to people following an illness, injury or other sudden event which may have reduced their physical, emotional or psychological ability to manage their own lives.

Reablement is delivered in partnership with the service user, as the reablement worker and the individual both have responsibilities in working towards recovery and the agreed goals. This enables people to be in control of their choices and to maintain their independence safely and appropriately. Again this service remains in development but as can be seen in Figure 5.7 below the levels of activity are increasing as this service evolves.

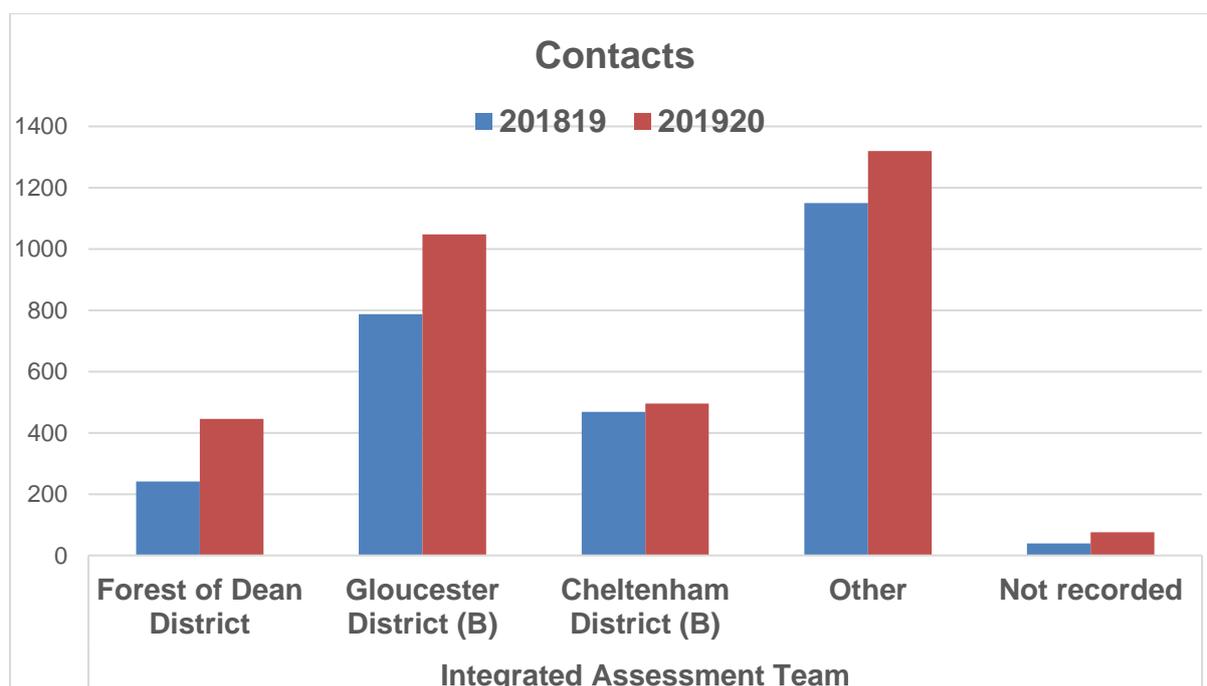


Figure 5.7 – Contacts undertaken within Integrated Assessment Team

5.2.4 Additional Community Bed Provision

The community based services are also supported by a range of assessment unit beds for reablement, rehabilitation (including acquired brain injury), non-weight bearing and Discharge to Assess for Continuing Healthcare and Adult Social Care assessments and therapeutic input as outlined below in Figure 5.8.

These strategically positioned units, in line with our Enhanced Independence modelling, allows for bed based support to be provided as close to a person's locality as possible whilst maximising efficiencies for nurses, social workers and therapists by co-location rather than the previous model of county wide spot purchasing. The enhanced nursing input and staffing ratios within these units also relieve pressure on community hospital beds. In addition, the system has continued to support admission avoidance and direct GP access observation beds.

Capacity Sept 2020	Locality	Type of Bed	No. of Beds
Ashley (Greville)	Cheltenham	Assessment	15
Kingham (Jubilee)	Cotswold (Bourton)	Assessment	14
Chestnut Court	Quedgeley / Stroud	Assessment	20
Millbrook Lodge	Brockworth / Tewks	Assessment	20
Great Western Court	Gloucester	Residential Reablement	30
Wheatridge Court	Gloucester	Reablement / Rehabilitation / ABI	27
Malvern View	Winchcombe	Admission Avoidance / GP Observation	6
Windsor Street	Cheltenham	Admission Avoidance / GP Observation	4
		Total	136

Figure 5.8 – Community bed based capacity September 2020

We are confident that there is sufficient community bed capacity available to meet the needs of the Gloucestershire residents however, should additional capacity be required the Integrated Brokerage Team are able to spot purchase additional demand in any locality where applicable and / or appropriate.

The above assessment units, as part of the Enhanced Independence offer in Gloucestershire, are monitored regularly to maximise the usage and access to community beds and the ability for people to remain safe in their own place of residence.

It is worthy of note, that during the COVID pandemic the two hospitals in the Forest have had to significantly reduce bed capacity (currently operating at a total of 30 beds across both sites) due to the configuration of the current inpatient environment and the capacity and flow of patients has not been significantly impacted. The flexible model of alternative community provision has enabled the capacity to be flexed appropriately.

5.2.5 Rehabilitation Model

The need for a new approach to rehabilitation in Gloucestershire was identified in a GCCG commissioned external review completed in January 2015. Findings reported a fragmented rehabilitation pathway, no general rehabilitation “offer” or specification and service provision which showed significant clinical variation both in access and skill set.

Following this review, the Rehabilitation Steering Group and a cross organisational Consensus Group of local clinicians (with expertise in working in rehabilitation) agreed

that Gloucestershire would adopt both the definition of rehabilitation and the principles and expectations of “what good looks like” produced nationally as part of “commissioning good rehabilitation” (NHSE, 2016) and out of this work a set of standards for the delivery of ‘core rehabilitation’ across Gloucestershire were agreed.

In 2016/17 Occupational Therapy (OT) and Physiotherapy (PT) activity data within community hospitals was analysed to ascertain the levels of rehabilitation being undertaken in community hospitals and compare against what was agreed to be good practice in terms of intensity and outcomes. The analysis used a definition of 3-6+ therapeutic contacts indicating some form of rehabilitation had occurred and the key findings were;

- PT sessions were shorter in length than OT but required more frequently in order to achieve the level of mobility required to enable people to function in their own home.
- Due to the level of dependency and probable deconditioning 48% of people needing Physiotherapy required 2 people to carry out all or part of the treatment session.
- OT sessions consisted of assessment and discharge planning as opposed to treatment, were longer in length but required less frequently.
- Rehab support workers needed to be more focused on functional rehabilitation needs as opposed to “walking practice”.
- There was room for improvement in goal setting and outcome measurement.

However, the most significant finding was that;

At the point of the review, which took place over 3 months; nobody occupying a community hospital bed, with the main reason for admission as “rehabilitation”, received a rehabilitation contact from a therapist or therapy assistant on 5 days/week.

The combination of benchmarking work, evidence for the efficacy of improved access to PT, lack of national guidance on recommended staffing levels and production of agreed quality standards has led to an expert consensus group opinion that a level of staffing is required in order to deliver;

- Physio (combination of qualified and unqualified) – minimum 30 mins/ day over 5 or 7 days 52 week/year
- OT – (combination of qualified and unqualified) – minimum 45 mins/ day over 3 days 52 week/year.

The expert consensus suggested that by improving the therapy resource within community hospitals to be able to deliver the core rehabilitation standards across 7 days per week we would achieve;

- Patients being ready for discharge at the earliest possibly opportunity. If patients do not receive frequent input from therapy staff deconditioning can take place, which can increase the time it takes for people to reach a level of mobility and function to be able to return home.

- A reduced length of stay (LoS) as currently the gaps between therapy sessions mean improvements do not carry over from day to day and opportunities to shorten the rehabilitation period are missed.
- Increased therapy staff will support transfer of those people (often in the stranded/superstranded range) who require more intense therapy or more than 2 people to treat thus reducing LoS for this patient cohort in our hospitals.
- Increased ownership of discharge by OTs and PTs will help to drive timely discharge in addition to the above. The contribution of Allied Health Professionals (AHPs) in promoting timely discharge is increasingly acknowledged nationally.
- Increase in people able to be discharged to their usual place of residence due to increased levels of independence
- Reduced deconditioning during the inpatient stay leading to reduced LoS and demand on community based services on discharge

Based on both CCG and GHC reviews, in Gloucestershire 74% of 2681 admissions to community hospitals (17/18 data) for rehabilitation require physiotherapy as the primary need. The overall current average LoS across all community hospitals is 27 days. This 74% of patients would benefit from improved access to physiotherapy of up to 6 contacts a week which has the potential to reduce LoS by 2 days. A 2 day reduction in LOS could equate to approximately 5 beds being saved across the system.

This is particularly relevant to the new Forest of Dean Hospital where the bed modelling has assumed that there will be no patients with a length of stay >50 days and therefore a reduction in overall LoS is important.

The proposed model of care within the FoD new hospital is designed to meet these standards and include a 7 day therapy service. We therefore believe that we will be able to swiftly move forward with this model and achieve the benefits outline which will drive down the currently static length of stay position.

5.3 Length of Stay

Length of stay is the term the NHS uses to describe the number of days a patient stays in a bed. It can be affected by many different factors, including the severity of the illness, the availability of onwards care, the care provided to the patient in hospital and the availability of hospital beds. Our fundamental principle will be that we will only put people in beds where it is in their best clinical interest to be there, because we know that 10 days in hospital leads to the equivalent of 10 years ageing in the muscles of people over 80 (Gill et al 2004), and that one week of bedrest equates to 10% loss in strength, and for an older person who is at threshold strength for climbing the stairs at home, getting out of bed or even standing up from the toilet, a 10% loss of strength

may make the difference between dependence and independence (Hoenig & Rubenstein, 1991).

The current length of stay at the two hospitals in the FoD has remained relatively static for the last three years with an average of 25 days. See Figure 5.9 below.

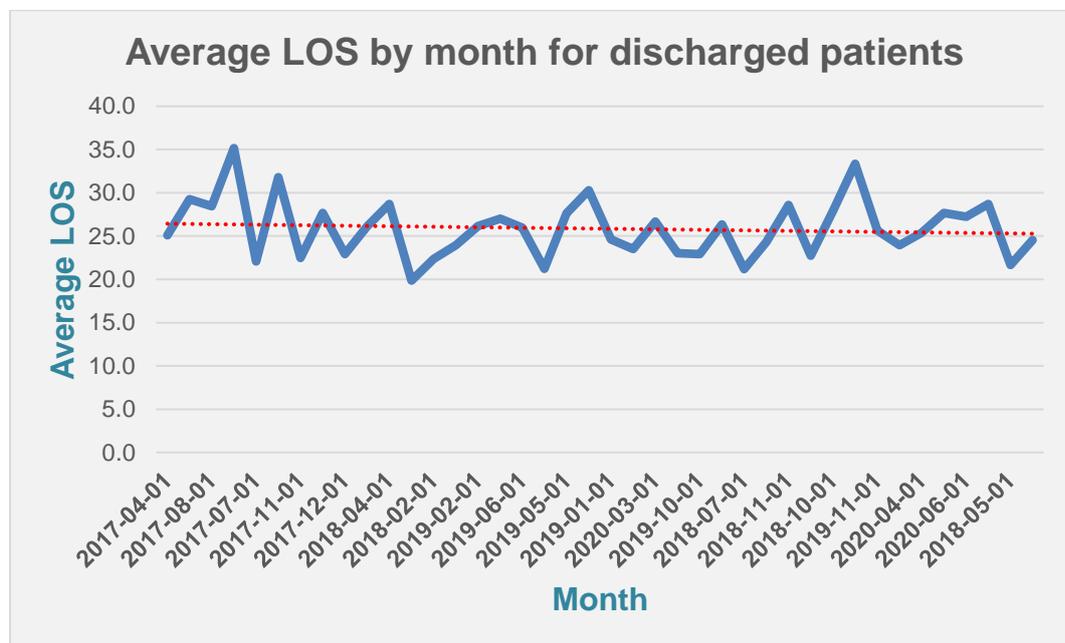


Figure 5.9 – Average LOS for patients in Lydney and Dilke Community Hospitals

Taking these factors into account, some of our key drivers for change and measures of success will be as follows:

- No-one should stay over 100 days in a hospital bed, and reduce over 50 day stays with a view to eliminating these moving forward. Over the years (2017/19 – 2019/20) whilst the numbers remain small there has not been a significant movement in those patients whose LOS was >50 days whilst the >100 days LOS has been eliminated at Lydney Hospital and is an average of 1 patient at the Dilke.
- Deliver the proposed rehabilitation model within the inpatient setting and achieve a minimum 30 mins/ day over 7 days of physio intervention and a minimum 45 mins/ day over 3 days for OT intervention. This investment into the rehabilitation model of care referenced above will be a key enabled to reduce the current static average LOS.
- Absorb the impact of demography, by using our bed stock more efficiently. We will do this by reducing length of stay to reach benchmarked opportunities, improving pathways and ensuring people are only admitted to beds where doing so really enhances their care.
- Deliver care closer to home where possible, and deliver care in centres of excellence where evidence demonstrates that clinical outcomes will be improved.

- Continue to deliver improvements to our discharge processes to avoid any patients being delayed going home for non-medical reasons, such as access to care in the community

In addition to these factors, the recent experience of managing local provision through the COVID-19 major incident has highlighted again how the existing community hospitals in the Forest of Dean are not suitable to manage modern healthcare and the need for rigorous infection prevention and control measures. The fabric of the old buildings does not allow for extensive deep cleaning and to manage the beds during the pandemic it has been necessary to close a considerable number of the beds in the two Forest Hospitals since March. Since April 2019, admissions into the two Forest Hospitals have had to be reduced to an average of 6.5 per month compared to an average of 14 per month pre-COVID.

5.4 Proposed Bed Number and configuration

Given all of the ongoing investment that has been made into the community based alternatives and the demonstrable ongoing growth and update of these services, along with the ongoing discussions around Enhanced Independence Interventions and the ability to continue to review and flex our spot purchase capacity our proposal for the new Forest hospital has remained at 24 beds (based on modelled demand plus demographic growth, and mitigated by the impact of new care models).

Our proposal however has evolved to suggest that we should aim to build the new hospital with 24 single self-contained rooms, ensuring that we can manage care as safely as possible with regards to managing infection prevention and control.

Inpatient Staffing Ratio's

The development of the staffing model has been taken forward on the basis of a 24 bedded unit taking account of the fact that this is a relatively isolated unit, with minimal onsite support out of hours.

	Band 6	Band 5	Band 2
Early	1	1	4
Core		1	
Late	1	1	4
Night	1	1	2
Total per day shift	2	3	8
Total day shift/week	14	21	56
WTE (incl. 23% uplift)	3.4	5.2	13.8

Total per night shift	1	1	2
Total night shift/week	7	7	14
WTE (incl. 23% uplift)	2.3	2.3	4.5
Total WTE required	5.7	8.0*	18.3
		<i>*0.5 added to backfill B6 management time</i>	

Proposed therapy staffing

	Physio	OT
Band 6	1.0 (7 days per week, 9-5) 1.4WTE + 23% = 1.7WTE	1.0 (5 days per week, 9-5) 1.0WTE + 23% = 1.23WTE
Band 5	1.0 (5 days per week, 9-5) 1.0WTE + 23% = 1.23WTE	1.0 (5 days per week, 9-5) 1.0WTE + 23% = 1.23WTE
Band 3 (Rehab assistants)	2.0 (7 days per week, 9-5) 2.8WTE + 23% = 3.4WTE	

- The WTE for qualified staff is the same as is in the current establishment for the current Lydney Hospital. However the skill mix is slightly different in that we considered the need for additional senior cover overnight and have therefore shifted B5 resource to B6 resource on night duty. This recognises the level of dependency and acuity of the patients and the remoteness of the hospital from other services. This is comparable with the model in most of our community hospitals however, we accept that this is not always in the funded establishment
- The WTE for HCAs has been increased by 0.5WTE from that in the current establishment for Lydney Hospital. This is to allow a full late shift rather than a twilight shift which is in the current establishment – the twilight shifts are difficult to fill and leave a gap during a busy time of day when most of the admissions arrive (i.e. late afternoon/early evening)
- In addition to the above numbers we would have a 1.0WTE Band 7 Senior Sister and the 1.0WTE Band 8a Matron to ensure senior professional leadership in place.

For comparison purposes, the table below provides details of the current establishment at both existing sites. It should be noted that neither site operates at full establishment and both have significant utilization of bank and agency to maintain safe staffing levels.

Combined current Dilke and Lydney nursing establishment

	Band 8a (WTE)	Band 7 (WTE)	Band 6 (WTE)	Band 5 (WTE)	Band 2 (WTE)
Dilke	0.5	1.0	3.5	13.7	20.56
Lydney	0.5	1.0	3.5	10.2	17.5
Total	1.0	2.0	7.0	23.9	38.06

We recognise that there is a need for a clear and well-developed transition plan to move the staffing models from the existing two models to the requirements within the new hospital. This is something that GHC has experience in having undertaken similar changes to staffing models in Tewkesbury. As timings become clear in for the new hospital then we will ensure a suitable transition plan for both bed capacity and staffing models will be agreed with commissioners and partners across the ICS.

5.5 Urgent Care in the Community

As part of the ongoing development of the Fit for the Future programme we have established that there are clear drivers for change for community urgent care services. These have been developed from extensive public and stakeholder engagement and can be summarised as follows;

- Reduce confusion – the public have clearly stated that they find the current model of delivery confusing and inconsistent with too many entry points
- Accessibility - the recognition that a community urgent care service should be offered in every locality
- Sustainability - proposed changes must minimise the impact on the main Emergency Departments at both Gloucester and Cheltenham Hospitals.

An extensive piece of work was undertaken to review the model of provision of urgent care in the community across the whole of the county, but particularly focused on the Minor Injury and Illness units provided in the seven existing community hospitals. Recommendations have been proposed including that the national Urgent Treatment Centre model would not be implemented across Gloucestershire.

Countywide context for Minor Injuries and Illness services

Illness is core to the business of primary care, over time all MIIU services in the county will focus on injuries, with illness being redirected to primary care MIIU services will increasingly be pre booked ('talk before you walk') this will support the redirection of illness to primary care. Some PCN's and Practices are interested in delivering injury care in line with the Winchcombe model. This has the potential to be a cost effective model based on evidence of low use of urgent care services for the Winchcombe practice population

Forest of Dean Minor Injuries and Illness services context:

Our proposal for the new community hospital is that there will be an urgent care centre that is operating 7 days per week to replace the existing two centres at Lydney and Dilke hospitals. The new hospital will include space for an urgent care facility which will be open from 8am to 8pm, seven days a week. This unit would be supported by a range of diagnostic services including x-ray which would be open 7 days a week. It should be noted however, that only c5-6% of people who present to the urgent care services require an x-ray. The bulk of x-ray usage in the Forest hospitals currently is by people who are referred by their GP, or who are attending the outpatient department and require supporting diagnostic investigations.

Opening hours of the existing units have changed due to the recent pandemic, with Lydney MIIU now open from 8am to 8pm and Dilke MIIU remains closed temporarily (since March 2020). Prior to this, both units were open from 8am to 11pm, seven days a week. Before the changes that were made to respond to the pandemic, on average 26 people per day attended the MIIU at the Dilke with a similar number attending the MIIU at Lydney. The majority of people attend the MIIU's between 8am and 8pm, with only an average of 1 person per hour presenting between 8pm – 11pm. This activity is calculated for a mix of both minor injury and minor illness issues and over time we would be expecting more patients with minor illness to be seen by their GP as access to primary care continues to extend.

Activity analysis across the system demonstrates a typical split of injury to illness is that 62% of the activity is injury and the remaining 48% is illness - as set out in the GHC audit of activity at North Cotswolds Community Hospital, January 2019). Based on 2018 / 2019 data, the baseline figures for the Forest of Dean suggest that that year the Forest units saw 10,766 minor injuries attendances and 6,598 minor illness attendances.

Commissioning a primarily minor injuries only service from the new community hospital would reduce activity in the unit to around 10,766 contacts per annum (2018/2019 baseline). Modelling indicates this would reduce the size of the unit required and would lead to a reduction in staffing costs. The redirection of illness to primary care would equate to an additional demand on primary care practices amounting to 6,598 appointments per annum or on average an extra two appointments per working day in each of the PCN practices if illness is moved out of the centre (26 extra appointments per 252 working days practices in the locality are open).

To date, our working has assumed we will provide one Minor Injuries Unit in the Forest Hospital to provide services to the whole locality. Following the recommendation of the citizens jury to position the new hospital in Cinderford, we have received engagement feedback expressing concerns about access to urgent care provision for the district (these concerns are related in part to travel and access), and in particular with regards to provision for Lydney and the surrounding area in the south of the Forest of Dean.

We would like to fully acknowledge the concerns raised during our last phase of engagement around the availability of urgent care in the southern areas of the Forest and the challenge for residents in terms of distance and accessibility to the new hospital in Cinderford. We will therefore convene a working group including local stakeholders alongside the consultation to explore if it might be possible for us to develop other options for the provision of additional urgent care services in the Lydney area. We will work with the local community and healthcare partners to identify any potential solutions, which will then need to be tested to ensure they provide high quality, deliverable services into the future.

The proposal for the new hospital is that we provide a unit that can provide care in space terms to the patient numbers currently accessing both of the existing MIUs at the new hospital in Cinderford. Testing patient numbers against space requirements indicates that the impact of any potential Lydney / South Forest option would not make a significant enough change to patient numbers to affect the space requirement for the unit included in the infrastructure business case.

5.6 End of Life Care Provision for the District

There was interest in the recent engagement on the services model in the proposals regarding end of life. More detailed proposals for our proposed approach to delivering End of Life Care in line with national and local strategies for End of Life, are set out in the commissioning intentions paper attached at Annex 1.

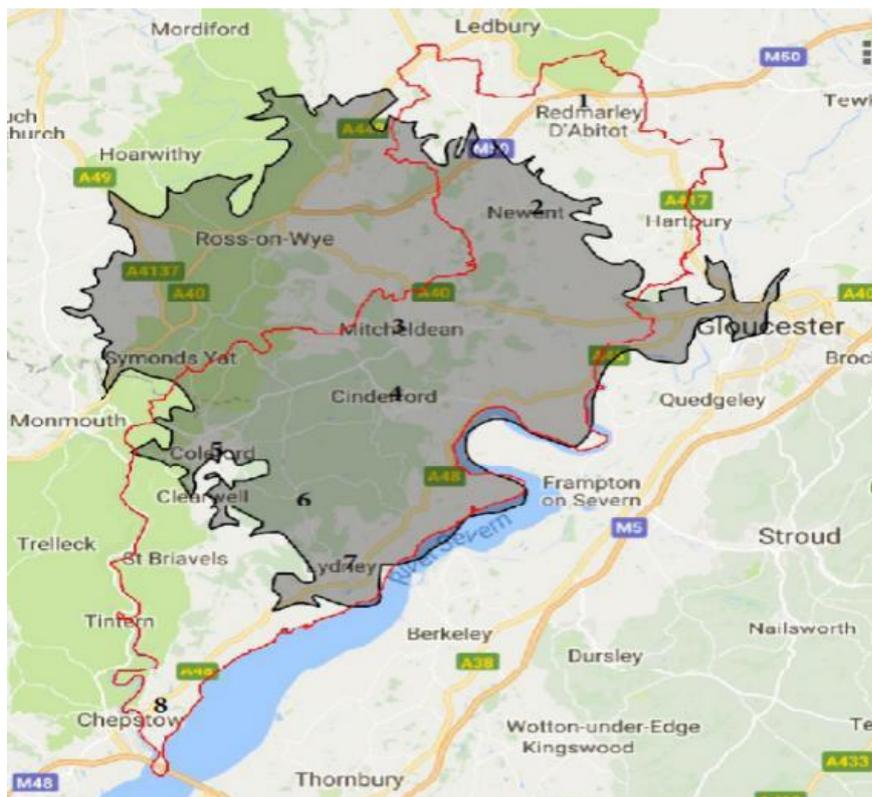
A local 'spot purchase' model has been put in place in the locality working in partnership with the Great Oaks Hospice, to provide bedded and outreach home based hospice care in the locality. The pilot for this was well underway before the peak of the pandemic with two care homes selected on the basis of their capability to manage people near and at end of life and their usual capacity and vacancy rate. During the peak of the pandemic most care homes nationally "locked down" and this was the case for the two homes concerned. The project therefore is currently on hold but we are in the process of recommencing discussions with the homes identified but remain confident that the pilot is delivering the anticipated benefits to the local population.

6. Travel and Access

Travel and access have been a consistent theme in all stages of the engagement processes. Detailed analysis has been completed to consider the travel implications associated with the change in service delivery. We have analysed the rates of car ownership and public transport services in the district. Over 80% of the people who responded during a public engagement event indicated that they have their own

motorised transport with 10% generally relying on public transport as their main mode of transport. Since the travel analysis was completed the decision has been made to locate the new facility in Cinderford and a site has now been acquired by Gloucestershire Health & Care NHS FT.

Figure 6.1 below show the locations that can access Cinderford within a 30-minute travel time by car which shows that the two main urban areas of Lydney and Coleford are within this parameter. The main town area impacted will be Sedbury as this cannot be reached within the 30-minute timeframe.



30 minutes drive from Cinderford

- | | | |
|----------------------|--------------|-----------|
| 1 Redmarley D'Abitot | 4 Cinderford | 7 Lydney |
| 2 Newent | 5 Coleford | 8 Sedbury |
| 3 Mitcheldean | 6 Parkend | |

In relation to public transport a 90-minute journey time was considered to arrive at Cinderford by either 8.30am or 1.30pm and then associated departure times. This showed that based in Cinderford people from Lydney could achieve 3 out of the 4 timeframes but were unable to achieve the 1.30pm arrival time in 90 minutes. Again, Sedbury was the most affected locality with only 3 out of the 4 scenarios being possible.

In the past we have successfully worked with local councils to ensure that bus routes are adjusted to provide better access to NHS facilities and we would seek to do the same for any new hospital located in the Forest of Dean. Additionally, there is a strong provision of community transport available across the Forest of Dean and we would continue to work with these providers to ensure a robust offer and particularly look to improve the impact for those residents most affected.

Whilst the proposal would see a significant proportion of service delivery based within the new facility at Cinderford, there are some services that we anticipate will still continue to be provided within community venues and health centres across the remaining localities. These are still to be confirmed and will be dependent upon the availability of suitable accommodation and ongoing developments within primary care premises. Additional mental health service provision continues to operate from Colliers Court and ongoing integration opportunities are being explored. Figure 6.2 below outlines the indicative assumptions in each locality.

Lydney	Newent	Coleford	New Hospital - Cinderford
HV Development Clinics	HV Development Clinics	HV Development Clinics	Full range of community led treatment clinics e.g. MSK, podiatry, dental and consultant led outpatient services consolidated from the two existing hospital sites
Baby Hubs	Baby Hubs	Baby Hubs	
Antenatal groups	Antenatal groups	Weaning hubs	
Weaning hubs	Podiatry	ICT hot desk facility	
School nursing	MSKAPS (out-reach)		
*Adult MSK Physio			
*Podiatry			
CYP SaLT			

Figure 6.2 – GHC proposed community service provision by locality across the FoD

*subject to suitable facilities/premises being available – not currently secured

7. Other Service Updates

In light of recent experiences with services due to COVID we will need to revalidate the following assumptions:

7.1 Ambulatory Care

The feedback we received was positive regarding the range of ambulatory care proposals identified by the previous work. This included services such as Endoscopy, a range of outpatient services and diagnostic services such as plain film x-ray, ultrasound and phlebotomy.

- Endoscopy – this remains an area of growth across the county with the changes in demand being driven by the expansion of the age range for the bowel screening programme and the demography of the population. Overall, the county has a shortfall in capacity for endoscopy procedures and therefore the provision of a unit

in the Forest of Dean will ensure a locally available service and reduce the pressure on services within the main hospital units. This remains consistent with our planning assumptions in 2017

- Outpatients – the need to have a range of local and accessible outpatient services in the community hospitals was an important element from the engagement exercises and the new hospital will have sufficient rooms to ensure that people continue to be able to access consultant led outpatient services in a convenient manner. The impact of Covid-19 has meant a change in the way services are currently delivered, including outpatient appointments and therapies, but that looking beyond this our intention is to continue to deliver services as close to home as possible and acknowledge that this may now include a greater use of technology and virtual appointments either by telephone or video where appropriate to do so.
- No changes are proposed to the range of diagnostics from the previous engagement and assurance processes. Services such as phlebotomy, ultrasound and plain film radiology will be available locally from the new facility.

8. Workforce & Finance modelling

Workforce

GHC has taken the opportunity to refresh its workforce modelling being mindful of the impact of COVID and the decision taken to move to 100% single rooms. We also can confirm that our assumptions include the updated rehabilitation model as outlined in our model of care.

The current assumptions remain that the bringing together of the workforce from the two current sites will lead to better service and staff resilience, increased job satisfaction and improved health and well-being of the staff.

Finance

The Outline business case was received by the former Gloucester Care Services Trust Board in July 2019 and this continues to be refreshed and developed. This work includes the revalidated workforce modelling to acknowledge the shift to 100% single rooms and the 7 day rehabilitation model. The service model proposal for the new hospital has not changed significantly and remains affordable in revenue terms.

At this stage, we do not have detailed financial models as we have been waiting for the service consultation to be start prior to taking forward any detailed financial modelling updates. However, the original case shows there is a saving from one hospital that offsets the capital charges and we are confident that this remains the case. Transitional costs have also been considered and are within the baseline model.

Transitional costs have been considered and are within the baseline model. Ongoing sensitivity analysis is being undertaken including accounting for current known risks in terms of any site 'abnormals' and potential 3rd party income from other public sector partners (e.g. South West Ambulance NHS Trust) who are considering relocating their local base. Capital costs continue to be refined in line with the development of the detailed design, within this there is ongoing value engineering work and the firming up of provisional and contingency sums. No application for capital is intended to fund the scheme.

No application for capital is intended to fund the scheme. Please note there has already been expenditure to date so the latest capital plan from GHC only shows future expenditure. The system is fully aware of the development of the Forest of Dean Hospital and the ICS Board received an update in August 2020 as to the progress and next steps. The Board confirmed a commitment to ensure that the investment in the new hospital is sustainable and can deliver the outcomes needed for the population.

9. Next Steps

The previous proposal to incorporate the Forest of Dean proposals with the wider FFTF programme are no longer so relevant, now that the community urgent care aspect of the FFTF programme has been taken out of the business case.

It is proposed, however, that we retain the association between the two which was built in the previous round of engagement. The proposed timeline for the Forest Hospital consultation in the autumn is therefore as follows:

Timeline for involvement and next steps:

Item	Date
Update proposals for consultation, prepare assurance documents	End July
CCG Governing Body / GHC Board closed session	August
NHSE/I Stage 2 Assurance	1 st October
Launch Services Consultation (aligned with FFTF launch)	Mid October
Close Services Consultation (8 weeks consultation period)	Mid December
Consideration and review of consultation outcomes	January
Complete FBC and progress to building of new hospital	March 2021

Annex 1 - Commissioning Strategy Paper (Updated for 2020):

1.1 Strategic Context

The proposal to develop a new Community Hospital in the Forest of Dean is a key part of developing provision of modern up to date health and care services and to support the evolving needs of local patients, carers and clinical staff.

Our locality plans are framed in the context of our countywide transformation programmes. Our core aim is to improve health and care delivery and population outcomes, within the available resource whilst ensuring system sustainability. The Forest of Dean review needs to reflect these core aims for our system, as well as taking a local place based perspective.

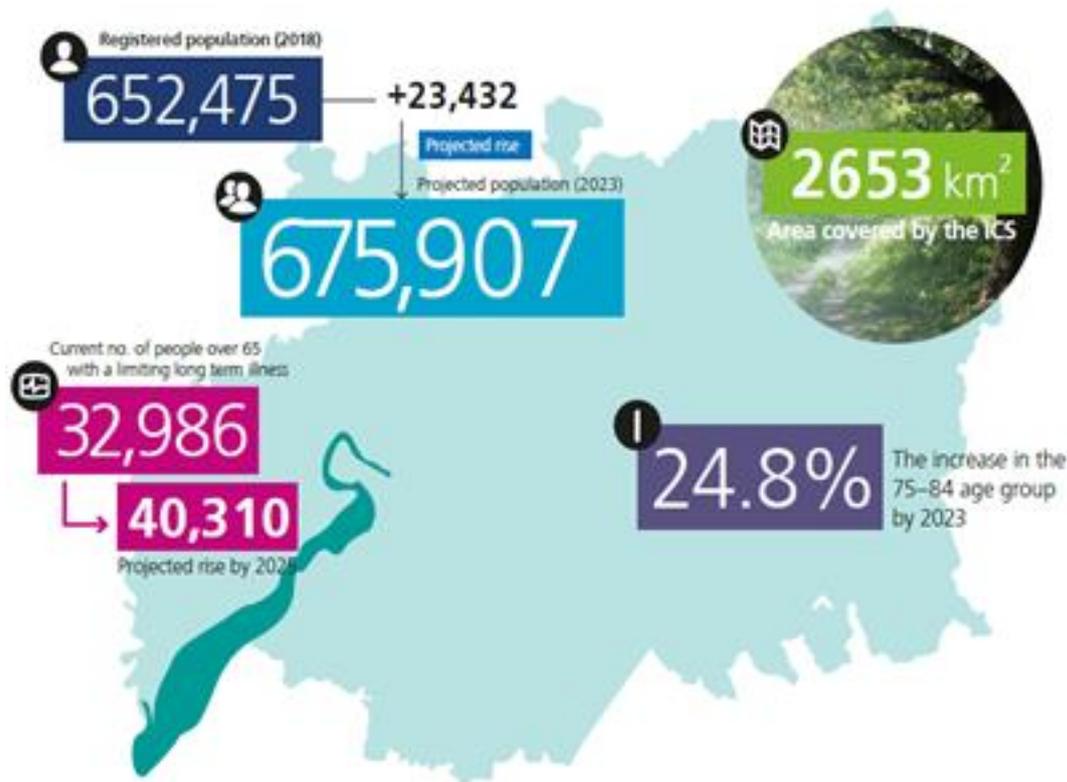
Some key facts about our system are summarised below:

- A growing population with increasingly complex needs – it is estimated 47,500 people over the age of 65 are living with long term conditions, which is projected to rise to 77,000 by 2030.
- Increasing demand for services and rising public expectations, coupled with low levels of personal responsibility in some areas regarding health.
- Innovation in new medical technology and medicines, which has the potential to improve lives for many people but needs funding for implementation.
- Considerable pressure on NHS and social care finances. Whilst we have done well to close the finance and efficiency gap for our system through our productivity programmes of work; the health and care community continues to face a significant gap in finances as demographics and treatment options change, requiring us to make innovative changes to the way we deliver services in the future.
- A need to strengthen mental health care and support given rising incidence and prevalence of mental health conditions.
- Significant pressures on our NHS and Social Care workforce capacity, with the potential for gaps to arise in key roles unless action is taken to develop new roles and ways of working.

Our long term ambition is to have a Gloucestershire population, that is:

- Healthy and well – taking personal responsibility for their health and care, reaping the personal benefits that this can bring.
- Living in healthy, active communities and benefitting from strong networks of community services and support.
- Able to access consistently high quality, safe care when needed in the right place, at the right time,

The diagram below shows the scale of the system challenges for the One Gloucestershire footprint.



1.2 Locality Context

The Forest of Dean can be divided into three distinct areas i.e. the Forest “core” in the central belt, and areas to both its north and south. There are differences between the “core” with its more pronounced industrial history and the other two areas. There are also contrasting landscape types. Within the southern part of the district, south of the A40, is an area which includes on its edge, the towns of Cinderford, Coleford and Lydney. This area contains the Forest of Dean itself with its managed woodlands, and is the source of a rich and distinctive cultural heritage.

The Forest of Dean is a predominantly rural locality. Access is restricted by the River Severn, and there are only two main road links and a single rail link. As a result, there are significant areas of the Forest which are considered as being “Least accessible” based upon the availability of ten key facilities (namely, a post office, supermarket, library, primary school, secondary school, children’s centre, GP, pharmacy, A&E / MIU, and fitness facility). Additionally, the CCG has assumed responsibility from Wales for commissioning healthcare services for those people who live in the district, but who are registered with a Welsh GP. This adds a further 8,811 people to the overall population considerations.

The Forest of Dean locality is subject to the same pressures as for our whole county outlined in the strategic context above. As with all of the distinct locality areas that

make up our county, the locality has unique population characteristics. These have been analysed and a detailed locality needs assessments have been completed

The following key facts emerge:

- The local population has grown by 5.4% between 2008 to 2018 from 82,099 to 86,543. This is compared to an average of 7.8% growth for Gloucestershire as a whole and 7.6% for the South West region.
- The locality is projected to see a significant increase in the number of older people (aged 65+), while projections for children, young people and the working age group show a decline in the next 25 years.
- Significant areas of the Forest which are considered as least accessible based on accessibility to 10 key facilities (post office, supermarket, library, primary school, secondary school, children's centre, GP, pharmacy, A&E or MIU, fitness facility).
- Three leading causes of death in the Forest of Dean are cancer, cardiovascular disease (CVD), and respiratory disease, respectively.
- The locality has a higher prevalence rate for the majority of Long Term Conditions than the county as a whole.
- The number of people aged 18+ with a learning disability is forecast to increase to 1,617 people by 2025, this represents an increase of 65 people or 4.2%.
- There is estimated to be over 1,350 people aged 65 and over with dementia in Forest of Dean District and this is forecast to rise by almost three quarters to over 2,330 in 2030.
- The locality has the highest rate per 100,000 of people receiving community-based adult social care services in the county but like the rest of the county, numbers have declined since 2013/14.
- The locality has a greater share of the population with caring responsibilities when compared against the county as a whole for every age band.
- For the last seven years the Forest of Dean has had a higher percentage of excess weight in 4-5 year olds and 10-11 year olds compared to Gloucestershire and England.
- The Forest of Dean is generally the worst performing District in the county at Key Stage 4 and Key Stage 5 with just 60.4% of resident pupils achieving 5+ A*-C grades at GCSE compared with an average of 69.6% for the county in 2014.
- In 2011 14,627 residents commuted outside the district to work and 6,015 commuted in – a net outflow of 8,612, the largest in Gloucestershire
- The Annual Population Survey (October 2015 – September 2016) indicates that 3.1% of the population are from an ethnic minority group.
- Forest of Dean is the district in Gloucestershire that displays the fewest extremes in deprivation however about 13% (1,800) of children live in low income families.
- The district has no LSOAs that rank in the top 10% most deprived in England, but 1 that ranks in the top 20% - Cinderford West

For an in depth analysis of the locality population health, please see the ICS locality profile for the Forest of Dean which is available on request.

Analysis of the population and trends within each age band for the locality are set out in the Figure 6.1 below. In addition to the existing population trends some housing growth is anticipated. We know that the total population of Gloucestershire is set to increase from 622,000 in 2015 to 713,000 in 2031, representing an increase of 90,000+ people over a 15 year period, an increase that will be driven by significant housing developments across the county.

	Forest of Dean	Gloucestershire	South West
2018			
0-19	18,454	142,244	1,232,947
20-64	47,055	356,341	3,136,588
65 and over	21,034	134,973	1,230,200
All ages	86,543	633,558	5,599,735
2008			
0-19	18,879	137,861	1,186,888
20-64	47,487	344,292	3,034,764
65 and over	15,733	105,457	983,392
All ages	82,099	587,610	5,205,044

Figure 6.1 - Updated Population trends 2008 – 2018 – Source: Office for National Statistics

In the Forest of Dean, latest housing trajectories indicates a further 4,805 homes need to be built between 2020 and 2031. Based on an average of 2.29 people per household, this could mean an extra 11,000 people. In the South of the Forest of Dean, we anticipate 2,207 homes and as such an extra 5,054 people by 2031. Figure 6.2 below shows the correlation of population growth to the new housing with a significant percentage of the change attributed to internal migration.

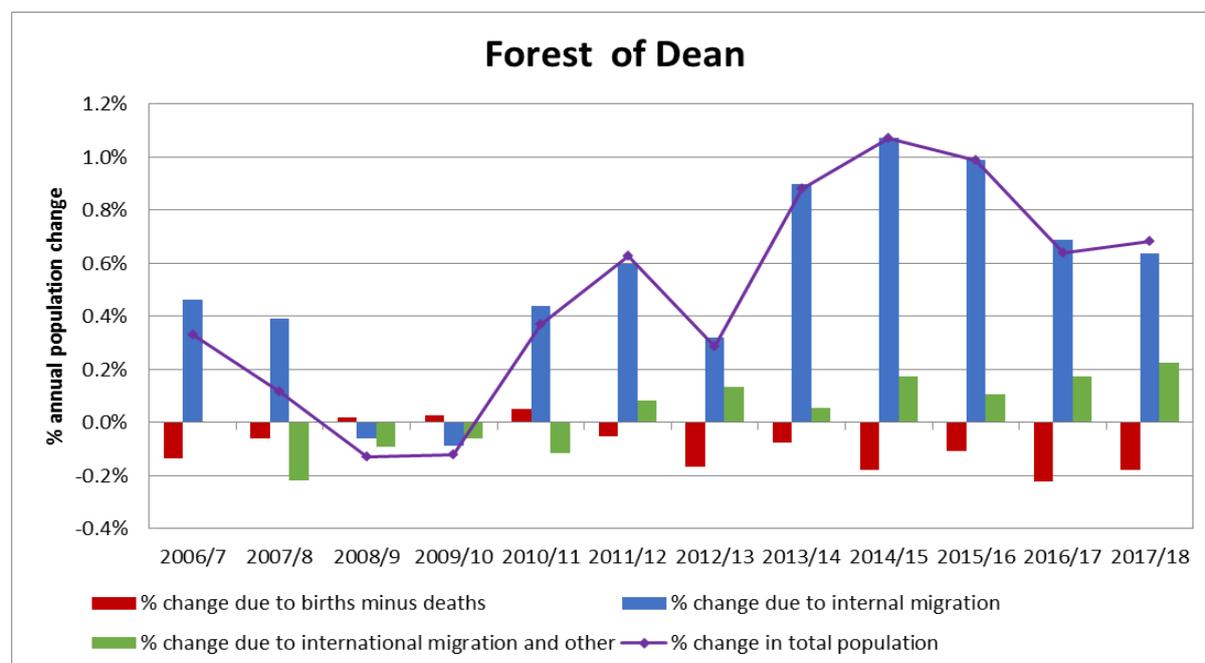


Figure 6.2 – Components of population change 2006/7 – 2017/18
Source: Mid 2007 and Mid 2018 Population estimates, Office for National Statistics

It is recognised that the draft Forest of Dean District local plan covering the next 20 years up to the period 2041 is due to be released for consultation during the Autumn/Winter of 2021. This will set out future housing requirement and land to deliver these requirements. For example, there is the future potential development of the Beachley barracks.

Some new housing will be in Wales, but some will be English resident patients meaning that there will be an increase in the number of people in the ‘cross border’ category, and whilst many of these individuals may well look to Bristol and Newport hospitals for their care it is likely that some will look to access their care in the Forest of Dean.

The impact of these developments has been considered within our planning proposals, and with regards to residents of Chepstow in discussions with the Aneurin Bevan Health Board who are responsible for planning and commissioning services for patients who are resident in Wales.

The Forest of Dean Locality is covered by one Primary Care Network (PCN), providing care for around 64,000 patients. The PCN area is made up of the following Practices:

Blakeney Surgery	Drybrook Surgery
Brunston and Lydbrook Practice	Forest Health Care
Coleford Family Doctors	Newnham Surgery
Dockham Road Surgery	Severbank Surgery

2. What local people said / Engagement outputs

2.1 Early engagement work

In 2015, a Forest of Dean Locality Reference Group was established to support the Forest of Dean Community Services Review. The Group has provided local insight to the review, which has supported the engagement and subsequent consultation work which has been undertaken over the last three years. The Group continue to meet and help develop plans for health care services in the locality.

Over the duration of the Forest hospital review a wide range of engagement activity has been undertaken with Forest of Dean residents regarding their health and care needs now and into the future. Health care professionals working in the Forest have been asked to give their insights and ideas for further improvement in delivering local services. This feedback has informed the development of options for community hospital services in the Forest of Dean. Key themes include:

Access to services

Most people said that care should be “close to home” whenever possible. Transport is a significant barrier to accessing services and those reliant on public transport often spend an entire day attending a short appointment at one of the acute hospital sites. Mobile services, such as the chemotherapy bus, are highly valued and consideration

should be given as to whether similar delivery mechanisms could be applied to other types of care.

Community Hospitals

There was general consensus from our engagement, that the current facilities need either replacing or significant refurbishment to bring them up to “modern-day standards”. The efficiency of running services from a single site would need to be balanced against ensuring accessibility of services. Improving local access to diagnostic services and support on discharge from both the acute and community hospitals were highlighted as areas for improvement.

Urgent care

The “out-of-hours” periods provide significant challenge to people living across the Forest of Dean. Opportunities for more integration of GP out-of-hours, pharmacy services, MiiU and community teams (including specialist and palliative care) should continue to be explored through the Integrated Locality Partnership to support people to be cared for at home or in the local community. Poor experience of engaging with the mental health crisis team, by both professionals and patients, was reported.

Outpatient services

We should aim to provide more outpatient services in the Forest of Dean. It would appear that local options are not always offered either by reception/booking office staff, or via the E-Referral system and patients report that they have only been able to get an outpatient appointment in the Forest of Dean following their specific request. The impact of Covid-19 has meant a change in the way services are currently delivered, including outpatient appointments and therapies, but that looking beyond this our intention is to continue to deliver services as close to home as possible and this could include in people’s own homes potentially using technology and virtual appointments either by telephone or video where appropriate to do so.

Community Nursing

Expanding the capacity of Integrated Community Teams and Rapid Response Teams is seen as key to supporting patients and avoiding admissions to both acute and community hospitals. Improving links to primary care and additional support from the voluntary sector will ensure more “joined up” community care.

Mental Health services

There is felt to be a general lack of support for people with poor mental health and a need for more low-level services, particularly for children and young people.

Education and information

There is considerable confusion regarding the configuration of services and the offer to local people. Many people appear to be unaware of what services are available where and although recent messages, such as making better use of pharmacies, are having a limited impact there is still a long way to go.

Integration/Partnership working

The opportunity for better integration between primary care, community teams and the voluntary sector is recognised. A community hub model has been suggested as a way to improve integration between services, in addition to providing a central point for patient information and education.

2.2 Consultation: Community Hospitals in the Forest of Dean

Building on this engagement work, a public consultation was launched on 12 September 2017 to gather feedback from Forest of Dean residents, health care professionals and community partners regarding *Health and Wellbeing for the future: Community hospitals in the Forest of Dean*.

The consultation sought feedback regarding three main items:

- The preferred option to invest in a new community hospital in the Forest of Dean, which would replace Dilke Memorial Hospital and Lydney and District Hospital, other options and impact.
- The proposed criteria for assessing the location for a community hospital in the Forest of Dean.
- If the option of a single new community hospital in the Forest of Dean was agreed, how a recommendation should be made on the location.

The full Outcome of Consultation report is available at:

<http://www.fodhealth.nhs.uk/wp-content/uploads/2018/01/FoD-Health-Community-Hospitals-in-the-Forest-of-Dean-Outcome-of-Consultation-Report-Jan-2018.pdf>

At meetings of both the former GCS Board and the Governing Body of GCCG in January 2018, the preferred option for a new community hospital in the Forest of Dean, which would replace The Dilke Memorial Hospital and Lydney and District Hospital, was approved. The Board and Governing Body also endorsed a series of recommendations, including the establishment of a Citizens' Jury to consider the location of the new hospital in the Forest of Dean.

2.3 Engagement: Location of a new community hospital in the Forest of Dean

Six weeks of public engagement on the location of a new community hospital in the Forest of Dean was undertaken from 21 May - 3 July 2018. The purpose of the engagement was to obtain public, staff and community partner views on the location of the new hospital. Three themes in particular emerge from the analysis of the feedback received:

Respondents' preferences for location is overall based on where they live

The responses to the engagement show that the majority of respondents selected a location which was closest to where they live (the first part of their postcode). This applies to respondents who identify themselves as members of the public, staff or community partners and across all demographics.

Respondents' comments about Public Transport and access

Availability of public transport and access was mentioned by many respondents irrespective of their preferred location (or no preference of location). Comments received in relation to public transport for all locations range from (in summary):

- public transport is better in this location than elsewhere else in the Forest of Dean so people can get here;
- public transport is worse in this location so people who live in this location cannot go to any other location;
- public transport is terrible everywhere in the Forest of Dean;
- improve public transport to wherever the new hospital is built; and
- economically deprived people rely more heavily on public transport so the costs for this group need to be considered.

Central Location

Irrespective of respondents preferred location, many commented on the importance of a geographically central location for a new hospital. Their comments highlight various interpretations and perceptions about the geography of the Forest of Dean.

The full Outcome of Engagement report is available at:

<https://www.fodhealth.nhs.uk/wp-content/uploads/2018/07/FOD-Health-Location-OOE-Report.pdf>

2.4 Citizens' Jury

In response to consultation feedback, GCCG and GCS jointly appointed Citizens Juries Community Interest Company (CIC) to run an independent citizens' jury which would make a recommendation regarding the location of the new hospital for consideration by the CCG Governing Body and the Board of GCS.

On 30 July 2018, 18 people gathered at Forest Hills Golf Club in Coleford and began a four-and-a-half day "citizens' jury" facilitated by the Jefferson Centre and Citizens Juries CIC. The central question for the Jury was whether a new community hospital for the Forest of Dean should be in or near Cinderford, Coleford or Lydney.

Over the four-and-a-half days, the citizens heard from and asked questions of witnesses, and worked in groups on the jury questions. The Jury members reached conclusions together, and were polled on their individual views. They identified individual and collective reasons for their answers. The Jury made the following recommendations:

- The location for the new community hospital in the Forest of Dean should be in, or near, Cinderford.
- The following supplemental actions should be undertaken by the NHS to best serve the Forest of Dean District:

- Improve transport accessibility options for communities throughout the region, ensuring accessibility for drop-offs, transfers, and other transport needs
- Consider how to incorporate on-site amenities (such as a cafe or a chemist) to maximise the benefits of the new hospital
- Ensure that a full range of necessary and suitable services are provided and that the new hospital is adequately staffed
- Plan for future use and needs of the entire Forest of Dean in the design and size of the building.

Consequently, at the meetings of GCS Board and GCCG Governing Body on 30 August 2018, approval was given to locate the new community hospital for the Forest of Dean in, or near, Cinderford. In addition, the following commitments were made:

- **Recommendation 1:** to undertake further engagement to ensure local people are fully involved in the development of the new community hospital in the Forest of Dean and the services that it provides.
- **Recommendation 2:** to ensure relevancy testing and targeted engagement, as described in the EIA report, form part of the development of the Full Business Case (FBC) for the new community hospital in the Forest of Dean.
- **Recommendation 3:** to work with partners to support wider ambitions to improve public transport and access routes within the Forest of Dean and work with community transport providers to promote the use of their services.
- **Recommendation 4:** to give due regard to the supplemental actions identified by the Citizens' Jury in the development of the new community hospital site. The Jury's ranking of the desired criteria for the new site can be utilised to inform decision making when acquiring a site in, or near, Cinderford.

Fit for the Future Engagement

Between August and October 2019 the Fit for the Future engagement process commenced which included specific elements relating to the FoD with a particular focus on services to be included in a future hospital (alongside wider county discussion on Community urgent care and Centres of Excellence) 9 drop in events; meetings with District Council and Town Council; workshop with Integrated Locality Partnership members, members of the public, staff and other stakeholders; workshop with Reference Group.

A Report was presented to HOSC in January 2020 outlining the key aspects of the feedback which have been incorporated into this updated commissioning strategy paper.

3. The Model of Care

The Model of Care for the Forest has been drawn from the outputs of the needs assessment, engagement feedback and reviews of best practice. Our plans aim to develop and strengthen community based services in the Forest of Dean, integrate

the delivery of these services and support people to live healthy lives in their homes or usual place of residence.

To develop our model of care we are supporting the development of a more resilient primary care sector and encouraging collaboration between GP practices to provide a range of services in new ways on a larger scale, through the Primary Care Network (PCN). The PCN supports practices to come together to work more effectively with the Integrated Community Teams, community mental health teams and with the district and voluntary sector to effectively plan and deliver health care for their population. As these teams develop in size they can develop greater specialism and expertise. These teams are supported by good access to advice and guidance from specialist nursing and consultant services and have direct links to the local social prescribing network and voluntary sector supporting people's wider wellbeing.

Practices increasingly work with patients using health coaching and motivational interviewing techniques to encourage people to set their own goals and to take responsibility for their own wellbeing and lifestyles. They provide co-ordination of care for people with Long Term Conditions, developing personalised care plans and identifying key workers who can support people to navigate their care needs. Care for people can be provided within a range of community settings including people's own homes, practices and health centres.

Community teams will be supported by a centre/community hospital in the Forest which brings together a number of services that can be offered at scale for the population of the Forest. There are a number of services that require a minimum level of activity to be safe and financially viable. Bringing together these services in a new modern purpose built centre will offer us the opportunity to provide more joined up care for people. Consolidating services also gives us the opportunity to provide a better offer of care and a more consistent service to people in the Forest. How we see these services coming together is set out below:

4. Urgent Care

Any urgent care service offer will need to work closely with urgent care provided on a daily basis within general practice, which represents the vast majority of urgent care delivered on any given day in Gloucestershire. Rather, the intention would be to enhance this by providing additional access. The potential is also there for the hospital facilities to provide a platform for delivering a 7 day service response for the locality.

5. Outpatients

Providing outpatients within community hospital facilities has been and continues to be a key part of our commissioning strategy to secure access to local services and provide care closer to home. We know that currently approximately 11,000 secondary care outpatient appointments provided by Gloucestershire Hospitals NHS Foundation Trust are seen within the Forest of Dean at the Dilke and Lydney, with a further 44,000 taking place at Cheltenham or Gloucester. A further 7,000 outpatient appointments are provided at the Dilke and Lydney sites by Gloucestershire Care Services.

Our future model for outpatients is to provide a consistent offer for people in the Forest of Dean, drawing on the high volume specialities to provide full day outpatient clinics making the most of our secondary care resource. People can be offered choice of their local centre/hub through Choose and Book and choose to be seen within the Forest for a range of specialties. By focusing on bringing more of our high volume specialties to the Forest we can offer people appointments in a timely manner so that their pathways can be completed within the national target of 18 weeks from Referral to Treatment. In addition to 'secondary care' outpatients people can be seen for outpatients for a range of community clinics (e.g. therapy, home oxygen, smoking cessation, diabetes clinics).

The NHS Long Term plan sets out the expectation that more outpatients care will be delivered through new channels such as online, and that this alongside greater use of referral management services like Cinapsis mean that the future national expectation is that face to face outpatient volumes will fall by approximately 30%.

The system has been running an outpatient transformation programme and we will continue to work with and respond to the latest innovations and new methods that come from this, particularly in light of the learning from the new ways of working that have been implemented as a response to COVID19. The use of digital solutions has been rapidly implemented throughout COVID19 and we are in the process of reviewing the efficacy, seeking patient and service user feedback on these approaches and considering how they may impact on service delivery moving forward.

Taking all of these factors into account, we will continue to review during the detailed design phase of the new hospital the space requirement that the new hospital should contain and recognise in our design that our clinic space will need to be used flexibly offering space for both 1:1 consultations, multi-disciplinary consultations, remote consultations incorporating the latest technology as well as providing group work space for peer support opportunities.

Our approach to designing outpatient consultation rooms supports our service transformation of our clinical pathways such as musculoskeletal and respiratory service redesign which are developing integrated multi-disciplinary teams in community based settings. The proposal is that the building should provide for additional clean air flow within 3 of the rooms (4 changes per hour) in order to support the delivery of a range of minor procedures such minor surgery or the treatment of ulcers and wounds in the community. This would offer the potential to extend the range of ambulatory care provision for people in the Forest and enable services such as a complex leg wound service to be available to people within the locality.

It should be noted that outpatient service delivery in the locality will not be limited services delivered in the community hospital. Outpatient services will continue to be delivered from health centres, mobile facilities and the Great Oaks hospice thereby providing a range of access to key community based services in the Forest.

6. Inpatients (Bed Based Care)

An improved inpatient service will support the needs of people in the Forest of Dean who need inpatient care in a community hospital. These beds currently provide inpatient care for patients aged 18 and over with:

- sub-acute illness (e.g. UTIs, falls, chest infections or wounds)
- rehabilitation needs,
- care needs during an episode of chronic disease that can't be managed at home
- end of life needs if they cannot or chose not to die at home.

The most common diagnoses for people admitted to Dilke and Lydney are hip trauma, urinary tract infections with complications, pneumonia, stroke care, head injuries, respiratory infections, chronic obstructive pulmonary disease or bronchitis and complicated skin conditions (pressure ulcers)

Our analysis of the needs of people from the locality who may benefit from this sort of bedded care suggest that the new hospital should prioritise beds that can support people with more active and intensive rehabilitation needs, supported by multi-disciplinary expertise. People with specialist stroke rehabilitation needs in the future will be admitted to the dedicated county-wide stroke rehabilitation unit and people with End of Life Care needs can be supported in community beds supported by expertise from the Great Oaks Hospice care team (see end of life section). The inpatient beds can also support step down discharge from the acute hospitals and acute admission prevention from general practice.

In light of the learning the system as a whole has gained from responding to the COVID19 pandemic and to ensure we can deliver the highest standard of privacy and dignity, ensure flexibility to meet single sex accommodation standards and maintain strong infection, prevention and control it is proposed that in line with modern building standards, the facility will comprise of 100% single rooms with the associated supporting day space to ensure the therapeutic benefits of the hospital stay are maximised. The design of the unit will be 'dementia friendly', using colour, lighting, signage, and assistive technology accordingly. A day room should be available within the unit for patients and relatives to have a separate space to support daily living activities and privacy away from the bedside.

The key principles of care at the facility will be compassion and commitment. Staff will be competent and communicate well with patients, their carers and other health and care professionals. Their emphasis should be on enabling people to reach their optimum level of recovery and to focus on discharge planning from the point of admission so that, where appropriate, people are supported to return to their usual place of residence or to a new care setting only when this becomes absolutely necessary. Research indicates that admission to inpatient facilities can have a negative impact on the health outcomes for frail older people so good discharge planning is paramount to supporting people to maintain independence.

The unit will be nurse led, with strong multi-disciplinary support from GP medical input, therapists and social workers. This multi-disciplinary input is key to assessing and planning for discharge from the point of admission. Rehabilitation should be delivered in line with best practice standards and the evolving Gloucestershire county wide model of care for Rehabilitation.

Since 2017/18 the length of stay at our community hospitals has remained fairly static at circa 25.8 days. The drivers for this levelling out are not clear, contributing factors are likely to include a combination of operational efficiencies (both in the system and in the hospitals), some changes to admissions criteria, the development of additional community services and support, and a consequent increase in the complexity of patients needing bed based care whilst at the same time not necessarily updated the model of rehabilitation at the same pace as the complexity changes might have required.

Some further observations are as follows:

- There are a number of patients in the Forest Hospitals who have experienced excessively long inpatient stays (known as super-stranded patients). These are defined as stays greater than 50 days. Given the evidence that demonstrates the negative impact of extended hospital stays (mobility, independence and infection) it is our aspiration that no patient in any community hospital should be in a bed longer than 50 days.
- Often patients get 'stuck' in beds not due to their medical needs but their complex social, housing, personal and health needs. We recognise that we need to work with system partners to reduce the frequency of these delays.
- The number of patients from the locality who have used a community hospital bed in any locality has fallen over the last 5 years (see table below). This trend has continued in the last two years. It may be that more of the lower complexity patients are now receiving care at home and in the community (which may also be a driver for the Length of Stay observations described above). Additionally, it can be seen that in 2019 the number of residents from the FoD who receive care outside of the locality rose by nearly 200% - this is attributed to the Vale Hospital becoming the dedicated specialist stroke rehabilitation facility and patients being transferred there as a preference over their local facility if their condition met the Vale admission criteria.

	Sep-14- Aug-15	Sept-15- Aug-16	Sept-16- Aug-17	Sept-17- Aug-18	Sept-18- Aug-19
Number of Direct Admissions to Lydney and the Dilke (no. of Forest Residents)	131	126	92	86	70
Transfers from Gloucestershire Hospitals Trust to Forest Hospitals (Number of Forest Residents)	310	271	235	252	282
Total Forest Residents in Forest Hospitals both Direct Admissions and Transfers	441	397	327	338	352
Direct Admissions to Other Community Hospitals (Number of Forest Residents)	16	7	6	3	4
Transfers from Gloucestershire Hospitals Trust to other Community Hospitals (Number of Forest Residents)	22	19	7	7	23
Total forest Residents in Other Community Hospitals both Direct Admissions and Transfers	38	26	13	10	27
Total Forest Residents in All Community Hospitals in Gloucestershire	479	423	340	348	379

6.1 Bed Planning Assumptions

The model of care within all of our Community Hospitals is for sub-acute, general rehabilitation and to support those who may have complex discharge needs.

There is no change proposed in this model of care from the existing utilisation of beds at the Dilke or Lydney Hospital to that proposed within the new facility. Predominately these beds are therefore used for patients stepping down from an episode of acute hospital care and in need of a period of intense rehabilitation to maximise their independence and outcomes. Additionally, the units will admit people directly from the community and therefore help prevent an acute hospital admission.

The impact of COVID has not resulted in an overall change in the admission criteria or rehabilitation offer made from the Community Hospitals. However, we acknowledge that throughout COVID there has been an enhanced focus on the rapid discharge model and the accelerated implementation of a 'Home First' approach.

As a consequence, we anticipate that we will see an impact in that more people will be going directly to their usual place of residence from an acute hospital admission

and therefore there should be less people requiring a community bed. Implementation of the Home First model would suggest that only 4% of patients in an acute hospital will then require a community hospital admission which again will be a consideration in the bed modelling in terms of the proposed bed reduction. Similarly, the community hospitals should be able to use the home first model to discharge patients in a timely manner which will help to reduce LOS and increase capacity.

The ICS has set out some key assumptions for community hospitals and bed-based care that drive all of our bed planning assumptions regardless of site or locality. Our vision for our county is that we expect to have less reliance on inpatient beds, including community beds over time (as more community based alternatives have been invested in such as rapid response providing care in people's own homes), and we should work to eliminated delayed transfers of care.

For the Forest hospital our beds planning therefore assumes the following:

- That we will not plan for future stays in community hospital beds that exceed 50 days. In 2019/20 the average number of patients whose stay still exceeded 50 days was 3.5 therefore continued focus and work in this area is still a priority.
- that a new bed based rehabilitation care model has been developed to improve outcomes and reduce length of stay over time through more intensive, multi-disciplinary team support (although no efficiency length of stay assumptions have been included at this point in our future model)
- That a local offer for people who require core rehabilitation and do not live in an area with a community hospital e.g. Gloucester City will be provided for with care in their own homes and local beds spot purchased as required

Length of Stay and Occupancy Assumptions

- Length of stay can be affected by many different factors, including the severity of the illness, the availability of onwards care, the care provided to the patient in hospital and the availability of hospital beds
- Our initial modelling has kept the length of stay constant to current observed levels, but our proposals are likely to see efficiency gains and improved length of stay as we plan to introduce a more consistent and coherent model for bed based rehabilitation
- Beds in community hospitals are planned in our future model to have an occupancy rate of 92% to enable efficient running, although in reality they often run effectively with a higher occupancy. Our model will set out a plan that assumes 92% occupancy.

Service Specific Assumptions:

- Our developing model of care for End of Life care proposes that End of Life care will not as standard be delivered from community hospital beds, instead we will spot purchase beds as needed in the Forest with two homes selected who are able to provide the staffing and capacity to meet this need (currently being piloted) with outreach hospice care provided by the Great Oaks Hospice. At the present time the Forest hospitals have a higher number of deaths than our other community hospitals with EOL patients occupying up to 5 beds at any given time across the two hospitals. This will of course also include residents of other localities, who typically make up approximately 50% of the inpatients in Forest hospitals
- Following the development of the Vale inpatient stroke rehabilitation unit patients who need specialist stroke rehabilitation will not be admitted to Forest hospitals for this care

Ward Model

- Nursing Staffing ratios for community hospitals generally work on multiples of 12 to maximise cost efficiency this is the ratio that we have worked within. As such, to move beyond this to perhaps 30 beds would require a configuration of two 15 bedded wards which will considerably impact on workforce efficiency and effectiveness. The detailed 33N model tested this premise and concluded that we could safely plan on this basis.
- The modelling for the patient mix anticipated suggests that the most efficient staffing model would suggest bed cohorts of 12 beds (meaning optimal numbers would be 12, 24, 36 beds). This factor remains relevant even when taking forward a model of all single rooms to enable the best utilisation of our qualified and unqualified workforce and supporting infrastructure.
- We recognise that whilst we continue to have the current capacity available in the Forest of Dean then we will utilise this capacity as being the most efficient way to manage the system resources. At the point in what that capacity is removed then we will utilise the spot purchase beds as appropriate to ensure an equitable offer to the residents across the County. It is worthy of note that there is no linear relationship between demand and bed use. In Gloucestershire we have a higher than average bed use per capita of population but that is because we have a high bed stock, not because we have a higher level of need

6.2 Bed Planning Approach:

To support our bed planning approach the CCG and the former GCS jointly commissioned 33N, an external bed modelling consultancy firm to provide and independent review of the bed capacity required for the Forest of Dean. Acknowledging that this work was undertaken in 2018/19 the assumptions contained within this model have been reviewed and have been confirmed as remaining valid with no significant changes to activity trends and demographics.

Analysis of GCS community hospital activity data has been undertaken by 33N with the specific purpose of:

- Developing a view of how community hospitals function on a county level;
- Developing an understanding of the bed requirements for the Forest of Dean;
- Enabling “what if” modelling around changes in bed base, length of stay (LoS) and efficiency at hospital, county and locality level;
- Enabling bed modelling based on the breakdown of acuity, dependency and complexity of patients/

33N used a three-stage process to 1) extract; 2) cleanse and reclassify; and 3) visualise, analyse and model data.

Reclassification of data (stage 2) was undertaken in four stages:

1. Categorise Read Codes with an assigned severity rating into distinct groups (e.g. Nursing Care)
2. Distribute new codes into one of four broader groups (e.g. Clinical care)
3. Analyse scores using Canadian Frailty Scale and Falls Risk Assessment Tool (FRAT)
4. Validate reclassifications by aligning with GCS categories for acuity and dependency (e.g. Cognitive)

The following delineates two potential modelling assumptions and limitations for the Forest of Dean. First, the reasoning for using the Upper Quartile uplifted to 92% occupancy.

Bed base assumptions	Number of beds	% of time FoD beds oversubscribed for FoD residents
Bed base assuming mean occupancy.	20	52%
Bed base assuming UQ occupancy.	23	18%
Bed base assuming UQ uplifted for 92% occupancy	25	8%

Two potential scenarios are outlined below following the application of the planned changes to the model of care set out in this paper. Model 1 is a more conservative estimate of the impacts of changes to the model of care, Model 2 is a more optimistic view. It should be noted that no adjustment has currently been made for any LOS gains associated with the new model of care for rehabilitation or investment in Complex Care at home (a new service that has started delivering bed based care at home in the Forest locality). It is anticipated that these would also both make a positive contribution towards reducing the need for bed based care in the Forest of Dean locality.

Stage of modelling	Model 1	Model 2
Reduction in demand for beds due to changes in Stroke care	0.5	1
Reduction in demand for beds due to changes in end of life care	2	2
Reduction in demand for beds assuming all LoS <=50 days	1	2.4
Total reduction in demand	3.5 beds	5 beds
New demand for beds	21.5	20
% of time FoD beds oversubscribed for FoD residents with 24 bed hospital	2.7%	0.8%

This shows that 24 beds will provide enough capacity even at times of surge for the majority of the year, with only very limited times applying where there may be an issue with admittance. To give an idea of scale, the 2016/17 data shows that 13 patients from the Forest out of the total cohort of 340 patients had an inpatient stay in a community hospital that was outside of the Forest of Dean. This represents 3.8% of the cohort based on these figures, therefore both model 1 and model 2 would represent an improvement on the current position.

It should be noted that the efficiency improvement anticipated from the new model of care have not been modelled into this model at this point as we do not have concrete data to assess impact. The new model of care represents an investment intended to further reduce the reliance on bed based care.

As with any model, there will be limitations to what can be derived from the data. The following known limitations will apply to the modelling assumptions:

- Calculations are based on GCS data only: no primary or acute care has been included. (We plan over time to develop a whole system bed model that brings together community, acute and primary care data but this is not yet available)
- System wide analysis of demand from the acute trust and primary care would help develop a comprehensive understanding of the community needs and the potential for activity to be shifted to or from other areas of the health and social care system.
- The improvements in occupancy for the Forest of Dean and the improvement in rehabilitation scores seen in the data to date could be credited as being operational improvements within the hospitals. However, there is also a chance they could be due to statistical anomalies in demand
- The modelling does not assume further improvements to the model of care (e.g. end of life, frailty etc). These can likely be quantified with further analysis across the system and other providers.
- The assumptions for reductions in long LoS and stroke care in model 1 can be evidenced directly in the data available to 33N. Other assumptions have been provided by other areas of the system estimating likely impact of future anticipated changes
- The model assumes any pressures due to wider demographic changes will be managed with other models of care in the community. Given that the absolute number of patients from the locality using a community hospital bed has fallen

year on year for the last 5 years and there has been concurrent significant investment in community based models of care such as Rapid Response and Complex Care at Home team this is a pragmatic assumption on the evidence we have available.

Based on all of these factors and the thorough testing that has been undertaken our proposal is that the bed base of 24 beds as initially proposed as a baseline number should remain as the preferred capacity of the new community hospital for the Forest of Dean, and that at all times operational preference should be given to admit Forest patients to these beds.

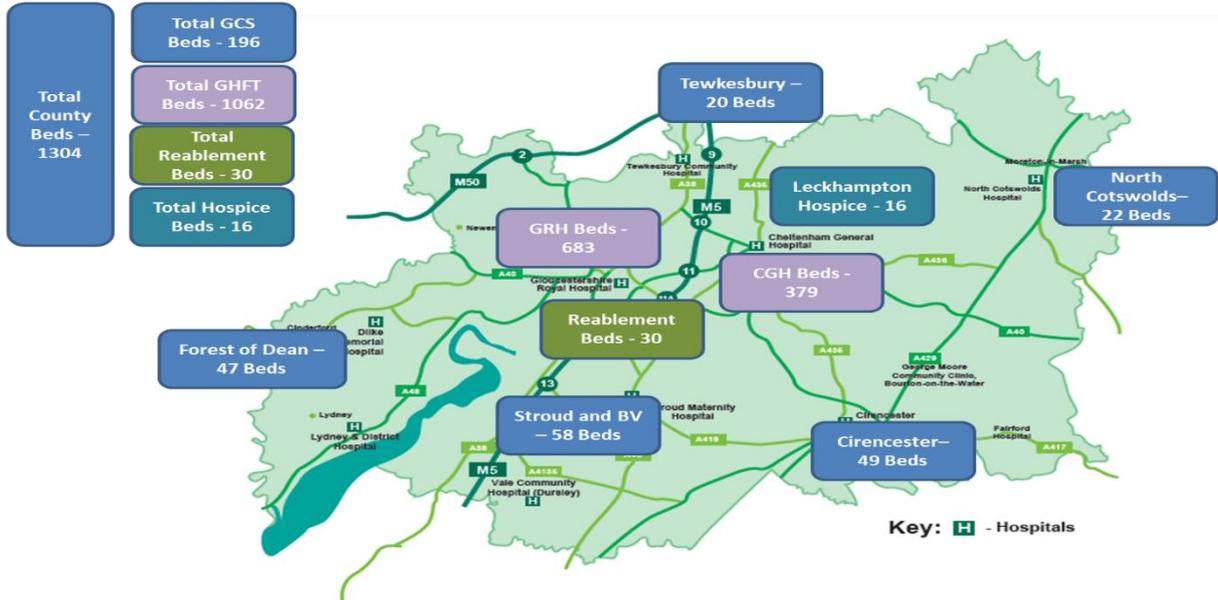
6.3 Fit with County Bed Model:

Our fundamental principle for the county bed model will be that we will only put people in beds where it is in their best clinical interest to be there, because we know that 10 days in hospital leads to the equivalent of 10 years ageing in the muscles of people over 80 (Gill et al 2004), and that one week of bedrest equates to 10% loss in strength, and for an older person who is at threshold strength for climbing the stairs at home, getting out of bed or even standing up from the toilet, a 10% loss of strength may make the difference between dependence and independence (Hoenig & Rubenstein, 1991). We know there is an opportunity to do better for our population in the future and our ICS partnership is working together to do that. Some of our key measures of success for our county approach to bedded care will be as follows:

- We will ensure no-one stays over 100 days in a hospital bed, and reduce over 50 day stays
- We will absorb the impact of demography, by using our bed stock more efficiently. We will do this by reducing length of stay to reach benchmarked opportunities, improving pathways and ensuring people are only admitted to beds where doing so really enhances their care
- We will deliver care closer to home where possible, but will deliver care in centres of excellence where the evidence demonstrates that clinical outcomes will be improved
- We will continue to deliver improvements to our discharge processes to avoid any patients being delayed going home for non-medical reasons, such as access to care in the community

By delivering these changes our proposal is that the Gloucestershire total beds number will remain broadly constant in our system, but that the nature and allocation of these beds will change over time to align in a way that will better support future population health needs.

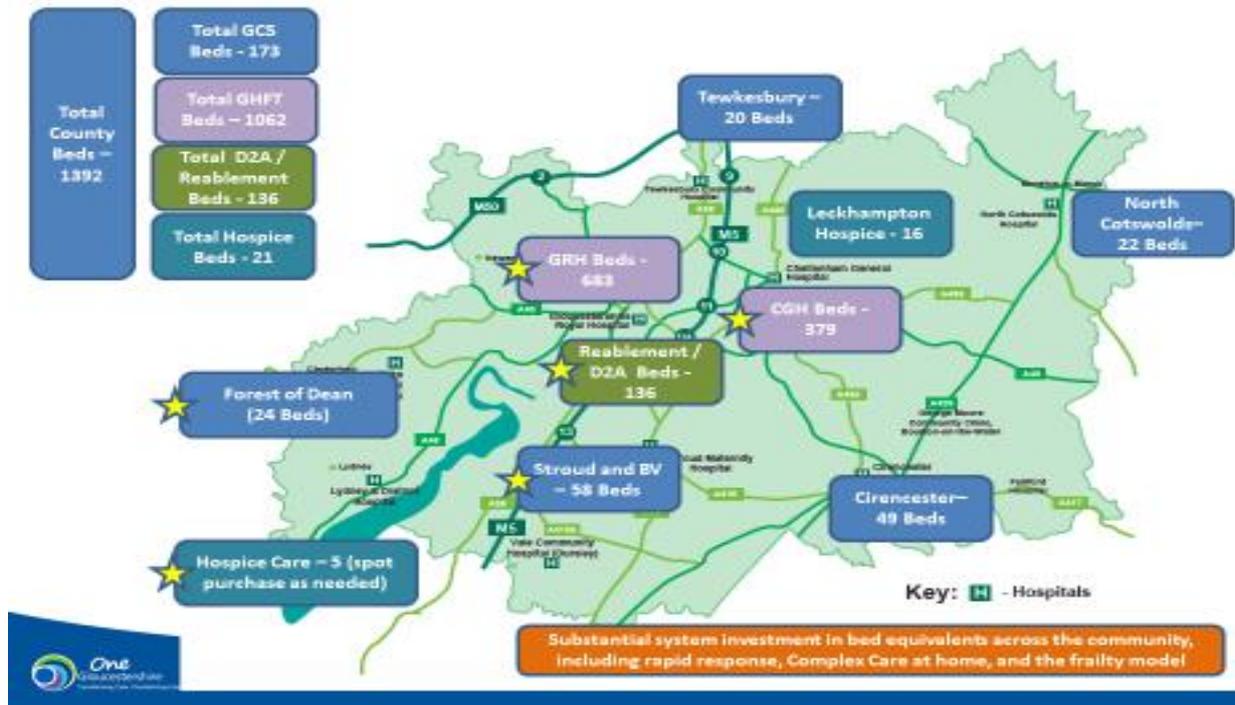
Current Bed Model – June 2018



This graphic shows the standard basic bed stock for our county.

Our proposals for how our bed model will evolve are set out on below. This graphic anticipates how our system would look post future consultation on service changes, should our proposals proceed as currently planned. The 'starred' boxes are highlighting areas where beds will be changed from the 2018 model. The changes to Stroud and Berkeley Vale (to create the new stroke rehabilitation unit) have already been implemented.

Future Bed Model – Post Consultation



As indicated above, some bed allocations across our system and locations change in the starred facilities, the changes can be summarised as follows. Detailed modelling has been completed on each scenario to develop this model:

- An additional five end of life care beds have been commissioned to provide care closer to home for people who are dying and who cannot be supported to die at home. This model has commenced in pilot form with two homes identified who are supported with additional expertise from Great Oaks Hospice. This will extend bespoke provision for bed based end of life care which can currently only be accessed at the Leckhampton hospice
- 14 beds in Stroud and Berkeley Vale locality have been operating as specialist stroke rehabilitation beds since February 2019, moving the care for those who have suffered a stroke into a community facility with enhanced rehabilitation support (8 stroke beds relocated from GHFT, 6 from other community hospitals)
- Community hospital beds in the Forest of Dean are reduced to a number aligned to the capacity needed to serve the Forest of Dean residents, and additional rehabilitation capacity is commissioned in Gloucester and Cheltenham to support care closer to home
- The total number of beds provided at our main acute hospital remains constant, but the allocation of certain specialty beds may change to support the centres of excellence model, based on public consultation

The end result of these changes is that the county bed stock available to our population remains consistent pre and post the planned consultation periods. The proposals are consistent with our objective to provide care closer to home where possible, and to centralise where this can improve health outcomes such as in the case of the newly centralised community stroke rehabilitation facility.

7. Diagnostics

The availability of diagnostic support is key to providing more 'one-stop-shop' care to people in the Forest, supporting outpatients, urgent care and inpatient care provision as required. Our future diagnostic model of care will include X-ray, blood testing and endoscopy, with the provision for 'hook ups' incorporated at the community hospital site to ensure mobile services can be based there as required.

X-ray and blood testing would be available to support urgent care services, outpatients and the wards in the Forest for routine and acute work. The expectation is that X ray would be open 8am to 8pm 7 days a week and be available for bookable appointments from general practice (e.g. for people with a persistent cough) and to support more acute needs (suspected fracture) from the Urgent Care Centre. Increased diagnostic provision can enhance clinical decision making and enable clinicians to more confidently provide care for people within the Forest.

In addition to X-ray and bloods the intention is to have a purpose built endoscopy suite to provide people with diagnostic endoscopic procedures. The aim is to preclude the need for people from the Forest of Dean to travel for an uncomfortable and common place (i.e. high volume) procedure. Endoscopic procedures are used to test for conditions which have a greater incidence the older we get. The Forest of Dean has an ageing population trend, predicted to increase further, and this is therefore a key range of tests which responds to the demographics in the Forest. The central diagnostic facility will be supplemented by continued growth in near patient testing within the community and general practice thereby providing greater opportunity to manage people's care within their home and within the district. The

7.1 Point of Care Testing Pilot

A countywide pilot to test a new point of care testing model in primary care commenced in April 2019, with two practices in the Forest of Dean involved. The pilot will enable practices to test the potential for delivery of new urgent care pathways delivered from GP practices, thereby avoiding the need for hospital attendances for patients with an urgent medical need where this can be appropriately managed by primary care.

Early findings from the pilot indicate that there is a significant potential to reduce emergency attendances at hospital. The pilot will be in delivery for 6 months at which point a full evaluation will determine if a full roll out is to be proposed. The initial tests to be offered will be CRP, D-dimer and a 5-point white cell differential, using two small desktop analysers. Additional tests may include potassium and standard troponin assays. These are available for a maximum of 3 sites, however, given that these may require a different level of technical expertise as they involve a centrifuge for plasma level analysis, the testing and offer requires consideration on risk and benefit.

The Patients eligible for testing are selected by the clinician whenever he/she feels that the additional information yielded might help to make the decision as to whether to admit the patient to hospital or not. This information is collected as part of the evaluation process.

8. Elective Care (Theatres)

Outpatient services are currently delivered across the Forest of Dean locality, from a range of locations that includes the health centres and the two community hospitals. The range of services is broad, and includes clinics delivered by a range of different providers that includes Gloucestershire Care Services and Gloucestershire Hospitals Trust. Our approach to outpatients has been set out above. Day case activity is not currently delivered in the Forest of Dean hospitals (although Lydney hospital does currently have a decommissioned theatre suite on the site). As part of the development of the future service model, the volumes of elective day case activity accessed by the population of the Forest of Dean was analysed.

In 2014/15 the resident population accessed 4,638 day case procedures at any hospital site. The two procedures that comprised the majority of this activity volume were cataract surgery and endoscopic procedures. No other day case procedures

were accessed in sufficient volumes that would have made local provision viable. Both areas of provision were discussed with clinical colleagues at the hospitals trust and scenario planning was completed to assess the likely volumes, and how this could be delivered at a hospital site in the Forest of Dean. This analysis concluded that the volumes of cataract surgery were too small to provide the necessary throughput for cataract surgical lists that is required to ensure productivity is met. Community theatre lists are already delivered for cataract surgery in Tewkesbury, Cirencester and Tetbury. Forest of Dean patients currently access services at both Tewkesbury and Gloucester, and adding a cataract surgical facility at the Forest hospital would detract from these existing clinics, such as to make the existing community lists unviable alongside being unviable as a stand-alone offer.

The same analysis was completed on the Endoscopy proposal and it is proposed that there is sufficient activity in this specialty to make a local endoscopy suite and list viable in the new Forest Hospital. Endoscopy is a growing specialty that has an association with an ageing population, and as such has the potential to offer a real benefit for local residents who in significant volume would not then need to travel to Gloucester to access these services.

9. Maternity

There are a small number of low risk births that already occur in the FOD (women not under shared care or consultant led care). For these women home births are currently already available as a local option. During the engagement period, we received feedback that we should consider whether additional local maternity services, specifically a maternity/birthing unit in the Forest of Dean would be a viable proposal. Consideration has been given to the numbers required to deliver a safe and sustainable birthing unit at a Forest hospital. Our initial assessment is that the numbers are insufficient to deliver a safe service that would ensure value for money.

It should be noted that as part of the wider maternity services review for the county the concept of offering a series of 'pop up birthing units' has been explored. The affordability and viability of this proposition has been considered alongside quality and safety perspectives and it has been concluded that this cannot be effectively provided within the FoD locality. We will continue to promote home births where appropriate for all women who are low risk living in the locality

10. End of Life

Our model of care for Specialist Palliative Care and End of Life Care has been developing through the End of Life Clinical Programme. Our definitions of each are as follows:

- End of Life: - Patients are 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:
 - a) Advanced, progressive, incurable conditions;

- b) General frailty and co-existing conditions that mean they are expected to die within 12 months;
 - c) Existing conditions if they are at risk of dying from a sudden acute crisis in their condition;
 - d) Life threatening acute conditions caused by sudden catastrophic events.
- Specialist Palliative Care: Palliative care is an interdisciplinary approach to specialized medical and nursing care for people with life-limiting illnesses. It focuses on providing relief from the symptoms, pain, physical stress, and mental stress at any stage of illness. The goal is to improve quality of life for both the person and their family.

In line with the rest of Gloucestershire, care for patients with life-limiting conditions, and for those who are dying is delivered by a wide range of health and social care professionals and across many settings. For the Forest of Dean, this includes peoples' own homes, care homes and hospitals, both community and acute.

Many people die without the need for Specialist Palliative Care intervention and are managed fully by their generalist team of GP's and community nurses with input from care services drawn from the voluntary and private sector, commissioned by the CCG and or Local authority. Specialist Palliative Care is available to all who require it in the Forest of Dean and this offer includes access to a consultant, specialist nurses, specialist Occupational Therapy, a day Hospice and Hospice at Home services (provided by the Great Oaks Hospice). Should a specialist palliative care inpatient bed be required then those living in the Forest of Dean have equal access to the commissioned specialist beds at the county inpatient Hospice which is based in Leckhampton, Cheltenham.

There is a national mandate to improve the choices available at the end of a person's life, this includes their preferred place of death and who cares for them. Evidence shows that when asked, people in the majority state that they would prefer to die in their own homes. In order to support this choice agenda, the CCG has a number of mechanisms in place that enable people to be cared for in their own home or if they prefer in a care home.

For those who are at the end of their lives and rapidly deteriorating, a high level of support from skilled individuals can be provided supported by Fast Track Continuing Healthcare Funding. This is a non-means tested fund that enables a package of care to be purchased by the NHS and delivered in peoples' own homes or to fund a care home placement. People are actively encouraged to choose their preferred care home, although in some circumstances family members will be best placed to do this. In the Forest of Dean, the Great Oaks Hospice at Home is funded by the fast track mechanism and is frequently the first choice of provider for those wishing to die in their usual place of residence, Hospice at Home staff are able to provide additional support to an existing package of care or care home environment if a person is already in receipt of a package of care or placement and wants to have consistency of provider.

In order to continue to enable as many people to die in their preferred place, supported by kind and competent staff, the CCG is working in partnership with local stakeholders in the Forest of Dean to deliver the strategic aims contained within the Gloucestershire End of Life strategy. Within the last 18 months the following has been achieved in order to facilitate delivery of the choice agenda at the end of our lives within the Forest of Dean:

- an increase in grant funding to Great Oaks Hospice
- increased capacity within the Great Oaks Hospice at Home team
- End of life masterclass training for community and District Nurses
- Just in Case medication Boxes
- Subsidised End of Life education programme aimed at care home staff
- Bespoke training for care agency staff

Our working expectation therefore as set out in section 6, Bed Based Care, is that we will increase the number of people who are supported to die in their own home or place of choice, and that the number of people who will receive End of Life care in a hospital bed including in our new community hospital will significantly reduce.

11. Out of County (Gwent activity)

The Forest of Dean has a border with Wales, and has a particular circumstance where some patients who are resident in England receive primary care from a Welsh GP practice (including in one case a GP practice which is based in England but is a branch surgery of a Welsh practice over the border). There are also patients resident in Wales (with a Welsh post code) who receive GP services from English GP practices. Our core analysis for beds and services is based on registered GP practice; therefore the Welsh patients who are registered with an English GP will be included in core numbers. Specific analysis has been undertaken to analyse the activity associated with English resident patients who have a Welsh GP.

A summary of this activity is shown at Annex 1.

12. Primary Care

Our aim is to support a resilient and sustainable primary care sector in the Forest of Dean, working with practices to explore how they can collaborate more effectively and develop new models of care in which they can be a key part of a wider multi-disciplinary team. Increasingly, our practices are developing shared services, to greater skill mix in their teams and using technology to support alternative approaches to face-to-face consultations. The new NHS long term plan has described a future vision where primary care GP practices will increasingly work together in networks called Primary Care Networks (PCNs). PCNs are being set up to support practices to develop services around local communities.

The development of PCNs will mean that patients and the public can access resilient high-quality care from local clinicians and health and care practitioners, with more services provided out of hospital and closer to home, with a more comprehensive and integrated set of services, that anticipate rising demand and support higher levels of self-care with appropriate referrals and more 'one-stop shop' services where all of their needs can be met at the same time. Different care models for different population groups (such as frail older persons, adults with complex needs, children) that are person-centred rather than disease centred.

13. Self-Care and Prevention

The model of care developing in our county promotes the philosophy of both physical and mental wellbeing, support people to choose healthier lifestyles and support those with long term conditions to become expert in managing their conditions. It also recognises the vital role that the district council, community groups and the voluntary sector play in promoting health and wellbeing and supporting individuals with non-medical interventions.

Social prescribing is already a key feature of the health and care system in the Forest of Dean. Social prescribing offers a means to connect people to local community and voluntary groups to help people to improve their wellbeing and reduce isolation. The scheme is currently run by the community engagement team in the District Council who use motivational interviewing techniques and their in-depth knowledge of community assets in the Forest to provide people with alternatives to health care. The scheme operates closely with general practice and accepts referrals from GPs, community staff and the minor injury and illness units. We want to strengthen this model and offer a stepped approach to social prescribing which also offers non-medical interventions to those with clinical needs.

14. Mental Health and Wellbeing

Mental health services are not specifically delivered from the community hospital sites. Local services are delivered from the new Colliers Court development and a range of community sites. In recognition of the role that mental wellbeing plays in a wide range of health conditions, the community hospital should be designed to support wider wellbeing. The Community hospital should have provision for a multi-purpose wellbeing room which can be used for a range of purposes including by local community groups and healthy lifestyle messages. The site itself should also consider the impact of the environment on mental wellbeing and aim to provide a calming space, reflecting the local setting of the Forest of Dean and making the most of the opportunity to include works by local arts organisations to promote a local identity. Consideration should be given to the outside space, including opportunity for arts and horticulture to be offered to inpatients as part of their recovery and rehabilitation journey.

15. Community-based services

Gloucestershire Health and Care trust employs a wide range of clinical staff including nursing, medical, dental and allied health professionals. These staff work in close

partnership with social care staff from Gloucestershire County Council. This collaborative approach is designed to ensure that services can respond to an individuals' health and social care needs, which often overlap, to provide the most appropriate service.

In terms of the Forest of Dean, the Trust's community-based healthcare services are provided in the community hospitals, as well as in GP surgeries / health centres, people's own homes, schools and children's centres: the Trust also provides in-reach services into nursing and residential homes and social care settings. In summary, the Trust's services currently include:

- The community hospitals based in Lydney and Cinderford
- Adult Integrated Community Teams (ICTs) which comprise community nurses, physiotherapists, social workers, occupational therapists and reablement workers: these ICTs serve to promote people's independent living by providing person-centred care within a person's own home or community;
- Rapid Response service which complements the ICTs by providing an intensive 24/7 service for adults who require urgent care that can be successfully delivered at home, thereby avoiding hospital admission
- A range of specialist services including intravenous (IV) therapy, pulmonary rehabilitation, community diabetes, heart failure, cardiac rehabilitation etc.
- Services to support children and young people, including public health nursing, school nurses, therapy services (physiotherapy, speech and language therapy etc), and childhood immunisations
- Countywide services provided at the community hospitals, GP practices or in people's homes, including speech and language therapy, community equipment, podiatry, adult musculoskeletal physiotherapy, dental and sexual health services.

16. Infrastructure (Estates and Equipment)

This model of care needs to be underpinned by 21st century infrastructure so that we can support the delivery of better quality and more efficient care through our building and facilities. We know that the physical environment plays a significant part in supporting people's recovery and also in supporting staff to feel valued. A modern community hospital building gives us the opportunity to design space flexibly with the future in mind. It also gives us the opportunity to improve adjacencies between services, improve patient flow and develop co-location of key services. We would also design an environmentally friendly facility in keeping with the heritage of the Forest. We will work with members of the community in designing and decorating the facility.

In addition to a modern community hospital we are committed to improving the quality of primary care estate in the Forest as prioritised in the Primary Care Infrastructure Plan. The new £5.4m Cinderford Medical Centre, which can accommodate over 15,000 patients is now built and open. The two GP practices serving Coleford, Lydbrook and surrounding area, who plan to merge, have had their Business Case for a £5.14m facility on the edge of town at the Coombs approved by the CCG. Subject

to planning permission, building work is expected to commence during the Summer of 2021 and be open around the Summer of 2022. Able to cater for around 15,000 patients, it will house the new combined practice and some services provided by Gloucestershire Health & Care Foundation NHS Trust (GHC). It will replace the existing Brunston building, Coleford Health Centre and the Lydbrook Health Centre (used as a branch surgery by the Brunston Practice).

The development of primary care facilities across Lydney and the surrounding area also remains a priority. The CCG looks forward to working with local practices, GHC and key stakeholders to develop proposals. On the assumption that project work commences in the Autumn of 2020, it is estimated that the Business Case could be ready for consideration by the Autumn of 2021. Subject to NHS approval and planning permission, building work could start by the Autumn of 2022. The building could be open by the Autumn of 2023. The building would include GP services and it is anticipated some community services provided by GHC. It is estimated the facility might need to cater for up to 18,000 patients dependent on the practices involved and taking into account house building and population growth up to 2031. Around £7m capital investment would be needed for land and a building that size.

The model of care will also be supported by advances in technology. Critical to the success of this model is the use of technology to support self-care and remote monitoring, the use of technology to access consultations and advice from specialists remotely and the ability to share patient records across health and care providers. New advances in diagnostics will support the delivery of more care closer to home.

17. Workforce

In developing this model of care with improved facilities we believe we can attract more people to work in health and care in the Forest. We have significant challenges in recruiting clinical and care staff across our providers, with the low quality of the current estate proving one barrier to attracting new staff. Consolidating some of our community services onto one site can also mean that we can continuously staff these services and offer them consistently to the Forest of Dean. We can also provide a more attractive environment for visiting staff to come and deliver services to people of the Forest of Dean.

Our model focuses on developing multi-disciplinary team working across the community and into the community hospital too. This enables us to make the most of the people and skills available to us. We are keen to avoid duplication and stretching our staff over too many disparate services. To achieve this integrated way of working we will invest in training and development, seek to co-locate services as much as possible and support teams organisationally with shared governance and connective IT systems.

Our goal is to empower people and their family and carers to take greater control of their own health. We can provide people with the tools to self-care and upskill our

clinicians in working in partnership with people to set and achieve care goals. We will connect the workforce to the voluntary sector and community groups, using our enhanced social prescribing model to facilitate this, so that we are developing a care workforce in its widest sense.

18. Summary and Next Steps

This model of care addresses the triple aim of the Five Year Forward View in the following ways:

- Health and Wellbeing Gap
 - Providers working together in new models of care in the community to provide co-ordination of care for people with greatest care needs
 - Development of enhanced social prescribing offer
- Care and Quality Gap
 - Improved Urgent Care offer ensuring we are able to see, diagnose and treat to a consistent model of care
 - Stronger and more consistent offer of outpatient services provided within a timely fashion
 - Inpatient facility with greater focus on admission prevention, rehabilitation and supporting people to go home or transfer to a new care setting
 - Integrated primary care and community hospital facility developing stronger relationships and access to multi-disciplinary expertise
- Finance and Efficiency Gap
 - Consolidation of community hospital resources onto one site
 - Integration with new primary care health centre providing modern facilities across the district to ensure we are fit for the future

Annex 2

GWENT GP Practice Patients Activity At Dilke & Lydney Community Hospital – Activity - Apr - Oct 2017

ENGLISH WITH WELSH POST CODE : GWENT GP Practice Patients Activity At Dilke & Lydney Community Hospital - Activity

<i>Apr - Oct 2017</i>								
Service Category	Apr	May	Jun	Jul	Aug	Sep	Oct	Totals
Children's Young People Health Service Total	0	<10*	<10*	0	0	0	<10*	
Countywide: Adults Speech and Language, Physiotherapy and Podiatry	33	37	27	47	40	44	63	291
Inpatients Total (all hospitals)	0	26	51	101	155	23	20	376
Integrated Community Team Total (includes district nursing, Community Teams etc)	14	39	35	26	36	10	20	180
Minor Injury and Illness Unit Total	101	123	119	108	116	117	96	780
Specialist Nursing Total	0	1	2	0	1	0	0	4
Grand Total	148	226	235	283	348	194	199	1633

WELSH POST CODE: GWENT GP Practice Patients Activity At Dilke & Lydney Community Hospital - Activity

Service Category	Apr	May	Jun	Jul	Aug	Sep	Oct	Totals
Countywide:	1	2	0	0	1	0	0	4
Minor Injury and Illness Unit Total	115	134	133	135	118	101	109	845
Grand Total	116	136	133	135	119	101	109	849

Annex 3 – Key Themes from 2019 engagement

The most recent engagement was focussed on the services that would be provided in the new hospital. The main areas of feedback from this period were as follows:

Inpatient services

- Concern about bed reduction – in relation to a rise in population and demographics – questions were raised as to whether the modelling for the new hospital had been done on current throughput and utilisation, and whether the proposals had taken account of demographic changes in the district
- An expressed concern that the bed planning had not accounted for people who wish to die in the community hospital – not everyone wishes to die at home.

Access to consistent urgent advice and treatment

- Concerns were raised that the urgent care offer being located in Cinderford would make it hard for people in the south of the Forest to access care, especially given the limited public transport options available for local people
- Transport – particularly from South of forest to Cinderford
- Access to GP's OOH to support urgent care OOH

Outpatients and diagnostics

- Current range of services at both sites should continue
- Diagnostics – phlebotomy, endoscopy, x-ray and Ultrasound should be included

Annex 4 – Best Practice Checklist

Four Tests		
4 key tests	<ul style="list-style-type: none"> • Strong public and patient engagement • Consistency with current and prospective need for patient choice • A clear clinical evidence base • Support for proposals from clinical commissioners 	<p>Extensive engagement activities have been taking place since 2015 as documented in section 3 of the report. A dedicated website is available at https://www.fodhealth.nhs.uk/</p> <p>The latest engagement took place in 2019 as part of the wider Fit for the Future programme and the feedback has been incorporated into our updates throughout this document and will be the areas focused on in the final stage of consultation proposed to commence mid-September 2020.</p> <p>The FoD project was subject to a stage 2 assurance review by NHS England in August 2017. The assurance letter confirmed assurance against the four key tests of service change.</p>
Additional Test		
	<p>Proposals including significantly reducing hospital bed numbers will have to meet one of the following three conditions:</p> <ul style="list-style-type: none"> • Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or • Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or • Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting It Right First-Time programme). 	<p>Evidence has been provided that demonstrates bed modelling has been undertaken and revalidated (see Commissioning Intentions in Annex 1) and that suitable alternatives to the bed based model to deliver care closer to home for the residents of particularly Gloucester and Cheltenham. This is detailed in section 4 of the report and demonstrates the continued expansion of alternative community based models such as:</p> <ul style="list-style-type: none"> • Complex Care @ Home, Rapid Response, and Reablement services • Analysis of hospital bed efficiency, a credible plan to improve performance and modelling of its impact is demonstrated with the introduction of a 7 day therapy service to continue to improve Length of Stay (LoS).

Assurance Checks

<p>System</p>	<ul style="list-style-type: none"> • Is it clear how the proposal fits into the STP financial plan? Is the contribution to achieving financial balance for the health economy clearly stated and robust? • Are the impacts on individual providers and commissioners understood? • Is there a reasonable level of financial risk assessment undertaken with supporting sensitivity analysis and downside planning and mitigation? • Do the proposals deliver value for money (VfM)? 	
<p>Finance, Trust</p>	<ul style="list-style-type: none"> • Is the proposal/business case financially deliverable, affordable and value for money? • Does the financial modelling have a robust starting point (e.g. alignment to allocation/control totals, understanding of underlying position)? • Are demand management and activity growth assumptions reasonable in the context of national benchmarks? Is there evidence to support the expected impact of proposed new models of delivery? • Is the financial modelling consistent with the workforce and activity modelling? • Are the transitional costs (including non-recurrent revenue and capital) identified and properly accounted for? How will they be funded? • Are planned savings reasonable and realistic and has appropriate sensitivity analysis been carried out? 	<p>The Outline business case was received by the former Gloucestershire Care Services Trust Board in July 2019 and continues to be refreshed and developed.</p> <p>The workforce modelling has been revalidated to acknowledge the shift to 100% single rooms and the 7 day rehabilitation model and remains affordable in revenue terms.</p> <p>Transitional costs have been considered and are within the baseline model</p> <p>Ongoing sensitivity analysis is being undertaken including accounting for current known risks in terms of site abnormalities and potential 3rd party income from other public sector partners (e.g. South West Ambulance Trust) who are considering relocating their local base.</p>

<p>Capital</p>	<ul style="list-style-type: none"> • Have the capital investment implications been considered in terms of the viability, deliverability and sustainability of the proposal and the economic (value for money and return on investment) impact? Have a number of options been considered? • Is each option sustainable in service and revenue and capital affordability terms and can each option demonstrate that it is proportionate and that it is capable of meeting applicable VFM and return on investment criteria? 	<p>Capital costs continue to be refined in line with the development of the detailed design, within this there is ongoing value engineering work and the firming up of provisional and contingency sums.</p> <p>No application for capital is intended to fund the scheme</p>
<p>Clinical quality / Strategic fit</p>	<ul style="list-style-type: none"> • Full impact analysis (of the proposals) across CCG and NHS • England commissioned services and shared sign up of all parties to the analysis (applied to all proposals) • Alignment with STP delivery 	<ul style="list-style-type: none"> • Full CCG support is in place for the proposals and there is strong alignment to the ICS strategic priorities. • Proposals support delivery of the 3 gaps described in the Five Year Forward View which are outlined in section 19 of the paper
	<ul style="list-style-type: none"> • What contribution do the proposals make to each of the 3 gaps described in the Five Year Forward View (health and wellbeing gap; care and quality gap; funding and efficiency gap)? • Clear articulation of quality, experience and outcome benefits quantified if possible • Clinical case fits with best practice or emerging national models • Aligned with delivery of national strategies (e.g. 7DS, U&EC, MH, cancer, maternity) • All key clinical interdependencies have been fully considered • Full options appraisal undertaken (inc. network approach, cooperation and collaboration with other sites and/or organisations) • Macro-impact is properly considered including on other organisations / systems • Does the proposal align to the ambitions of Long Term Plan? 	<ul style="list-style-type: none"> • The case for change is robust, neither hospital remains fit for purpose and cannot be developed in a reasonable way to provide a suitable facility for modern day delivery of services. • Both have significant backlog maintenance issues and the costs for this have been considered in terms of the VFM decisions. • The proposals align with the Long Term Plan and focuses on delivering care closer to home in both people's homes and in community based facilities

	<ul style="list-style-type: none"> • All relevant patient flows and capacity are properly modelled, assumptions are clear and reasonable • What are the changes in bed numbers? • Activity and capacity modelling clearly linked to service change objectives • Activity links consistently to workforce and finance models • Modelling of significant activity, workforce and finance impacts on other locations / organisations 	<ul style="list-style-type: none"> • Outputs of accurate modelling with assumptions clearly stated have been clearly outlined in section 4 and within the • Commissioning intentions detailed in Annex 1 • Changes to bed numbers are outlined in section 4 and within the commissioning intentions detailed in Annex 1 with a clear narrative of the community based alternatives that are in place • The workforce model has been aligned to the new activity analysis and has been incorporated into the draft financial model
	<ul style="list-style-type: none"> • Do you have a workforce plan integrated with finance and activity plans? • Are you making most effective use of your workforce for service delivery and is it compliant with all appropriate guidance? • Consider the implications for future workforce • Have staff been properly engaged in developing the proposed change? 	<ul style="list-style-type: none"> • Staff remain fully engaged in the process – they have been part of the engagement and consultation events and a number of briefings and presentations have been made specifically to staff within the existing hospitals affected. The last session was held in June 2020 and staffing briefings were made available following this. <p>No staff redundancies are anticipated as part of the new hospital development</p>
	<ul style="list-style-type: none"> • Has the travel impact of proposed change been modelled for all key populations including analysis of available transport options, public transport schedules and availability / affordability of car parking. 	<p>Travel impact assessment has been completed and is available upon request. This has considered journey times for both public transport and by car. Car parking charges are not proposed by the Trust on the site.</p>

	<ul style="list-style-type: none"> Have the implications for ambulance services (emergency and Patient Transport Service) been identified and impact assessed and appropriate discussions been held with ambulance service providers? 	<ul style="list-style-type: none"> Ongoing discussions are taking place with the South West Ambulance Trust in terms of location of a satellite base for ambulances – provision has been made for parking facilities in the design
<i>Estates / infrastructure</i>	<ul style="list-style-type: none"> Credible activity/throughput analysis and indicative designs that demonstrably reconcile to up-to-date estates strategies at site, provider and STP levels; indicative capital costs using recognisable benchmarks and based on compliance with all applicable design, technical, building and space standards; and known site constraints and key adjacencies identified and provided for. 	<ul style="list-style-type: none"> Capital costs are built up using Healthcare Practice Guidelines and the Trust has the support of Gleeds to ensure appropriate benchmarks and costings are available.
	<ul style="list-style-type: none"> How will the proposed change impact on the ability of the local health economy to plan for, and respond to, a major incident? Has a business impact analysis been conducted for all impacted organisations and appropriate changes made to Business Continuity Plans? Local Health Resilience Partnership impact assessment on resilience? 	
	<ul style="list-style-type: none"> Are there plans to appropriately and effectively engage and involve all stakeholders (to include: staff, patients, carers, the public, Healthwatch, GPs, media, local authority overview and scrutiny functions, Health and Wellbeing Boards, local authorities, MPs, other partners and organisations) and fulfil commitments under s.14Z2 and s.13Q of the Health and Social Care Act? 	<ul style="list-style-type: none"> Consultation plan for October 2020 has been developed taking account of social distancing measures and also acknowledging the extensive engagement and consultation processes that have taken place over a number of years. There is a residents committee in place for the immediate neighbours to the new hospital site and wider stakeholders have been involved including the members of the ILPs and PCNs, the FoD Health Forum and the voluntary sector. Draft consultation document is submitted separately and Public / stakeholder Communications plan is submitted separately

	<ul style="list-style-type: none"> • There has been an appropriate assessment of the impact of the proposed service change on relevant diverse groups? • Has engagement taken place with any groups that may be affected? • What action will be taken to mitigate any adverse impacts? • Does proposal make best use of technology? • Assessment of the impact on local informatics strategy & IT deployments • Are there likely to be any data migration costs or implications for specialist or network technology/equipment contracts associated with the service? 	<ul style="list-style-type: none"> • EqIA has been completed and is available upon request • Ongoing discussions are taking place to ensure that the learning from new ways of working following COVID are fully understood and incorporated where appropriate. This includes the impact of technology and remote consultations.
	<ul style="list-style-type: none"> • Consistent with rules for cooperation and competition • Consideration given to the most effective use of estates • Robust programme and risk management arrangements • Identify and reduce privacy risks 	

Annex 5 – Overview of Service Profile across the Forest of Dean

		Dilke	Lydney	Community services that are not hospital-based that provide alternative capacity to community hospital beds?
a. What services were provided at the 2 current community hospitals pre-Covid?	Community beds	27 inpatient beds	20 inpatient beds	
	MIU	MIIU	MIIU	
	Outpatients	Outpatients services GHC:	Outpatients services GHC:	
		MSKAPS	MSKAPS	Full range of mental health community based services
		Adult SLT	MSKAPS Podiatry	Podiatry
		District Nursing	Diabetic	Community Dental Services
		Home Oxygen	Heart Failure Service	Health visiting service
		IV Therapy	Bone Health	School Nursing Service
		Falls Service	Parkinson's	Children's Therapy Services
		Diabetic	Complex Leg Wound Service	Integrated Community Team
		MSKAPS Podiatry		Rapid Response Team
		Parkinson's		Complex Care at Home
		Bone Health		Reablement Team
		Heart Failure Service		
		Outpatient Services GHFT:	Outpatient Services GHFT:	
		Vascular	Audiology	
		PUVA Phototherapy	ENT	
		Thoracic	Diabetic nurse	
		Diabetes	Stoma Care	
		General Surgery	Ophthalmology	
		Paeds Dietician	Orthoptics	
		Gastro	Oncology	
		Obstetrics	Urology	
		Colorectal	Visual Fields	
		Pain medicine	Midwifery	
		Respiratory	General Medicine	
		Paed Orthoptics	Orthopaedics	
		Orthoptics	Contenance	
		Urology	Rheumatology	
		GOAM	Paediatrics	
		Orthopaedics	Vascular	
		Contenance	General Surgery	
		Rheumatology	Respiratory	
		Paediatrics	Gynaecology	
		Multiple Sclerosis		
		Renal Nephrology		
		AAA screening		
		Leg Ulcer		
		Gynaecology		
		Midwives		
		Post Natal		
		New Born Hearing		
		Diagnostics	Plain Film X-ray	Plain Film X-ray
		Ultrasound	Cystoscopy	
	Other	MSK Physiotherapy	MSK Physiotherapy	
		Children's Therapy Services		

	New Site	Other alternatives to bedded provision and associated expansion of these?
What services are proposed as part of these proposals?	Community beds - 24 beds	- Ongoing implementation of end of life pilot with Great Oaks hospice support care provided in residential care home settings
		- Continued utilisation of spot purchase bed capacity across the county
	MIU – Single Unit	
	Out patients – Full range of outpatient activities as taking place across both sites delivered by both GHT and GHC	
Diagnostics – Plain Film X-ray, ultrasound, endoscopy, phlebotomy		
Other - MSK Physiotherapy		

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8th February 2021

Dear Ingrid

The Governing Body has now met to consider the outcome of the Forest of Dean consultation. Following our discussions at the Governing Body last week, I am now pleased to confirm our firm commissioning intentions for the new community hospital for the Forest of Dean. I trust that this confirmation will mean you can now proceed with the work to develop the capital business case over the coming months. We note that there will also be ongoing discussions led by our Directors of Finance in the next few months with regard to the prioritisation and allocation of the 21/22 system capital envelope. The business case once finalised will need to be subject to ICS and CCG review and approval (with regards in particular to any financial implications at the system level) and will also require regulatory approval from NHSE/I.

We confirm our commissioning intentions are as follows:

- **Inpatient Beds:** Whilst it is acknowledged that the feedback has not been wholly positive on the bed numbers, after careful consideration of all of the issues, the Governing Body has decided to confirm our intention to commission 24 beds in predominately single rooms for the new Forest Community Hospital.
- **Urgent Care:** The Governing Body has confirmed our intention to include a Minor Injuries Unit in the new hospital in line with our previous commitment, to enable the work on the business case for the new hospital to proceed. We consider that it is safe to now de-couple the work to develop an offer for the South of the Forest from the Forest Community Hospital Business case, given that our analysis confirms the financial impact of developing an additional offer for the South of the Forest is likely to be wholly a revenue consideration and will not impact to a material degree on the capital scheme for the hospital. With at least three years before the hospital is likely to be open, we consider that there is ample time to test and potentially pilot any new proposed offer, and for this to be taken into account at a system level before firm revenue commitments are made regarding the urgent care service in the Forest hospital.
- **Ambulatory Care (Diagnostics and Outpatients):** We confirm our commissioning intentions for ambulatory care services as set out in the consultation proposals, noting that these have been broadly supported in the consultation. Where possible, we are keen that the ongoing development of the service model for the district should seek to maximise the potential for all residents in the district to be able to access outpatient and diagnostic care as close to home as possible, including maximising the use of virtual means where appropriate.
- **Travel and Access:** The Governing Body noted that issues relating to travel and access remained central to respondents views on the services proposed. A strong geographical partiality was observed in every area of feedback in the consultation, with responses becoming more negative the further

respondent's homes were located from the site of the proposed new community hospital. Ongoing work to support transport and travel in the district, and work to consider opportunities further developments of out of hospital care (such as virtual outpatients) are therefore key to how we need to work to support ongoing service improvement for local residents in the Forest of Dean.

If you have any questions regarding the intentions set out in this letter, please do not hesitate to come back to me and we will be happy to arrange a meeting to discuss.

Yours sincerely



Dr Andy Seymour
Clinical Chair
Gloucestershire Clinical Commissioning Group

cc. Paul Roberts, Chief Executive, Gloucestershire Health and Care NHS Foundation Trust
Mary Hutton, ICS Lead/Accountable Officer, Gloucestershire Clinical Commissioning Group

Bed Modelling for Gloucestershire

Bed model principles:

Our fundamental principle will be that we will only put people in beds where it is in their best clinical interest to be there, because we know that:

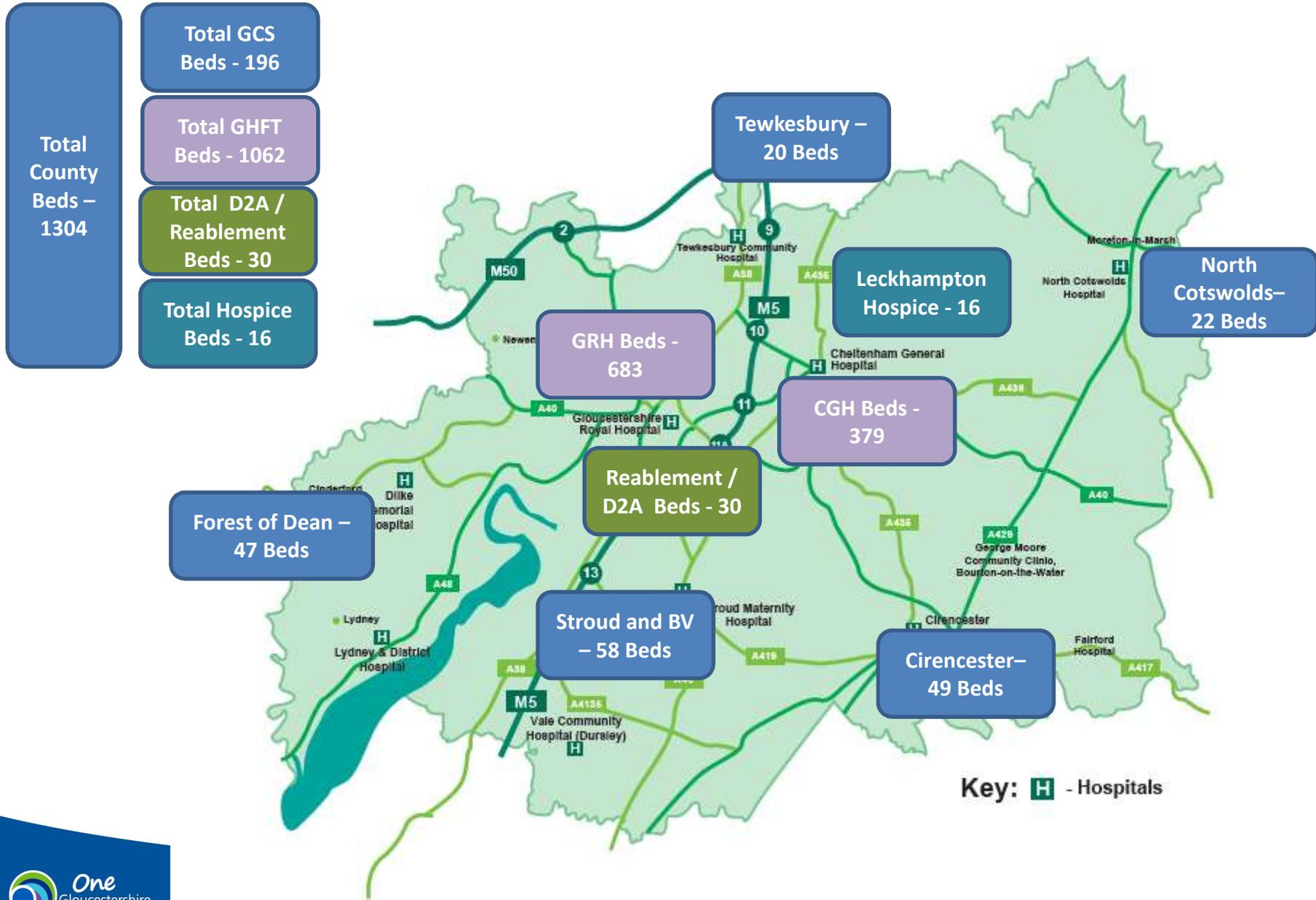
- 10 days in hospital leads to the equivalent of 10 years ageing in the muscles of people over 80 (Gill et al 2004)
- one week of bedrest equates to 10% loss in strength. For an older person who is at threshold strength for climbing the stairs at home, getting out of bed or standing up from the toilet, a 10% loss of strength may make the difference between dependence and independence (Hoenig & Rubenstein, 1991)

We know there is an opportunity to do better for our population in the future and our ICS partnership is working together to do that. Some of our key measures of success will be as follows:

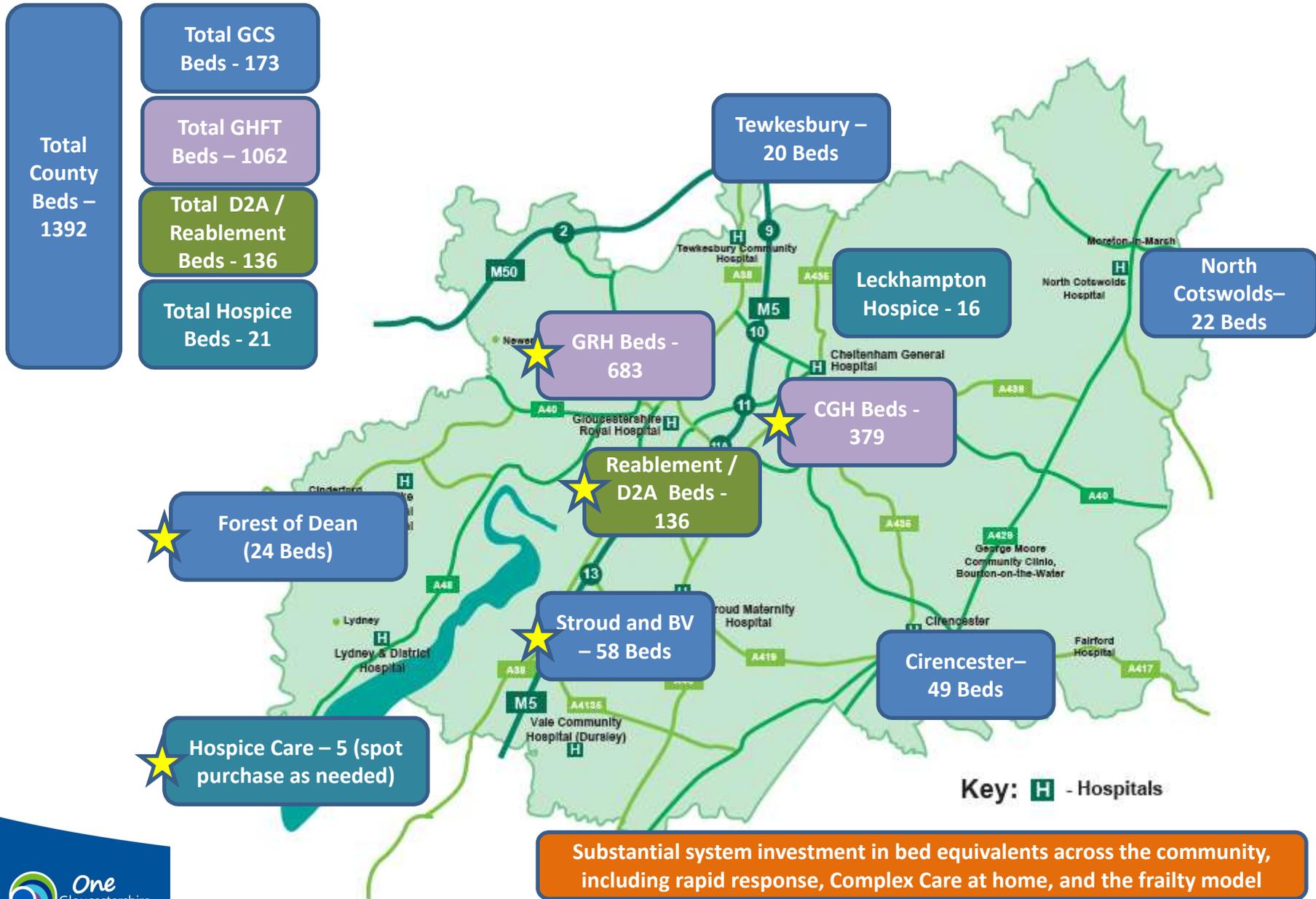
- We will ensure no-one stays over 100 days in a hospital bed, and reduce over 50 day stays with a view to eliminating these by 2020
- We will absorb the impact of demography, by using our bed stock more efficiently. We will do this by reducing length of stay to reach benchmarked opportunities, improving pathways and ensuring people are only admitted to beds where doing so really enhances their care
- We will deliver care closer to home where possible, but will deliver care in centres of excellence where the evidence demonstrates that clinical outcomes will be improved
- We will continue to deliver improvements to our discharge processes to avoid any patients being delayed going home for non medical reasons, such as access to care in the community

By delivering these changes our proposal is that the Gloucestershire total beds number should stay constant, but that the nature and allocation of these beds will change over time to align to better support our future population health needs and enable us to absorb future population growth impacts

Current Bed Model – June 2018

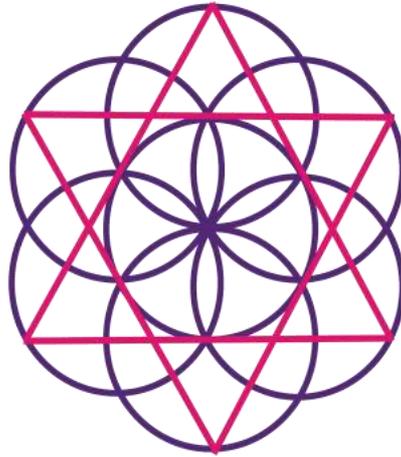


Future Bed Model – Post Consultation



Bed model assumptions:

- Key assumption is that the total beds stay constant in our system
- Some bed allocations across our system and locations change in the starred facilities, the changes can be summarised as follows. Detailed modelling has been completed on each scenario to develop this model:
 - The system has invested in substantial additional capacity to provide bed equivalents across the community including Rapid Response, Complex Care at home and the Frailty Model
 - 14 beds in Stroud and Berkeley Vale locality become specialist stroke rehabilitation beds, moving the care for those who have suffered a stroke into a community facility with enhanced rehabilitation support (8 stroke beds relocated from GHFT, 6 from other community hospitals)
 - Community hospital beds in the Forest of Dean are reduced to a number (tbc) aligned to the capacity needed to serve local residents, and additional community capacity and rehabilitation capacity is commissioned in Gloucester and Cheltenham to support care closer to home
 - The total number of beds provided at our main acute hospital remains constant, but the allocation of certain specialty beds may change to support the centres of excellence model, based on public consultation
 - Reablement and Discharge to Assess (D2A) capacity increased in our system to provide care closer to home for patients who need onwards care or rehabilitation support
 - An additional five end of life care beds / hospice at home places will be commissioned to provide care closer to home for people who are dying. This will extend bespoke provision for bed based end of life care (currently only at Leckhampton hospice)



**EQUALITY IMPACT ANALYSIS ON THE
POTENTIAL LOCATION OF A COMMUNITY
HOSPITAL IN THE FOREST OF DEAN
FOR NHS GLOUCESTERSHIRE CLINICAL
COMMISSIONING GROUP and GLOUCESTERSHIRE
CARE SERVICES NHS TRUST**

**Mina Jesa & Hari Sewell
Independent Equality Consultants**

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INTRODUCTION

This report has been commissioned by NHS Gloucestershire Clinical Commissioning Group (GCCG) and Gloucestershire Care Services NHS Trust (GCS) and sets out the Equality Impact Analysis (EIA) for the location of a new community hospital in the Forest of Dean. The focus of the EIA will be to scope out impact on the possible location of a community hospital, either in Cinderford, Lydney or Coleford.

The overarching aim of the EIA will be to establish whether there will be any specific groups or communities, within the Forest of Dean, who will be disadvantaged in any way if the hospital was to be built in any of the three potential locations identified above. As defined by the Equality Act 2010 (more information on this is in the next section of the report), the focus of this EIA will be upon the eight characteristics, which fall within the Public Sector Equality Duty (PSED). However due to the demographics of the Forest of Dean consideration will also be given to any impact the current transport infrastructure may have by way of highlighting issues relating to access of services specifically for these groups and any issues relating to deprivation will also be considered.

Whilst this piece of work is a small part of a broader piece of work developed as part of the wider One Gloucestershire Sustainability and Transformational Partnership, it is an intrinsic part of the decision-making process which will help an independent Citizens Jury decide on the location of the new hospital.

BACKGROUND AND CONTEXT OF THE REVIEW

As part of the Forest Health and Care review, following extensive engagement and consultation, a decision was taken by GCCG and GCS to replace the two existing hospitals in the Forest of Dean with a newly built one. The reasons for this decision were that Dilke Memorial Hospital and Lydney and District Hospital were increasingly unable to provide modern, efficient, effective and high-quality care. Other reasons included:

- maintenance of the two hospitals was becoming increasingly difficult;
- there were ongoing challenges of recruiting and retaining staff with the right skills;
- the current physical environment of both hospitals was not fit for purpose;
- some care provision, such as endoscopy services, were only available outside of the local area;
- the current set up was proving to be fragmented and disjointed.

Whilst the two community hospitals currently provide a range of services which include outpatients services, some diagnostic services, minor injury and illness services and inpatient beds it was deemed that overall the healthcare needs of local residents were not being met effectively.

In developing future community hospital provision GCCG and GCS have agreed a set of objectives which they will endeavour to meet by 2021/2022. These are to:

- Support the delivery of new models of care
- Improve local access to services
- Ensure appropriate service capacity
- Provide a high quality physical environment

These objectives will be underpinned by the following criteria:

- Flexibility and adaptability
- Support new ways of working
- Achievability
- Affordability
- Acceptability

The overarching benefits GCCG and GCS envisage will come from this service change are;

- a new community hospital facility for local people, fit for modern healthcare;
- significantly improved facilities and space for patients and staff;
- more consistent, reliable and sustainable community hospital services, e.g. staffing levels, opening hours;
- a wide range of community hospital services including beds, accommodation to support outpatient services and urgent care services;
- services and teams working more closely together;
- better working conditions for staff and greater opportunities for training and development so they can recruit, retain the best healthcare professionals in the Forest of Dean.

EQUALITY IMPACT ASSESSMENT: THE LEGAL CONTEXT

The Public Sector Equality Duty (PSED) is part of the Equality Act 2010 and came into force in April 2011. Section 149 of the Act sets out the main duty and states that authorities must, in the exercise of their functions, “have due regards to the need to” eliminate any conduct that is prohibited by the Act. This includes discrimination, harassment and victimisation related to the ‘protected characteristics’;

Age

Disability

Gender reassignment

Pregnancy and maternity

Race

Religion or belief

Sex

Sexual orientation

Whilst ‘Marriage and civil partnership’ is also a protected characteristic, under the Equality Act 2010, it is not covered by the PSED in the same manner as the other protected characteristics, listed above and is for the purposes of the duty to eliminate discrimination.

The PSED has three main facets and these are to:

1. eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act;
2. advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
3. foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Having due regard to the need to 'advance equality of opportunity' between those who share a protected characteristic and those who do not includes having due regard to the need to remove or minimise disadvantages suffered by them. Having due regard also means public bodies, such as GCCG and GCS, have to ensure steps are taken to meet the needs of such persons where those needs are different from persons who do not have that characteristic, and encourage those who have a protected characteristic to participate in public life.

As an essential part of meeting their PSED public authorities have to ensure an Equality Impact Analysis ("EIA") is carried out. An EIA is an analysis of a proposed organisational policy, or a change to an existing one so that it can be determined whether the policy has a disparate impact on persons from the protected characteristics. Whilst there is no longer a prescriptive way of doing this, case law has provided guidance in how to undertake an equality impact analysis, namely:

- ensure there is a written record of the equality considerations taken into account;
- ensure any decision-making included consideration of the actions that would help to avoid or mitigate any negative impacts on particular groups;
- ensure the decisions made are done so on evidence;
- ensure the decision-making process is more transparent.

METHODOLOGY

Underpinned by the three main facets of the PSED above, this EIA will set out information about the background and context of the review undertaken by GCCG and GCS, which has led to the position of agreeing the two existing community hospitals will be replaced with one new hospital; detail around engagement and consultation activity; the demographics of the Forest of Dean, with specific reference to protected characteristics; the anticipated differential impact when looking at the three potential locations, specifically in terms of equality; any mitigating factors which will help to manage any risks associated with the impact. The report will then conclude with recommendations and as the work on this project will continue to evolve, in turn so will this EIA.

This EIA was developed based on information and secondary data from sources, as set out below. The CCG and GCS undertook primary data collection which has fed directly into the EIA. This is set out in the section of this report on engagement and consultation.

The review of data formed part of the methodology as follows:

Function within methodology	Information or data reviewed, or method
Understanding of how inequalities are manifest in the lives of people bearing protected characteristics (as relevant to the proposals discussed herein).	Based on a combined experience of over 20 year's experience in the field of equalities. Review of the two biennial reports of the Equality and Human Rights Commission and the landmark Equalities Review, which informed the Equality Act 2010 ¹ , which highlight inequalities for protected characteristics.
Mapping the distribution of protected characteristics resident across the Forest of Dean, to inform the assessment of the impact of choice of town, including travel time and cost.	Interrogation of the Instant Atlas data for Gloucestershire and the Forest of Dean in particular.
Interrogate feedback about preferences expressed by residents, in terms of location of the new hospital or concerns raised to determine any variations by protected characteristics	Output reports from the GCCG and GCS engagement process.
Review case law to identify learning to inform this methodology by anticipating what may have served as an Achilles heel in relation to assessing impact on equality, for organisations leading reviews or service configurations	Cases identified via the Consultation Institute.
Use key lines of enquiry to maintain an absolute focus on the primary objective which is to determine if the choice of town for location the new hospital would have a detrimental impact on one or more protected characteristic.	<ul style="list-style-type: none"> •Q1: Does a choice of town mean that geographically based population groups (with protected characteristics) will be more disadvantaged more than others in terms of <i>journey times</i>? •Q2: Does a choice of town mean that geographically based population groups (with PCs) will be more disadvantaged by one town more than others in terms of <i>journey costs</i>? •Q3: Is there a difference in the inclusive design of public transport provision for people with particular protected characteristics: age (older people); gender (women, proportionately more are in caring roles); disabled people – depending

¹ <https://www.equalityhumanrights.com/en/publication-download/how-fair-britain> and <https://www.equalityhumanrights.com/en/britain-fairer> and http://webarchive.nationalarchives.gov.uk/20100806180051/http://archive.cabinetoffice.gov.uk/equalitiesreview/upload/assets/www.theequalitiesreview.org.uk/equality_review.pdf

	<p>on which town is chosen?</p> <ul style="list-style-type: none"> •Q4: Is there a difference in accessibility (including inclusivity of design) of ‘community transport’ provision for people with particular protected characteristics as in Q3? •Q5: Does a choice of town mean that population groups that are not geographically based will be more disadvantaged by one site more than others in terms because of a greater distance from services targeted at specific protected characteristics? <p>[Example: If there was a lesbian and gay men’s counselling service close to a hospital currently and the choice of either Cinderford, Lydney or Coleford meant a greater distance from this targeted service</p> <ul style="list-style-type: none"> •Q6: Has the information from the engagement with community and stakeholders about the proposals indicated a particular set of concerns, when analysed by protected characteristics? • •Q7: Did the responses to the engagement indicate a geographical pattern which is also correlated to clusters of population groups with protected characteristics?
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Table 1: Methodology and sources of data and information

CASE LAW

To date there are three cases in law which have shaped the way Equality Impact Analysis need to be carried out. The first is the Brown case, the second; the Branwood case and the third; the Bracking case.

The Brown case is a well-known case, which was important solely for its ruling on Impact Assessments and the promulgation of the six ‘general principles’. These are:

- **Knowledge** – Those in the public authority who have to take decisions must be made aware of their duty to have due regard to the need to eliminate unlawful discrimination, advance equality and foster good relationships across all protected characteristics.
- **Proportionality** – A higher or lower level of “due regard” must be exercised, depending on volume and severity.

- **Consultation** – This must be timely, based on giving clear information and asking the right questions.
- **Timeliness** – “Due regard” must be exercised before and at the time the policy is being considered.
- **Sufficient information** – All relevant factors must be taken into account, so in other words the decision must be exercised in substance, with rigour and an open mind.
- **Real consideration** – Considering the duty in substance, with rigour and an open mind; it is not a question of ‘ticking boxes’.
- **No delegation** – The duty will always remain the responsibility of the public body subject to the duty.

The judge in the Branwood case sought to supplement and update the ‘Brown Principles’ and in the Bracking case the judge set out yet another promulgation of a set of Principles, some of these based on the “Browns Principles”. Whilst the latter two cases have added some confusion to the process, equality leads on the whole tend to veer towards the ‘Browns Principles’ by way of ensuring the robustness of the Equality Analysis process.

FOREST OF DEAN DEMOGRAPHICS

The Forest of Dean is predominately a rural locality and has a population of 85,385. Various documents, produced by the Local Authority (Gloucestershire County Council), as well as the 2011 Census have informed this section. Whilst specific references are included in footnotes some of the documents looked at include:

<https://www.gloucestershireccg.nhs.uk/wp-content/uploads/2016/03/FOD-Understanding.pdf>

<http://www.fodhealth.nhs.uk/wp-content/uploads/2017/09/Understanding-the-FOD-July-16.pdf>

https://www.gloucestershire.gov.uk/media/2846/gcc_1217_ph-annualreport-v2-64076.pdf

<http://www.maiden.gov.uk/instantatlas/equalities2018/district/atlas.html>

<http://www.nomisweb.co.uk/reports/localarea?compare=1946157374>



Forest of Dean
Profile.doc

Research and various studies have evidenced that health issues and needs of those within some of the Protected Characteristics will differ from the wider population. The following information addresses each Protected Characteristic in turn and looks at what the prevalence of the issues and numbers of individuals may be in the Forest of Dean. Where information specifically about the Forest of Dean has been unavailable statistics for Gloucestershire as a whole has been used to help form a view about Forest of Dean residents, although it should be noted that there will be some specific differences. For example, upon speaking with colleagues from the local NHS, it became apparent that access to a car was possibly more likely in the Forest of Dean than for Gloucestershire residents in

general and certain geographical areas where BME residents live are amongst the most affluent.

AGE

The age of an individual, when accompanied with additional factors such as other 'protected characteristics' may affect their health and social care needs. Individuals may also experience discrimination and inequalities because of their age. Analysis of the 2008 European Social Survey² in 2012 found that age discrimination was the most common form of prejudice experienced in the UK, with 28% of respondents saying they had experienced prejudice based on age. In this section the age category to which most attention is given is 65+, as this is the age band that faces the most age-based discrimination.

In the Forest of Dean there are a higher proportion of people aged 65+, when compared with countywide and national figures. If looked at in terms of a broader age group, figures for 2016³ show 21.5% fall within the 0-19yr age bracket, 54.8% fall within the 20-64yr bracket and 23.7 fall within the 65+yr bracket.

In terms of future growth, by 2039, Gloucestershire's 65+ population is projected to experience the greatest growth, Gloucestershire's 0-19yr olds is also projected to increase, but at a slower rate and the working population (20-64yr olds) is projected to increase by very little. It can therefore be anticipated this will be similar for the Forest of Dean.

Analysis of the 2011 Census shows that Gloucestershire residents aged 65 or over were more likely than those under 65 to:

- have a long-term limiting illness;
- be in poor health;
- be living on their own;
- be without access to a car;
- be providing unpaid care of 50 hours or more a week;
- be living in a household without central heating;

People aged 50 or over were more likely than those under 50 to:

- be living on their own;
- be providing unpaid care;
- have no qualifications.

² European Social Survey, Experiences and Expressions of Ageism: Topline Results UK from Round 4 of the European Social Survey https://www.europeansocialsurvey.org/docs/findings/ESS4_gb_toplevelines_experiences_and_expressions_of_ageism.pdf Accessed 18/12/2017.

³ ONS Mid Year Population Estimates 2016, <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesandnorthernireland> Accessed 01/12/2017.

The ageing population will have financial and resource implications, as this will likely be the age at which health and social care needs of individuals will increase.

DISABILITY

Under the Equality Act (2010) a person has a disability if he or she has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities. This is consistent with the Census definition of a limiting long-term health problem.

According to 2011 census figures the Forest of Dean has 19.6% of the total population reporting a long term limiting health problem and, in Gloucestershire as a whole, is the only district exceeding the national figure of 17.6%

Dementia is one of the major causes of disability in older people with approximately 1,410 individuals predicted in 2018⁴. If broken down further it is estimated there would be:

76	(65-69yr age range),
159	(70-74yr age range)
232	(75-79yr age range)
322	(80-84yr age range)
322	(85-89yr age range)
299	(90+ age range).

Evidence shows that people with learning disabilities have poorer health than the general population, much of which is avoidable, and that the impact of these health inequalities is serious; people with learning disabilities are three times as likely as people in the general population to have a death classified as potentially avoidable through the provision of good quality healthcare⁵. Men with learning disabilities die on average 13 years younger than men in the general population and women with learning disabilities die on average 20 years younger than women in the general population⁶. These inequalities result to an extent from the barriers which people with learning disabilities face in accessing health care⁷.

The predicted number of people, in the Forest of Dean, with learning disabilities in 2018 is likely to be approximately 1,600.

With the ageing population increasing it is likely the number of people with limiting long-term health problems will also increase in the future and it is evident that there are differences in outcomes in areas such as employment, housing and caring between people who have a long-term illness and those who don't.

⁴ Poppi, <http://www.poppi.org.uk/> Accessed 18/12/2017

⁵ Learning Disability Profile, Public Health England Ibid

⁶ ibid

⁷ ibid

GENDER

The gender of an individual, combined with additional factors such as living alone, may affect their health and social care needs. Individuals may also experience discrimination and inequalities because of their gender. A report by the European Social Survey found 24% of respondents had experienced prejudice based on gender. Discrimination on the grounds of gender was reported by more respondents than discrimination based on ethnicity⁸.

The population by gender for the Forest of Dean in 2016⁹ was 49.2% male and 50.8% female. Statistics for Gloucestershire as a whole have shown that as age increases gender differences also become more noticeable, with females outnumbering males by an increasing margin. This said the proportion of men in the older population is increasing as life expectancy of these men increases. With such statistics not readily available specifically for the Forest of Dean one may anticipate a similar trend for residents of the Forest too.

Further analysis, for Gloucestershire, of the 2011 Census shows;

- Women were more likely than men to head lone parent households with dependent children. In Gloucestershire, 89.9% of such households were headed by a woman, a figure which was in line with the national figure.
- Women were more likely than men to be living in a household without access to a car, and to be living in a single person household.
- Amongst people aged 50-64, women were more likely than men to be providing unpaid care. Amongst people aged 65 and over, men were more likely than women to be providing unpaid care.
- Amongst people aged 16-24, men were more likely than women to have no qualifications. Amongst people aged 25-34, women were more likely than men to have a level 4 qualification (a degree or higher).
- Amongst people aged 25-64, men were more likely than women to be in higher managerial, administrative or professional qualifications.

Analysis of health data for Gloucestershire shows that:

- men have a shorter life expectancy than women;
- healthy life expectancy was the same for men and women in 2013-15

⁸ European Social Survey, Experiences and Expressions of Ageism: Topline Results UK from Round 4 of the European Social Survey http://www.europeansocialsurvey.org/docs/findings/ESS4_gb_toplines_experiences_and_expressions_of_ageism.pdf Accessed 29/11/2016..

⁹ ONS population estimates 2016 and 2006 <https://www.nomisweb.co.uk/query/construct/summary.asp?mode=construct&version=0&dataset=2002> accessed 18/12/2017

- the difference in life expectancy between men and women is greater in the most deprived decile of Gloucestershire compared with the least deprived decile;
- men have higher mortality rates than women from causes considered preventable;
- men have higher suicide rates than women;
- women over 80 have higher rates of hospital emergency admissions due to falls than men over 80

GENDER REASSIGNMENT

Gender reassignment is defined by the Equality Act 2010 as a person who is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning their sex by changing physiological or other attributes of sex. This means an individual does not need to have undergone any treatment or surgery to be protected by law.

Evidence shows that when transgender people reveal their gender variance, they are exposed to a risk of discrimination, bullying and hate crime¹⁰. Transgender people are more likely to report mental health conditions and to attempt suicide than the general population¹¹; one study found that 48% of 16-24 transgender people had attempted suicide¹². Research has also found that transgender people encounter significant difficulties in accessing and using health and social care services due to staffs' lack of knowledge and understanding and sometimes prejudice¹³. Research carried out by Stonewall in 2015 found that a quarter of health and social care staff were not confident in their ability to respond to the specific care needs of transgender patients and service users¹⁴

An increasing number of trans people are accessing Gender Identity Clinics; it is unclear if this represents an increase in the trans population or an increasing proportion of the trans population accessing Gender Identity Services¹⁵.

Whilst there are no official estimates of gender reassignment at either national or local level, in a study funded by the Home Office and the Gender Identity Research and Education Society (GIRES) estimated that between 300,000 and 500,000 people aged 16 or over in the UK are experiencing some degree of gender variance. These figures are equivalent to somewhere between 0.6% and 1% of the UK's adult population. By applying the same

¹⁰ Gender Identity Research and Education Society (2009) Gender Variance in the UK. <http://www.gires.org.uk/assets/Medpro-Assets/GenderVarianceUK-report.pdf> Accessed 18/12/2017

¹¹ House of Commons Women and Equalities Committee, 2016, Transgender Equality . www.publications.parliament.uk/pa/cm201516/cmselect/cmwomeq/390/390.pdf Accessed 18/12/2017

¹² Nodin, N. et al, 2015, The Rare Research Report: LGB&T Mental Health – Risk and Resilience Explored. www.queerfutures.co.uk/wp-content/uploads/2015/04/RARE_Research_Report_PACE_2015.pdf Accessed 18/12/2017

¹³ Stonewall (2015) Unhealthy Attitudes www.stonewall.org.uk/sites/default/files/unhealthy_attitudes.pdf Accessed 18/12/2017

¹⁴ Ibid

¹⁵ LGBT Foundation (2017), Transforming Outcomes: A Review of the Needs and Assets of the Trans Community <http://lgbt.foundation/transformingoutcomes> Accessed 18/12/2017

proportions to the Forest of Dean’s 16+ population, we can estimate that there may be somewhere between 430 and 710 adults in the district that are experiencing some degree of gender variance.

PREGNANCY AND MATERNITY

The Equality Act protects women who are pregnant, have given birth in the last 26 weeks (non-work context) or are on maternity leave (work context) against discrimination in relation to their pregnancy.

There were 844 live births in the Forest of Dean in 2016¹⁶. The largest proportions of these deliveries were in the 25 to 29 year old age group compared to the national trend where the highest proportion of live births is within the 30 to 34 year old range.

RACE

The Equality Act states that race includes colour, nationality, ethnic or national origins and the Census of 2011 found that the Forest of Dean had the lowest proportion of people from Black and Minority Ethnic communities, at a total of 1.5% of the total population. Broken down even further the ethnic breakdown of the Forest of Dean is;

Ethnicity	Number	Percentage
White	80,699	98.5
English/Welsh/Scottish/Northern Irish/British	79,227	96.7
Irish	277	0.3
Gypsy/Irish Traveller	78	0.1
Other White	1,117	1.4
Black and Ethnic Minority	1,262	1.5
Mixed/Multiple Ethnic group	528	0.6
Asian/Asian British	473	0.6
Black/African/Caribbean/Black British	199	0.2
Other ethnic group	62	0.1

A recent report by the Equality and Human Rights Commission¹⁷ found that people from Black and Minority Ethnic groups continue to experience discrimination and inequality in education, employment, housing, pay and living standards, health, and the criminal justice system;

- Amongst people aged 65 and over, Asian/Asian British people and Black African/Caribbean/Black British people were more likely than people from other ethnic backgrounds to have a long-term limiting illness and to be in poor health;

¹⁶ ONS, 2016, Live Births by Area of Usual Residence

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsbyareaofusualresidenceofmotheruk> Accessed 11/01/2018

¹⁷ Equality and Human Rights Commission (2016), Healing a divided Britain: the need for a comprehensive race equality strategy

- People of Gypsy or Irish Traveller origin were considerably more likely to be in poor health compared with all other ethnic groups (15.9% of Gypsy/Irish Travellers compared with 4.6% of White British people).
- Households headed by people from 'other White', mixed/multiple, Asian/Asian British, Black African/Caribbean/Black British and 'other' ethnic backgrounds were all more likely than households headed by people from White British backgrounds to have fewer bedrooms than was required;
- People from mixed/multiple and Black African/Caribbean/Black British backgrounds were more likely than other ethnic groups to live in social housing;
- People from White British and White Irish backgrounds were less likely than other ethnic groups to be living in private rented housing;
- People from all groups which were not White British were more likely than White British people to be living in a household without access to a car or van;
- Amongst people aged 25-34, people from White backgrounds were less likely to be unemployed than people from Black and Minority ethnic backgrounds.
- Amongst people aged 25-34, people from White Irish and Asian/Asian British backgrounds were more likely to have level 4 qualifications (a degree or higher) than White British people, whilst people from Black African/Caribbean/Black British, 'other' White, and 'other' ethnic backgrounds were less likely than White British people to have this level of qualification;
- Amongst people aged 16-24, people from mixed multiple, White Irish, 'other' White and 'other' ethnic backgrounds were all more likely than people from White British backgrounds to have no qualifications. In the same age group, people from Asian/Asian British backgrounds were less likely than White British people to have no qualifications. The percentage of people in this age group with no qualifications was similar for Black African/Caribbean/Black British people and White British people;
- Amongst people aged 25-49, people from White Irish, White British and 'other' White backgrounds were less likely to be unemployed than people from Black and Minority ethnic backgrounds;
- Amongst people aged 25-49, White Irish and Asian/Asian British people were more likely to be in higher managerial, administrative and professional occupations than White British people, whilst people from Black African/Caribbean/Black British, 'other' White, mixed/multiple, and 'other' ethnic backgrounds were less likely than White British people to be in such occupations.

Whilst specific figures for the Forest of Dean are not available the 2011 Census showed differences in outcomes in a number of areas in Gloucestershire as a whole.

RELIGION/BELIEF

According to the 2011 Census, Christianity is the most common religion within all ages in the Forest of Dean and represents 65.8% of the population. Whilst the next main group stated they had no religion at 25.2%, statistics show 1.1% of the population account for people who follow Buddhist, Hindu, Jewish, Muslim and Sikh religions. 7.9% of people chose not to state their religion or belief.

In summary then the Forest of Dean has a higher proportion of people who are Christian, have no religion or have not stated a religion than the national figures. In contrast it has a lower proportion of people who follow a religion other than Christianity, which reflects the ethnic composition of the district.

MARRIAGE AND CIVIL PARTNERSHIP

As mentioned earlier in the report Marriage and Civil Partnership do not fall under the PSED in the same way as the other protected characteristics, however the Equality Act 2010 does protect individuals who are in a civil partnership, or marriage, against discrimination.

Evidence suggests being married is associated with better mental health. There is less evidence on the benefits of being in a civil partnership; however, it is likely the benefits will also be experienced by people in similarly committed relationship such as civil partnerships¹⁸.

The statistics for Forest of Dean are reflected in a similar way in that there is considerable variation in marital status between age groups. As you would expect, people aged 16-24 are the most likely to be single, while those aged 65+ are the most likely age group to be widowed or a surviving partner from a same sex civil partnership. Same sex civil partnerships are most common amongst 35-49 year olds, where they account for 0.2% of the total age group. The proportion of people that are married, separated or divorced increases with age, until 65+ when it begins to fall, to take into account the increasing proportion of people who have lost a partner.

LANGUAGE

According to the 2011 Census, 949 people in the Forest of Dean or 1.2% of the population did not speak English as their main language. In addition to this those people not able to speak English at all were unable to speak English well, accounted for 226 people or 0.3% of the population.

Gloucestershire figures show Polish is the most common language, followed by Gujarati, and then Chinese. Whether this is the same for the Forest of Dean it is unclear.

¹⁸ Department of Health (2011), No Health Without Mental Health: A cross-Government mental health outcomes strategy for people of all ages - Analysis of the Impact on Equality (AIE)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213763/dh_123989.pdf Accessed 18/12//2017

DEPRIVATION

The Indices of Deprivation are a national measure of deprivation and provide a means of comparing areas relative to one another and are based on Lower Super Output Area (LSOA) geography.

According to a 'District Profile' produced by the Strategic Needs Analysis team there are 50 LSOAs in Forest of Dean and according to the overall Index of Multiple Deprivation, 6 of Forest of Dean's LSOAs are amongst the least deprived 20% in England, none are in the most deprived 20% in England.

The Indices of Deprivation also provide a measure of deprivation for various themes including Income Deprivation Affecting Children and Income Deprivation Affecting Older People. With this 3 of Forest of Dean's LSOAs are amongst the least deprived 20% in England in terms of In- come Deprivation Affecting Children, none are in the most deprived 20% in England. Two of Forest of Dean's LSOAs are amongst the most deprived 20% in England in terms of Income Deprivation Affecting Older People, while 4 are in the least deprived 20% in England.

HOW INEQUALITIES ARE MANIFEST IN THE LIVES OF PEOPLE BEARING PROTECTED CHARACTERISTICS

In carrying out the EIA, whilst interrogating any evidence of activity carried out by way of engagement, equality data etc. the following table provides a summary of the information which was considered when looking at variations and inequalities that may manifest for people with Protected Characteristics - as relevant to this project.

Protected characteristic	Examples of variations and inequalities (Compared with people who do not share the particular protected characteristic)
Age	Being physically disabled or with LTLI Sensory disability leading to communication problems Frailty (for older, older adults) Reliance on carer (e.g. for transport)
Disability	Learning disabled: diagnostic overshadowing Experiencing communication barriers Facing physical barriers
Gender reassignment	Face stigma Lack of knowledge Bias

	<p>Confusion about policies</p> <p>Scale of need is unknown due to poor monitoring</p>
Pregnancy & maternity	<p>Unique needs are often overlooked in services and design of estate</p> <p>Exclusions made about what is possible for pregnant women based on assumptions rather than individual capability</p>
Race	<p>Overlooking of dietary requirements</p> <p>Communication barriers, where literal translations do not capture meaning or create understanding.</p> <p>Exclusions based on misunderstanding about NRPF (No recourse to public funds)</p> <p>Unfamiliarity leads to lack of understanding (e.g. sickle cell)</p> <p>Some communities (e.g. Eastern Europeans) are likely to present at Emergency Departments</p>
Religion or Belief	<p>Needs for diets not always considered</p> <p>Prayer facilities</p> <p>Lack of understanding around bereavement</p>
Sex	<p>Men are more likely to present late (acute)</p> <p>Women are more likely to:</p> <ul style="list-style-type: none"> Have more caring roles Be more socio-economically disadvantaged Be more at risk of sexual and other violence perpetrated by men Present conditions related to the reproductive system
Sexual orientation	<p>Have their specific needs overlooked (e.g. lesbians not offered cervical smear test as assumptions are made about their needs as non-participants in heterosexual sex)</p> <p>Needs as gay men not considered for services related to HIV screening, for example.</p> <p>Scale of need is unknown due to poor monitoring</p>

TABLE 2: Inequalities faced by people who bear specific protected characteristic and the potential impacts

KEY FINDINGS OF THE TRAVEL ANALYSIS – THE IMPACT IN RELATION TO ACCESSIBILITY

GCCG and GCS commissioned an independent transport analysis, which will be received alongside this document by the Citizens' Jury and the Governing Body of GCCG and GCS Board. This EIA is concerned specifically with a) whether there are clusters of any group with a protected characteristic and b) therefore whether a choice of town for the hospital will have a disproportionate impact on one or more population groups as a consequence of a higher proportion of these or those groups being adversely affected in relation to travel from home to the hospital and back. Three dimensions of travel impact were considered in relation to protected characteristics: time, cost and availability of public transport with adaptations to cater for needs such as being physically disabled.

METHODOLOGY OF THE TRAVEL ANALYSIS

Eight locations were plotted at a spread of locations across the Forest of Dean as part of the transport review. Differential impact (depending on chosen town for the hospital) was measured against five agreed acceptable journey time models for each potential chosen location:

- A. driving time;
- B. travelling by public transport within 90 minutes to get to the town 30 minutes before a 9 AM appointment;
- C. Arriving home by public transport in 90 minutes to at (say) 10.30 AM after your 9AM appointment;
- D. as for 2 above, but for a 2pm appointment;
- E. as for 3 above but for a 2pm appointment.

The high-level findings of the transport review were:

- There are differences in car and public transport access provided by the three towns but the differences are not very great.
- The people in the north of the Forest of Dean District are not well served by any of the three locations, although they are best served by Cinderford.
- People in Sedbury cannot easily reach the hospital by public transport, especially if in Cinderford and Coleford.
- The relatively poor access available to the people in the north of the Forest of Dean District and Sedbury is mitigated by access to other hospitals outside the District and community transport.

These findings indicate that unless any of the protected characteristics were proportionately more densely resident in the north of the Forest of Dean District or Sedbury there would be no differential impact, based on aspects of equality. The review of demographic data in relation to the protected characteristic does not show any clustering in these areas. Population data was analysed on the Inform website (Instant Atlas Dynamic Report at <http://www.maiden.gov.uk/instantatlas/equalities2018/district/atlas.html>). The filters on the website enable combinations of analysis such as viewing statistics on protected characteristics in specific locations. The only protected characteristics for which this can be done however are: age, disabled people, race and religion or belief.

An additional conclusion is that there is no detriment in terms of transport cost for any protected characteristic. With regard to availability of public transport with adaptations to cater for needs, the providers of public transport serve the Forest of Dean. There is therefore, no detriment to any protected characteristic as a result of choice of town, on this dimension.

As stated in the introduction to this report, despite not being a protected characteristic in its own right under the Equality Act 2010, potential inequitable impact based on deprivation is being considered. A factor to take account of is that within the Forest of Dean, Cinderford is the town with the highest clusters of deprivation (the most deprived Lower Super Output Area in the Forest of Dean is in Cinderford West¹⁹). There is likely therefore to be a more adverse impact on people in Cinderford if the hospital was located in one of the other towns because the cost of transport will be a more significant obstacle for a greater proportion of residents.

PREVIOUS ENGAGEMENT AND CONSULTATION ACTIVITY

The Forest Health and Care Review was established in 2015 and since then GCCG together with GCS have carried out extensive engagement and consultation in relation to the proposed service changes.

The engagement and consultation activity has included conducting a stakeholder analysis at the outset to establish who the engagement team would need to engage with and in what manner. A copy of the Communications & Consultation Plan is attached at Appendix 1.

The team also used data from the Joint Strategic Needs Assessment (JSNA) to inform their earlier engagement work, as this report details demographic information for the Forest of Dean, as at 2015.

As part of the preliminary work, a 'Locality Reference Group' was established comprising of local stakeholders, (including members of the local voluntary sector organisations, carer/patient forums and partner organisations) who are well informed and connected to their local community. A Forest of Dean Locality Group ensures local GP's were also engaged from the outset. Members of both of these groups have attended meetings, briefings and the latter group specifically participated in two workshop style sessions.

Whilst the Locality Reference Group have not been regarded as representative of the Forest of Dean population, they have played an active role in shaping CCG and GCS engagement and consultation plans and their members have been proactive in eliciting feedback from their respective networks.

Stakeholder Engagement 2016: Stakeholder engagements events were also hosted across 26 locations and in addition to feedback from the other sources Gloucestershire CCG also received 73 completed online questionnaires.

¹⁹ The indices of deprivation:// <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>
This data set codes for Lower Super Output Areas rather than names, the code for Cinderford West 1 is E01022238.

Gloucestershire Care Services ran 18 engagement sessions for their staff and also encouraged other staff to provide feedback via an online questionnaire similar to one used for other stakeholders. In addition to this engagement drop-ins were held for staff from Gloucestershire Hospitals Foundation Trust, South West Ambulance NHS Foundation Trust (Forest Division) and the Palliative Care/Hospice at home team.

Other engagement activity has comprised of a section of the website being dedicated to the review, which has been regularly updated and the production of 1500 “business cards” to promote engagement and encourage feedback using the on-line questionnaire. GP surgeries also encouraged feedback through the use of their patient information screens in the waiting areas and updates outlining progress were published in both the Forest & Wye Valley Review and The Forester newspapers.

The link to the report summarising the outcomes of the engagement is as follows;
<http://www.fodhealth.nhs.uk/wp-content/uploads/2017/09/Stakeholder-Engagement-Report-July-16.pdf>

Consultation 2017: 52 Consultation events were hosted (1318 face-to-face contacts) There were 3,456 individual visitors to the consultation website, 27,498 Twitter impressions 3,779 Facebook impressions, Facebook consultation advertisement, total number of people reached 15,420, of which 11,918 was a result of paid-for advertising, and 3,502 as a result of organic sharing. There were 38,720 Facebook consultation advertisement impressions.

3344 surveys (including 354 Easy Read surveys) were submitted between 12 September and 10 December (receipt of postal surveys extended by 2 extra days to account for inclement weather conditions at the end of the consultation period). 28 items of Correspondence received (emails and letters)

Attendees at the events were encouraged to fill out survey forms either on the day, post event and these could be either sent in by freepost or submitted online. Individuals also had the option of writing letters outlining their views

Regular monitoring of consultation activity resulted in the consultation team hosting additional events, namely with Vantage Point for working age adults and also the Parents and Teacher Association (PTA) meeting in Huntley.

All quantitative data gathered was read and coded using a simple theme code. In addition, by way of an assurance exercise Healthwatch Gloucestershire attended sample Consultation events and sent a report of their observations in which they stated ‘...Healthwatch Gloucestershire was impressed by the level of preparation that had gone into the consultation which provided a good opportunity for residents of the Forest of Dean to participate and share their views...’

The Gloucestershire Health and Social Care Overview & Scrutiny Committee (HCOSC) were kept informed and engaged via an initial presentation, outlining the plans, and then through Accountable Officer's reports.

The link to the report summarising the outcomes of the consultation is as follows:

<http://www.fodhealth.nhs.uk/wp-content/uploads/2018/01/FoD-Health-Community-Hospitals-in-the-Forest-of-Dean-Outcome-of-Consultation-Report-Jan-2018.pdf>

As can be elicited from this report the consultation team works very closely with their colleagues in the communication team and other relevant teams to ensure information on any activity was disseminated as widely as possible and citizens of the Forest of Dean were encouraged to respond.

ENGAGEMENT AND CONSULTATION WITH SPECIFIC EQUALITY GROUPS

During the 2017 consultation some equality monitoring questions were included as part of the questionnaire. These were namely questions about gender, age, disability and ethnicity. A breakdown of respondents is included at Appendix 2.

Upon conferring with the CCG the decision not to include all of the Protected Characteristics was based on a matter of proportionality and relevance. The consultation team, having considered the scope of the review and service change decided to only include the Protected Characteristics listed above.

In order to ensure accessibility issues were addressed the consultation team produced an Easy Read version of the consultation booklet to encourage individuals with a learning disability and those with low literacy skills to partake in the consultation. These documents were also widely circulated and copies were delivered to the Camphill Village Trust, who have a number of supported living facilities in the Forest of Dean for people with learning disabilities.

Further discussions have led to an awareness that whilst the Black, Asian and Minority Ethnic (BAME) communities are relatively small in the Forest of Dean alternative methodology has to be employed to reach members of these communities and some work has already begun on this. The consultation team have made concerted efforts to visit local BME businesses in parts of the Forest of Dean to develop relationships and encourage engagement, something they identified they needed to do through gap analysis of their equality monitoring data.

During the course of the engagement and consultation activity the engagement team also ensured they targeted their efforts by visiting and engaging with specific groups they realised would be affected directly by the proposed service changes. These included carers, people with disabilities, a parent group, school and college.

RECENT ENGAGEMENT REGARDING LOCATION OF A NEW HOSPITAL

Following the GCCG Governing Body and GCS Board meetings on 25th January 2018, work on the consideration of a preferred location was initiated by the engagement and

communications teams. With criteria, to enable an objective consideration, already agreed the team produced a public engagement booklet with relevant information to aid residents of the Forest of Dean and others including staff to offer their views on a preferred location.

A print run of 10,000 booklets were distributed to locations such as GP surgeries, Pharmacies, Libraries, Post Offices, all of the venues where drop in sessions were going to take place and information about the consultation was also promoted using local media. Whilst Gloucestershire Healthwatch, took a very active role in the last consultation and engagement activity this time they retained the role of “critical friends”. A representative of Healthwatch Gloucestershire was a member of the Citizens’ Jury Oversight Panel, whose role is to ensure the information provided to the jury contains no bias.

Fifteen drop-in sessions were arranged at various locations across the Forest and additional dates added in the Newent area in response to feedback from residents.

The engagement was promoted to staff, and engagement materials made available. Staff engagement events were held at Lydney and Dilke Hospitals.

Visits to the website during the six week engagement period: 1,427 sessions. Articles were placed in local newspapers and information shared using social media. A two-page feature article was included in a local newspaper delivered free to households across the Forest of Dean. This article included a Freepost feedback form. Twitter activity: 16,283 impressions; Facebook activity: 1,441 impressions.

A total of 1680 surveys were completed, including 509 booklet surveys and 59 newspaper article surveys. [KEY FINDINGS FROM RECENT ENAGAGEMENT ACTIVITY REGARDING LOCATION OF A NEW HOSPITAL](#)

Following the first phases of engagement and consultation GCCG moved towards engaging about the options regarding the location for a new hospital (which are the subject of this EIA). A public engagement took place between 21 May and 3 July 2018 (deadline extended to allow for receipt of freepost surveys).

Appendix 3 provides a summary of the proportions of responses by protected characteristic for which data is available. It should be noted that not all people who completed a survey completed the demographic information questions.

There is no straightforward summary of the pattern of responses, across all protected characteristics. Key points to note are:

- As an overall proportion of those who responded, the combined total of those who identified a specific ethnicity amounted to 0.66%
- Women accounted for 63% of responses
- A third of people who responded were disabled and this is significantly higher than the population percentages (9% identified as having a disability that limited their activities a lot)
- The over 65 age group accounted for 41.80% of responses though they account for 5.3% of the general population.

Both disabled people, older people and women were proportionally more represented in the cohort of those who responded to the engagement work. Black and Minority Ethnic (BAME) groups were less represented amongst those who responded but numbers are small and do not lend themselves to making interpretations with confidence.

With regard to the choice of town, Table 4 shows the percentages of responses from the protected characteristics.

	Preferred Cinderford	Preferred Coleford	Preferred Lydney	No preference of location
Males	39%	43%	34%	38%
Females	58%	55%	64%	61%
Aged 65+	43%	36%	43%	51%
Aged 18-25	<1%	4%	2%	<1%
Under 18	0%	<1%	<1%	<1%
Not disabled	60%	61%	67%	64%
Learning disabled	1%	<1%	<1%	<1%
Disabled	34%	35%	29%	31%
White	85%	89%	93%	85%
Non-white	8%	6%	4%	9%

Table 4: Preferences expressed for each town analysed by protected characteristics

FINDINGS OF THE EQUALITY IMPACT ANALYSIS

The lines of enquiry allowed critical issues to be considered in relation to the central question of whether any one choice of town for the new hospital will have a differential impact on protected characteristics. Each question is set out and responded to here.

Q1: Does a choice of town mean that geographically based population groups (with protected characteristics) will be more disadvantaged more than others in terms of *journey times*?

Finding:

The transport mapping exercise summarised on page 18 showed that any of the three choices of town would mean that only some of the eight plotted locations could achieve the modelled journeys with acceptable travel times. No choice of town would increase the number of locations unable to achieve the modelled journeys.

Though the *number* of locations unable to achieve the modelled journeys is not affected by the choice of town, the EIA explored whether there is a particular difference in the *demographics* of the locations unable to achieve the modelled. The EIA found that the protected characteristics (for which data are available, namely age, gender, disability, race) are spread across the Forest of Dean in a way that means that no particular protected characteristic is disadvantaged by journey times.

Q2: Does a choice of town mean that geographically based population groups with protected characteristics will be more disadvantaged by one town more than others in terms of journey costs?

Finding:

There is not a particular disadvantage to any protected characteristic in terms of journey cost, depending on the choice of town, because the protected characteristics are spread across the Forest of Dean.

Q3: Is there a difference in the inclusive design of public transport provision for people with particular protected characteristics: age (older people); gender (women, proportionately more are in caring roles); disabled people – depending on which town is chosen?

Finding:

The EIA found that public transport providers serve the Forest of Dean and therefore there are no differences in the fleet.

Q4: Is there a difference in accessibility (including inclusivity of design) of 'community transport' provision for people with particular protected characteristics as in Q3?

Finding:

The travel review undertaken alongside this EIA noted in its findings that: *"The choice of hospital location will not make any difference to the service that community transport providers will be able to provide to FoD District residents"*

Q5: Does a choice of town mean that population groups that are not geographically based will be more disadvantaged by one site more than others in terms because of a greater distance from services targeted at specific protected characteristics?

Finding:

The EIA investigated whether there were any services targeted at any particular protected characteristic, associated with a current hospital that would, as a consequence of the hospital moving to a new town, be further away or dislocated from the hub of services at the hospital. The investigation into availability of local services as part of this EIA identified that there was no evidence of any targeted services that would be affected this way.

Q6: Has the information from the engagement with community and stakeholders about the proposals indicated a particular set of concerns, when analysed by protected characteristics?

Finding:

The analysis in this report indicated that there were differences in the proportions of protected characteristic that responded to the engagement work but that in many cases the numbers were small and not enabling meaningful judgements to be made. There was no evidence that the pattern of responses by protected characteristics affected the choice of town. There are however gaps in the engagement data with regard to protected characteristics other than age, disability, race and sex.

Q7: Did the responses to the engagement indicate a geographical pattern which is also correlated to clusters of population groups with protected characteristics?

Finding:

The main interpretation of the findings from the engagement activity considered as part of this EIA is that each town and surrounding area expressed a preference for the new hospital to be located in its area. There was no evidence of patterns of preferences relating to the location of clusters of any protected characteristic.

Overall there was no evidence to support a finding of differential impact for any protected characteristic. It is important to note however that the absence of evidence at this stage does not mean that there will be no differential impact on equality. For example, with data missing for religion or belief or sexual orientation, there may be impacts unique to a small group but which is significant for them. Some lines of inquiry have required knowledge about local services. For example: *Does a choice of town mean that population groups that are not geographically based will be more disadvantaged by one site more than others in terms because of a greater distance from services targeted at specific protected characteristics?* This was explored in a roundtable between the equality consultants leading this work and engagement team. Inclusion of targeted engagement with groups bearing protected characteristics in a further iteration of this work will offer more assurance.

The summary table of the EIA is found on the following page.

Protected	ADVERSE IMPACT IN RELATION TO THE LINES OF ENQUIRY						
	Q1 ²⁰	Q2 ²¹	Q3 ²²	Q4 ²³	Q5 ²⁴	Q6 ²⁵	Q7 ²⁶
Age	No	No	No	No	No	No	No
Disability	No	No	No	No	No	No	No
Gender reassignment	No	No	No	No	No	No	No
Marriage or Civil Partnership	No	No	No	No	No	No	No
Pregnancy and maternity	No	No	No	No	No	No	No
Race	No	No	No	No	No	No	No
Religion of Belief	No	No	No	No	No	No	No
Sex	No	No	No	No	No	No	No
Sexual orientation	No	No	No	No	No	No	No

Table 5: Equality Impact Assessment summary table

MITIGATING POTENTIAL ADVERSE IMPACTS ON EQUALITY

Discussions took place with members of the engagement team in relation to creating and populating a table outlining any adverse impact and examples of how these would be managed or mitigated. It was agreed this piece of work is the beginning of an ongoing project and the Equality Impact Analysis will be built upon as the work progresses therefore any work on mitigating factors will be carried out as part of the next phase.

²⁰ Q1: Does a choice of town mean that geographically based population groups (with protected characteristics) will be more disadvantaged more than others in terms of *journey times*?

²¹ Does a choice of town mean that geographically based population groups (with PCs) will be more disadvantaged by one town more than others in terms of *journey costs*?

²² Is there a difference in the inclusive design of public transport provision for people with particular protected characteristics: age (older people); gender (women, proportionately more are in caring roles); disabled people – depending on which town is chosen?

²³ Is there a difference in accessibility (including inclusivity of design) of ‘community transport’ provision for people with particular protected characteristics as in Q3?

²⁴ Does a choice of town mean that population groups that are not geographically based will be more disadvantaged by one site more than others in terms because of a greater distance from services targeted at specific protected characteristics?

²⁵ Has the information from the engagement with community and stakeholders about the proposals indicated a particular set of concerns, when analysed by protected characteristics?

²⁶ Did the responses to the engagement indicate a geographical pattern which is also correlated to clusters of population groups with protected characteristics?

CONCLUSION & RECOMMENDATIONS

It is clear to see that the Forest of Dean has an increasingly elderly population, who have a higher incidence of long-term conditions such as heart failure and diabetes. There is also recognition that compared to Gloucestershire as a whole there are pockets of higher level of economic inactivity, deprivation and social isolation in the Forest of Dean District. These kinds of issues are important in understanding health inequalities, however, having analysed the data for this EIA it is clear there is no differential impact between the three locations. There are pros and cons for each that are just as valid as they are for the others. It is inevitable that different individuals and groups will experience change differently as a result of factors associated with their identity however there is no evidence that people bearing any particular protected characteristic will be disadvantaged by either of the three options of town.

MOVING FORWARD

In light of the work carried out it is clear that the Equality Impact Analysis will be developed further as the project evolves. With this there are specific issues which will need to be addressed. These include:

‘RELEVANCY TESTING’

In order to manage any impact, it is imperative that at various stages of the overall change management programme relevancy testing is carried out with members of the Protected Characteristics.

In any kind of change, one cannot assume who will be affected, how and why. Therefore a discussion or dialogue on a 1:1 basis or through groups needs to take place where members of the Protected Characteristics are asked “this is what we are planning to do...what are your thoughts?...how do you envisage this may affect you?...why? etc.”

This kind of dialogue needs to continue as a loop throughout the process, where the particular groups are spoken to on a regular basis to ‘test out’ any change as the project evolves.

TARGETED ENGAGEMENT

Whilst it is appreciated that some of the numbers of minority groups are small there still need to continue to be efforts made to do some targeted engagement work. GCCG have begun to ‘drop-in’ to local BME businesses, for example, the Chinese take-away. However, these communities will have a wider network they will be getting their support from and it is therefore important these networks are identified and utilised as fully as possible.

Due to the small numbers it may be that instead of focussing on the Forest of Dean, focus is turned to larger communities in other parts of Gloucestershire, such as Gloucester or Cheltenham and ‘gate-keepers’ identified who can then help create links into the smaller communities within the Forest of Dean. Having someone from a similar background to the

communities being targeted is always helpful as the nuances of language and culture will be less of a barrier.

EIA ON STAFF

Staff are part of the network of stakeholders whose perspectives have been captured in the engagement work. The equality analysis of the impact of changes for employees needs to be undertaken as part of any Staff Affected by Change process related to the changes. It will be imperative that this is done to demonstrate due regard.

EQUALITY MONITORING

Monitoring of equality data requires a two-stage process: data collection and analysis. Often organisations will struggle at the first stage where they will only gather information on some of the protected characteristics and not all of them.

Gathering good equality data supports legislative requirements in that it aids prevention of discrimination. Whilst no-one is obliged to answer monitoring questions, often because they may be viewed as very personal, the quality of monitoring is only as good as the quality of data. This is why it is really important to provide an explanation that the process is worthwhile and necessary. With this the following is an example of an explanation which may be used to assure members of the public and staff that data collected will not only be confidential but there is a purpose behind doing so;

“We know from what people report to us and from formal research papers, that people with particular identities have different experiences of accessing and using services, and often derive potential benefits of services differently. The differences are usually negative compared with those who do not share those particular identities. As a result, we are asking people about aspects of identity so that we can know who is using services [or responding to engagement] so that we can take account of unique needs, with an understanding of the numbers of people from particular groups who respond. We do this to try and be fair and to comply with the law”

Forest of Dean Community Services Review Communication Strategy and Consultation Plan

1. Introduction

This Communication Strategy and Consultation Plan has been produced to support the Forest of Dean Community Services Review. It will ensure comprehensive communication and widespread public consultation over a period of at least 12 weeks.

This document has been informed following several months of local stakeholder engagement. Details of the engagement activity, feedback received and key themes can be found in the Stakeholder Engagement Report published on the CCG website: (<http://www.gloucestershireccg.nhs.uk/ForestHealth-YourSay//>).

2. Purpose

- Ensure that there is a clear framework for communication and consultation activity in place, which can be enhanced by the Forest of Dean Locality Reference Group.
- Ensure that information about the consultation is clear, easy to understand and widely available to the local community.
- Ensure that people know how they can have their say and influence the work of the programme.
- Ensure that information is presented in a consistent and coherent way, with an agreed set of key messages.
- Ensure information is regularly updated and that mechanisms are in place to respond to questions from stakeholders and people in our local communities e.g. Q/A summary.
- Ensure that stakeholder groups are communicated with in the right way and in a timely manner e.g. staff and community partners are aware of developments before media publication.
- Demonstrate and inform stakeholders of the outcome of the consultation and the impact that their feedback has made.

3. Our stakeholders

Strategic Partners	Closest to the project
<ul style="list-style-type: none"> • Gloucestershire Sustainable Transformation Plan (STP) Board • Gloucestershire Health and Care 	<ul style="list-style-type: none"> • Locality Ref Group: including representatives from hospital league of friends, Forest Health Forum, VCS

<p>Overview and Scrutiny Committee (HSOSC)</p> <ul style="list-style-type: none"> • Healthwatch Gloucestershire • Mark Harper MP • Forest of Dean District Council • Gloucestershire Health & Wellbeing Board • NHS England • NHS Improvement 	<p>organisations, FODDC</p> <ul style="list-style-type: none"> • CCG GB member, Dr Lawrence Fielder • Forest of Dean Primary Care Group • Forest of Dean GPs • GCSNHST Exec • GHNHSFT Exec • ²GNHSFT Exec • Great Oaks Hospice
<p>Keep informed</p> <ul style="list-style-type: none"> • SWAST • NHS 111 • Arriva • Aneuin Bevan Health Board • Welsh GPs with branch surgeries in the Forest of Dean • Community Health Council (ABHB Area) • Gloucestershire Local Medical Committee (LMC) • G-DOC • CareUK 	<p>Proactive two-way communication</p> <ul style="list-style-type: none"> • The public – via media • League of Friends – Dilke & Lydney hospitals • Forest of Dean Health Forum • Forest of Dean Carers Forum • Forest of Dean Practice Participation Group • Forest Voluntary Action Forum (FVAF) • GCSNHST staff • GHNHSFT staff • ²GNHSFT staff • SWAST staff • Social Care staff • Gloucestershire Care Providers Association • Transport providers

4. Key messages:

Overall:

- We owe a debt of gratitude to people of vision and generosity who have helped develop healthcare facilities and services in the Forest of Dean over many generations.
- Now, mindful of changes in healthcare, population and health, we need to create a provision for today and the future.

- We believe that residents in the Forest of Dean deserve the very best healthcare. There is a need to invest in new modern infrastructure to support health and care services and to meet local needs into the future.
- We have set out our preferred option for a single state of the art community hospital facility for local people, fit for modern healthcare.

Challenges:

- The two existing community hospitals are reaching the stage where they can no longer support the provision of modern, efficient, effective, high-quality care;
- The ability to maintain some essential services across two community hospital sites is becoming increasingly difficult with healthcare professionals working across different sites and the challenge of recruiting and retaining enough staff with the right skills;
- There are significant issues relating to cost of maintenance of the existing hospitals and restricted space for services;
- The current physical environment within the hospitals makes it difficult to ensure privacy and dignity for all patients and manage infection control;
- Too many people from the Forest of Dean are having to travel outside the local area to receive care that should be provided more locally, such as endoscopy;
- The current healthcare system can be fragmented and disjointed from both a patient and professional perspective;
- Healthcare needs within the Forest of Dean are not always being met effectively.

Benefits:

We want to achieve the following benefits for patients, health and care staff and the Forest of Dean community:

- a state of the art community hospital facility for local people, fit for modern healthcare;
- significantly improved facilities and space for patients and staff;
- more consistent, reliable and sustainable community hospital services, e.g. staffing levels, opening hours;
- a wide range of community hospital services, including beds, accommodation to support outpatient services and urgent care services;
- services and teams working more closely together;
- better working conditions for staff and greater opportunities for training and development so we can recruit and retain the best health and care professionals in the Forest of Dean.

5. Approach

This section describes the key communication methods/tools that will be used and sets out our approach to public consultation. It builds on the engagement work undertaken from September 2015:

Communication:

- Face to face pre consultation briefings: Community Hospital staff, Forest of Dean DC, MP, Locality Ref Group (including League of Friends), Media
- Written staff, stakeholder and media briefings issued
- Dedicated public webpage (and CCG website) – to host consultation materials/provide on-line feedback options
- Hardcopy and on-line consultation booklet
- Published FAQs that are updated in real time during the consultation
- Use of social media (twitter and FB) – to support the consultation process
- Consultation video – setting out the story/key messages
- Talking heads video promotion – encouraging participation in the consultation process
- Info cards and posters to promote the consultation process and feedback opportunities
- Regular media promotion/coverage to highlight consultation feedback opportunities
- Posters, media and social media to promote consultation events/information bus availability.

Consultation:

- Follow S14Z2 statutory consultation: 12 weeks
- Continued work with the Forest of Dean Locality Reference Group
- On-line survey and hardcopy booklet with centre page tear out pre-paid survey
- pre-paid options feedback postcard (as part of consultation booklet)
- Deliberative workshops with key stakeholder groups, including those identified through the Equality Impact Assessment
- Community outreach via the Information Bus and drop-in style events.

6. Key Considerations

Communication and consultation activity will ensure that all audiences are treated equally in terms of access to information and opportunities to provide feedback.

The Forest of Dean Locality Reference Group will be asked to monitor the effectiveness of our communication and range of consultation opportunities as part of their role in the review work.

The effectiveness of our Consultation will ultimately be reflected in the outcome report.

7. Timetable, key milestones and Action Plan

Pre Consultation and Consultation

Milestone	Detail	Date	Lead
Engagement Report completed	Publically available	Summer 2016	CS
Communication and Consultation Plan updated		March 2017	AD/CS
Commissioner case for change produced		April/May 2017	AH/ER//MH
Forest of Dean Locality Exec – full locality meeting		June 2017	MD/ER/AH
Strategic Outline Case (SOC) finalised		July 2017	KN/ER/MH
Begin work on Public consultation document	Based on final SOC	July 2017	AD/CS/ER/KN
HCOSC agenda planning meeting	Decision made on date of HCOSC for presentation of consultation	3 August 2017	BP
NHSE SC Stage 1 & 2 assurance meeting		9 August 2017	MH/ER/KN
Design of consultation document		18 August 2017	AD/ML
Production of consultation presentation	For use pre and during consultation	21 August 2017	AD
Production of written briefings	Staff, stakeholder and media release	22 August 2017	AD KP/ML – GCS staff
Design website for consultation	Including confirm dedicated URL	23 August 2017	RG/ML/AD/CS
Develop FAQs	For public website. To be regularly updated during consultation period	23 August 2017	AD/CS
Locality (stakeholder)	Receive	23 August 2017	CS/AH/ER/KN

Milestone	Detail	Date	Lead
Reference Group	consultation update		
FoD Primary Care Group (Locality Executive Group) meeting	Receive consultation update	Late August 2017 (TBC)	CS/AH/ER/KN
NHS Reference Group	Update on SOC and plans for consultation	30 August 2017	CS/BP/MH/KN
GCS Board meeting (closed session)	Presentation of final SOC and Consultation Plan	31 August 2017 (TBC)	MH/ER/KN
Production of 'talking heads' video <i>(promoting the consultation/feedback options)</i>	Based on agreed video script Produced, reviewed and approved by:	12 September 2017	ML-KP/CS
Production of easy read booklet	Hardcopy and for the website	By 12 September 2017	KP/CS/KN
GCS Staff briefing	Dilke and Lydney	11 September 2017	IB/TR/ML/KP
Locality Stakeholder Reference Group		11 September 2017	CS/AH/ER/KN
MP briefing	Via telephone	11 September 2017	MH/ER/KN
Leader of FODDC briefing	Via telephone	11 September 2017	MH/ER/KN
Face to face media briefing	Under Embargo. Forest location	11 September 2017	MH/KN/CH (TBC) AD/ML
HCOSC meeting (to be held in FoD)	Presentation on the day	12 September 2017	MH/KN/ER
GP and Staff Briefings issued		12 September 2017 (PM)	ML
FODDC briefing session		12 September 2017 (PM)	CS/AH/ER
Written Stakeholder briefing issued		12 September 2017 (PM)	AD
Media Release issued		12 September 2017 (PM)	AD
Info cards distributed	Promoting consultation feedback options	From 12 September 2017	SH
Posters distributed	Promoting consultation	From 12 September 2017	SH

Milestone	Detail	Date	Lead
	feedback opportunities including events/info bus dates/times		
Distribution of consultation booklets	Public places. Booklet with freepost centre page tear out survey	From 12 September 2017	SH
S14Z2 statutory consultation begins: 12 weeks		12 September 2017	
Consultation materials available on-line	Also available in public places	12 September 2017	AD/CS/RG
Social media launch	Twitter/FB	13 September 2017	SH/ML
Promotion of 'talking heads' consultation video	Through consultation website, GP practices and social media to encourage participation in the consultation	From 13 September 2017	SH/MB
Programme of consultation events		From late September 2017	CS/KP/BP
Consultation period ends		10 December 2017	
Complete Outcome of Consultation Report		December/January 2018	CS (TBC)
Consideration of Outcome of Consultation Report		January 2018	ER/KN Project Board
HCOSC receive presentation – outcome of consultation report		January 2018	MH/KN
GCS Board and CCG Governing Body decision	On preferred option (not location)	January 2018	MH/KN

8. Evaluation and contingencies

Evaluation will be measured through:

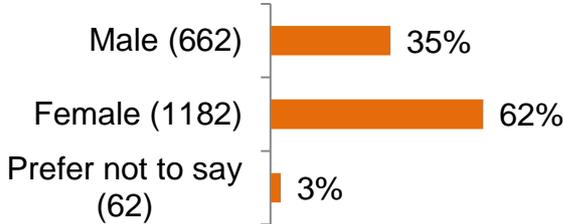
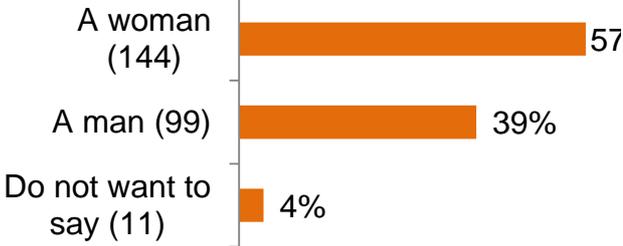
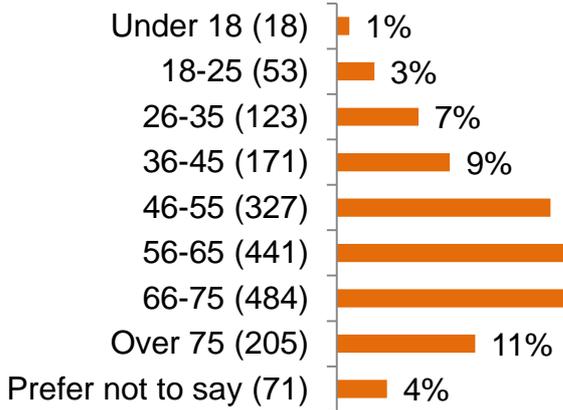
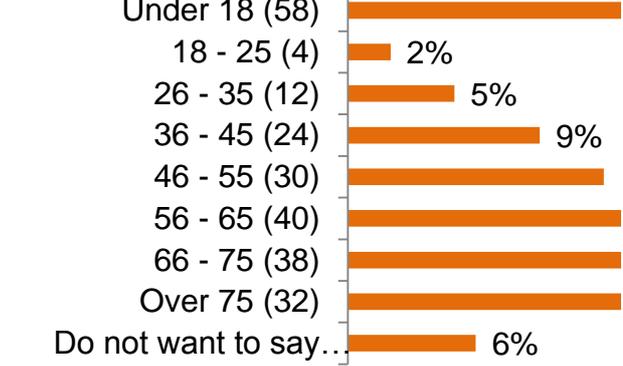
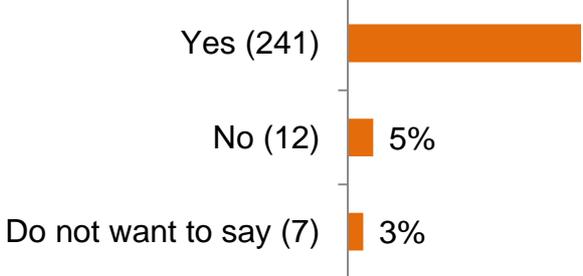
- Level of interest/volume of feedback to the Consultation e.g. surveys, following face to face opportunities e.g. debates, public drop ins, information bus visits, interaction through social media, Q/A summary.
- Responses to the Consultation – responses should demonstrate that we have provided the right level of information to enable people to contribute to the project.
- Equality Impact Assessment will ensure robust consultation and communication.
- Degree of influence achieved – what changes were made and how can that be evidenced – i.e. Outcome of Consultation report.
- Satisfaction with the Consultation process and support for the final decision.

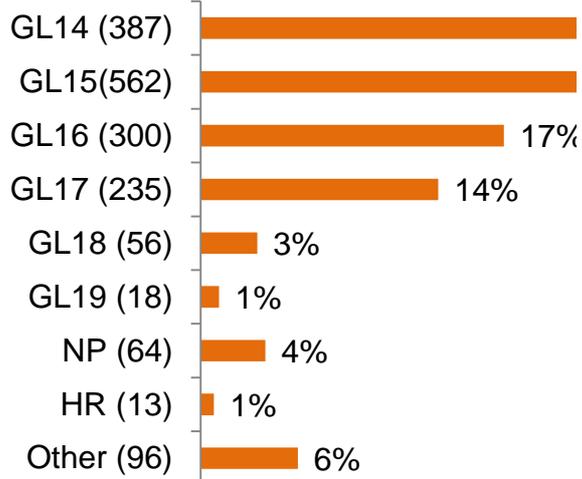
9. Consultation and Feedback

Following a twelve week period of statutory consultation a full report, detailing feedback received, will be presented to the Gloucestershire Health and Care Overview and Scrutiny Committee in January 2018. The report will be made available via the CCG and GCS websites, distributed to other local partners and on specific request.

The outcome of consultation report will also inform GCS Board and CCG Governing Body decision making.

Appendix 2: Equalities Monitoring from Consultation

Main survey	Easy Read																																																												
<p>What is your gender? (1906 responses)</p>  <table border="1"> <thead> <tr> <th>Gender</th> <th>Count</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Male</td> <td>662</td> <td>35%</td> </tr> <tr> <td>Female</td> <td>1182</td> <td>62%</td> </tr> <tr> <td>Prefer not to say</td> <td>62</td> <td>3%</td> </tr> </tbody> </table>	Gender	Count	Percentage	Male	662	35%	Female	1182	62%	Prefer not to say	62	3%	<p>Are you? (254 responses)</p>  <table border="1"> <thead> <tr> <th>Gender</th> <th>Count</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>A woman</td> <td>144</td> <td>57%</td> </tr> <tr> <td>A man</td> <td>99</td> <td>39%</td> </tr> <tr> <td>Do not want to say</td> <td>11</td> <td>4%</td> </tr> </tbody> </table>	Gender	Count	Percentage	A woman	144	57%	A man	99	39%	Do not want to say	11	4%																																				
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<p>Main survey</p> <p>What is the first part of your postcode? (1731 responses)</p>	<p>Easy Read</p> <p>Do you live in the Forest? (260 responses)</p>  <table border="1"> <thead> <tr> <th>Response</th> <th>Count</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Yes</td> <td>241</td> <td>93%</td> </tr> <tr> <td>No</td> <td>12</td> <td>5%</td> </tr> <tr> <td>Do not want to say</td> <td>7</td> <td>3%</td> </tr> </tbody> </table>	Response	Count	Percentage	Yes	241	93%	No	12	5%	Do not want to say	7	3%																																																
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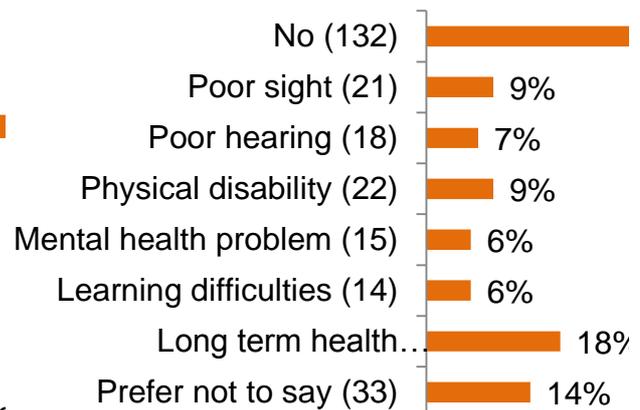
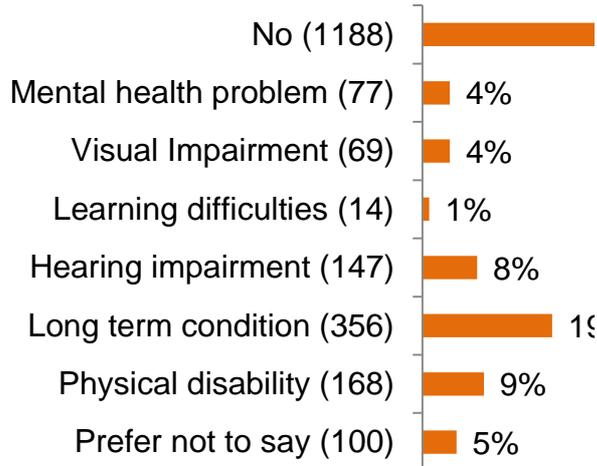


Main Survey

Easy Read

Do you consider yourself to have any disability? (tick all that apply) (Responses: 1875)

Do you have a disability? (Responses: 243)



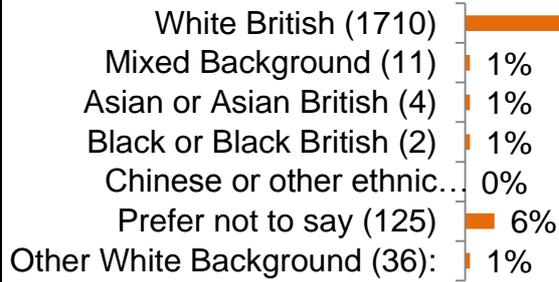
Main survey

Easy read

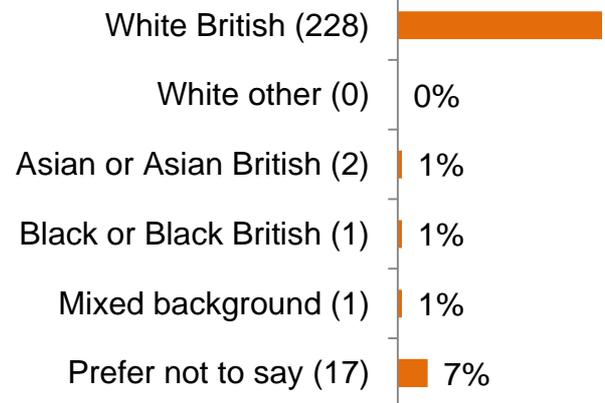
To which of these ethnic groups would you

To which of these ethnic groups would you

say you belong? (1888 responses)



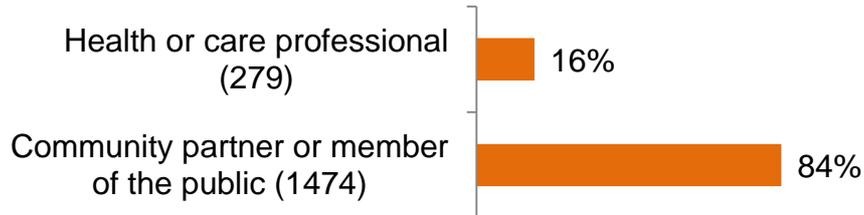
**say you belong?
(249 responses)**



Main survey only

Are you?

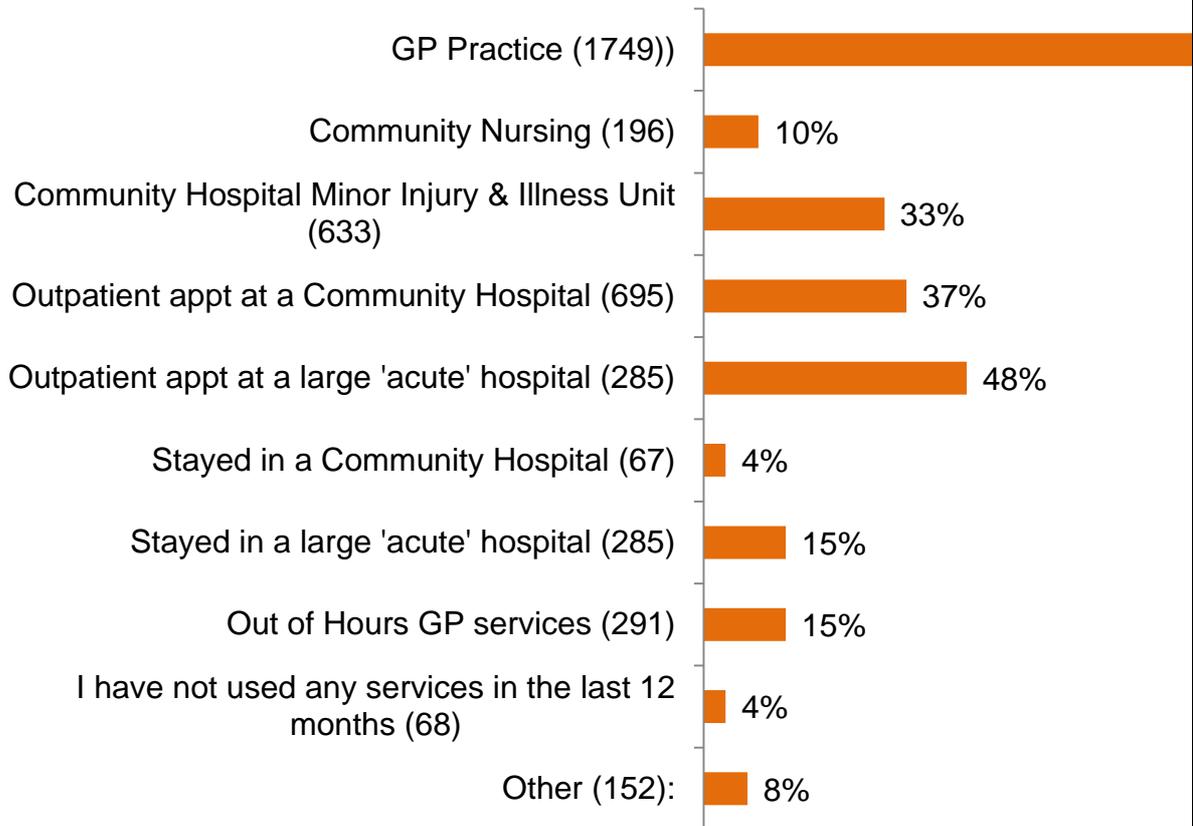
(1753 responses)



Main survey only

Which of the following health and care services have you, or your family, used in the last 12 months?

(Responses: 1899)



Appendix 3: Equalities information from the Engagement regarding Location of a new hospital

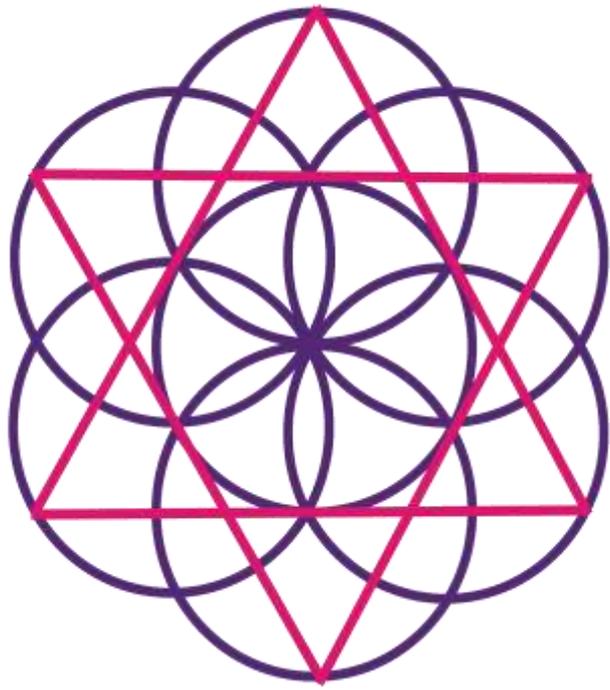
I am:			Response Percent	Response Total
1	Male		32.18%	539
2	Female		66.15%	1108
3	Prefer not to say		1.67%	28
			answered	1675
			skipped	5

My age group is:			Response Percent	Response Total
1	Under 18		0.24%	4
2	18-25		2.80%	47
3	26-45		19.81%	332
4	46 - 65		37.29%	625
5	Over 65		36.99%	620
6	Prefer not to say		2.86%	48
			answered	1676
			skipped	4

Do you consider yourself to have a disability? (Tick all that apply)			Response Percent	Response Total
1	No		69.04%	1155
2	Mental health problem		4.18%	70
3	Visual Impairment		3.17%	53
4	Learning difficulties		0.66%	11
5	Hearing impairment		7.41%	124
6	Long term condition		16.14%	270
7	Physical disability		9.38%	157
8	Prefer not to say		3.89%	65
			answered	1673
			skipped	7

To which of these ethnic groups would you say you belong? (Please tick one)

			Response Percent	Response Total
1	White British		91.83%	1539
2	White other		1.55%	26
3	Mixed		0.48%	8
4	Asian or Asian British		0.06%	1
5	Black or Black British		0.18%	3
6	Chinese		0.06%	1
7	Prefer not to say		3.70%	62
8	Other (please specify):		2.15%	36
			answered	1676
			skipped	4



B1. WLC Summary

Gross Internal Floor Area: 3,802 m²
Discount Factor: 3.50% (3% yrs 31-60)

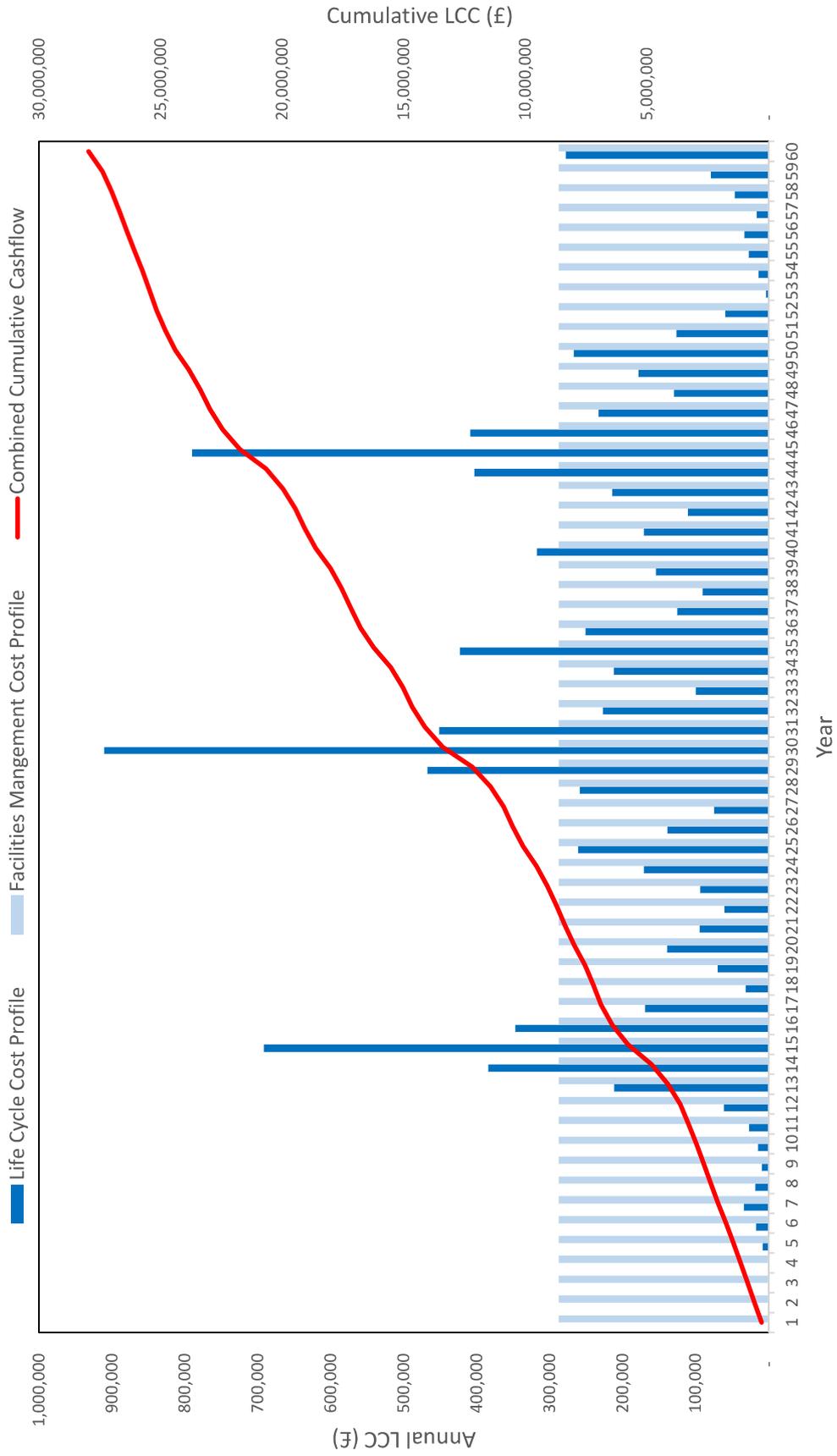
	REAL			NPV			
	CAPEX	LCC	FM	CAPEX	LCC	FM	WLC
30 Year Totals							
Total Cost	13,268,476	4,764,256	8,626,358	13,268,476	2,311,359	5,292,879	20,872,714
Cost per m ² gfa	3,489.87	1,253	2,269	3,489.87	608	1,392	5,490
Cost per m ² gfa average per annum	116.3	41.8	75.6	116.3	20.3	46.4	183.0
CAPEX ratio over concession period	100%	36%	65%	100%	17%	40%	157%
CAPEX ratio over concession period average per annum	3.3%	1.2%	2.2%	3.3%	0.6%	1.3%	5.2%

	REAL			NPV			
	CAPEX	LCC	FM	CAPEX	LCC	FM	WLC
60 Year Totals							
Total Cost	13,268,476	10,704,979	17,252,716	13,268,476	4,008,442	7,610,509	24,887,427
Cost per m ² gfa	3,489.87	2,816	4,538	3,489.87	1,054	2,002	6,546
Cost per m ² gfa average per annum	58.2	46.9	75.6	58.2	17.6	33.4	109.1
CAPEX ratio over concession period	100%	81%	130%	100%	30%	57%	188%
CAPEX ratio over concession period average per annum	1.7%	1.3%	2.2%	1.7%	0.5%	1.0%	3.1%

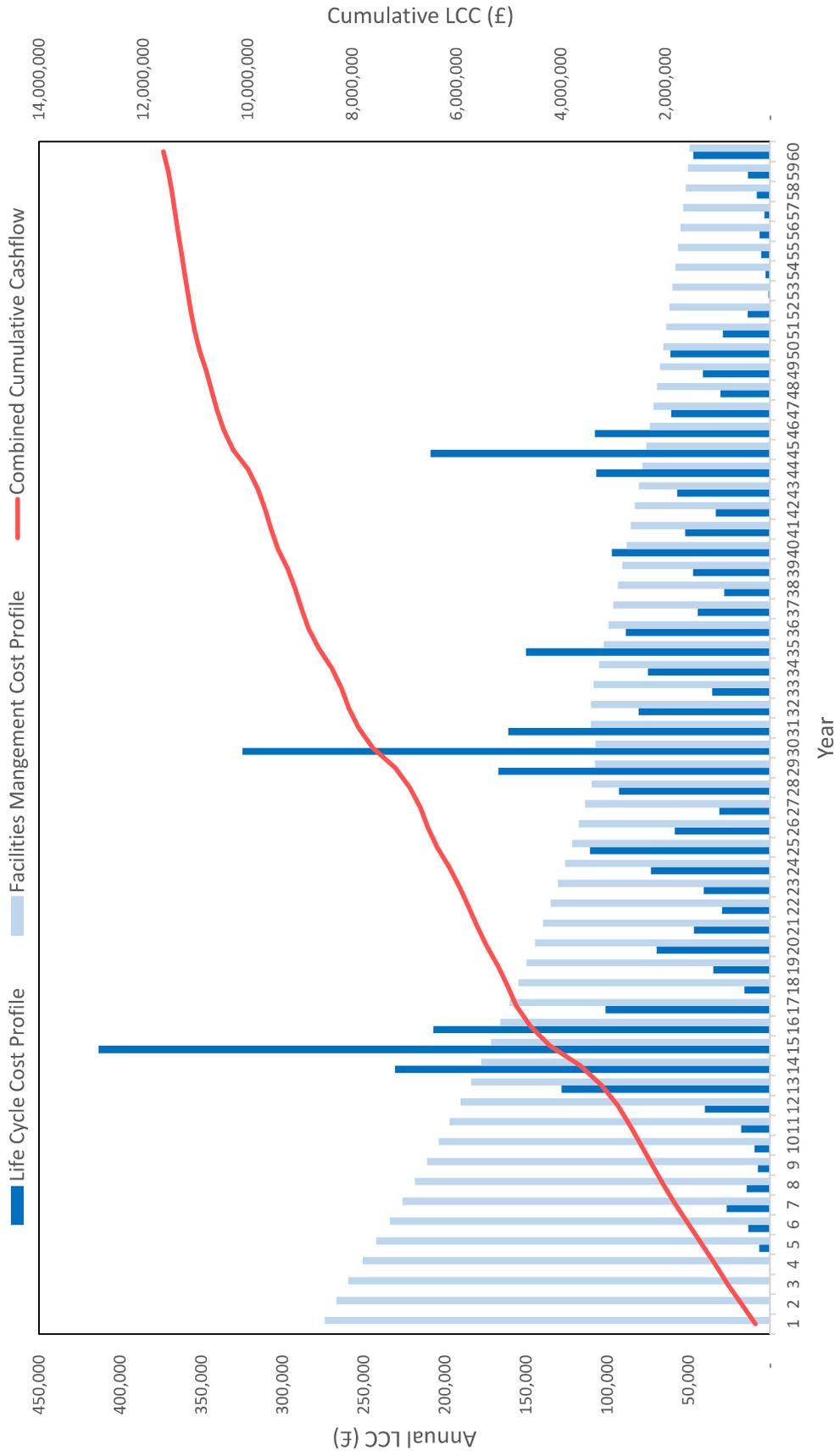
B. Smoothed Cashflow Summary

Year	Dis-count	Tail-Off	REAL				DISCOUNTED			
			LCC	FM	Annual	Cumulative	LCC	FM	Annual	Cumulative
1	3.50%	0%	-	287,545	287,545	287,545	-	274,095	274,095	274,095
2	3.50%	0%	-	287,545	287,545	575,091	-	266,705	266,705	540,801
3	3.50%	0%	-	287,545	287,545	862,636	-	259,534	259,534	800,334
4	3.50%	0%	-	287,545	287,545	1,150,181	-	250,757	250,757	1,051,091
5	3.50%	0%	8,291	287,545	295,836	1,446,017	6,517	242,277	248,794	1,299,885
6	3.50%	0%	16,911	287,545	304,457	1,750,474	13,283	234,084	247,368	1,547,253
7	3.50%	0%	33,823	287,545	321,368	2,071,842	26,567	226,169	252,735	1,799,989
8	3.50%	0%	18,099	287,545	305,644	2,377,486	14,175	218,520	232,695	2,032,684
9	3.50%	0%	9,346	287,545	296,892	2,674,378	7,298	211,131	218,429	2,251,113
10	3.50%	0%	14,281	287,545	301,827	2,976,204	9,521	203,991	213,512	2,464,624
11	3.50%	0%	26,716	287,545	314,261	3,290,465	17,699	197,093	214,792	2,679,416
12	3.50%	0%	61,129	287,545	348,674	3,639,139	40,099	190,428	230,526	2,909,942
13	3.50%	0%	211,577	287,545	499,123	4,138,262	128,343	183,988	312,331	3,222,274
14	3.50%	0%	384,005	287,545	671,550	4,809,812	230,749	177,766	408,515	3,630,789
15	3.50%	0%	691,944	287,545	979,489	5,789,301	413,348	171,755	585,103	4,215,892
16	3.50%	0%	346,962	287,545	634,507	6,423,808	207,245	165,947	373,191	4,589,083
17	3.50%	0%	169,335	287,545	456,881	6,880,689	101,061	160,335	261,396	4,850,480
18	3.50%	0%	30,989	287,545	318,535	7,199,223	15,599	154,913	170,512	5,020,992
19	3.50%	0%	69,610	287,545	357,155	7,556,378	34,843	149,675	184,517	5,205,509
20	3.50%	0%	139,220	287,545	426,765	7,983,143	69,685	144,613	214,298	5,419,807
21	3.50%	0%	94,482	287,545	382,027	8,365,170	46,920	139,723	186,643	5,606,450
22	3.50%	0%	60,731	287,545	348,276	8,713,447	29,368	134,998	164,366	5,770,815
23	3.50%	0%	93,794	287,545	381,339	9,094,786	40,606	130,433	171,038	5,941,854
24	3.50%	0%	171,006	287,545	458,552	9,553,337	73,160	126,022	199,182	6,141,036
25	3.50%	0%	261,073	287,545	548,619	10,101,956	110,872	121,760	232,632	6,373,668
26	3.50%	0%	138,828	287,545	426,373	10,528,329	58,600	117,643	176,243	6,549,911
27	3.50%	0%	75,105	287,545	362,650	10,890,979	31,092	113,665	144,757	6,694,668
28	3.50%	0%	258,682	287,545	546,227	11,437,207	93,004	109,821	202,825	6,897,494
29	3.50%	0%	467,620	287,545	755,165	12,192,371	167,024	107,710	274,734	7,172,227
30	3.50%	0%	910,697	287,545	1,198,242	13,390,613	324,682	107,328	432,011	7,604,238
31	3.00%	0%	451,698	287,545	739,243	14,129,856	160,951	110,272	271,224	7,875,462
32	3.00%	0%	226,838	287,545	514,384	14,644,240	80,860	110,121	190,981	8,066,443
33	3.00%	0%	99,824	287,545	387,369	15,031,609	35,497	108,469	143,966	8,210,409
34	3.00%	0%	211,818	287,545	499,363	15,530,972	75,151	105,310	180,461	8,390,870
35	3.00%	0%	422,977	287,545	710,522	16,241,494	150,046	102,242	252,289	8,643,159
36	3.00%	0%	250,968	287,545	538,514	16,780,008	88,645	99,264	187,910	8,831,069
37	3.00%	0%	125,484	287,545	413,029	17,193,038	44,323	96,373	140,696	8,971,765
38	3.00%	0%	90,419	287,545	377,965	17,571,002	28,225	93,566	121,791	9,093,556
39	3.00%	0%	154,519	287,545	442,064	18,013,066	47,369	90,841	138,210	9,231,766
40	3.00%	0%	317,328	287,545	604,873	18,617,939	97,133	88,195	185,328	9,417,094
41	3.00%	0%	171,100	287,545	458,646	19,076,585	52,160	85,626	137,787	9,554,881
42	3.00%	0%	110,423	287,545	397,968	19,474,553	33,267	83,132	116,400	9,671,280
43	3.00%	0%	214,117	287,545	501,662	19,976,215	57,027	80,711	137,738	9,809,019
44	3.00%	0%	403,362	287,545	690,907	20,667,122	106,868	78,360	185,228	9,994,247
45	3.00%	0%	790,142	287,545	1,077,687	21,744,809	208,944	76,078	285,022	10,279,269
46	3.00%	0%	408,561	287,545	696,106	22,440,915	107,737	73,862	181,599	10,460,867
47	3.00%	0%	232,806	287,545	520,351	22,961,266	60,713	71,711	132,424	10,593,291
48	3.00%	0%	129,737	287,545	417,282	23,378,548	30,457	69,622	100,079	10,693,370
49	3.00%	0%	178,535	287,545	466,080	23,844,628	41,327	67,594	108,921	10,802,291
50	3.00%	0%	266,856	287,545	554,401	24,399,029	61,173	65,626	126,798	10,929,089
51	3.00%	0%	126,683	287,545	414,228	24,813,258	28,954	63,714	92,668	11,021,757
52	3.00%	0%	59,196	287,545	346,741	25,159,999	13,503	61,858	75,361	11,097,119
53	3.00%	0%	3,556	287,545	291,101	25,451,100	700	60,057	60,756	11,157,875
54	3.00%	0%	13,577	287,545	301,122	25,752,222	2,634	58,307	60,942	11,218,817
55	3.00%	0%	27,154	287,545	314,699	26,066,921	5,269	56,609	61,878	11,280,695
56	3.00%	25%	32,973	287,545	320,519	26,387,440	6,340	54,960	61,300	11,341,995
57	3.00%	40%	16,487	287,545	304,032	26,691,472	3,170	53,360	56,529	11,398,524
58	3.00%	55%	46,178	287,545	333,723	27,025,195	7,976	51,805	59,781	11,458,305
59	3.00%	70%	79,424	287,545	366,969	27,392,164	13,481	50,585	64,066	11,522,371
60	3.00%	85%	277,985	287,545	565,530	27,957,694	47,183	49,396	96,579	11,618,951
			10,704,979	17,252,716	27,957,694	27,957,694	4,008,442	7,610,509	11,618,951	11,618,951

C. Breakdown of LCC Costs Annual Cashflow Histogram
(Costs Smoothed but not Discounted)



**D. Breakdown of LCC Costs Annual Cashflow Histogram
(Costs Smoothed and Discounted)**



5.0 Assumptions & Exclusions

5.1 The following assumptions have been used in calculating the Life Cycle Costs:

- Base date for life cycle costs: 3Q2021
- Gross internal floor area (GIFA) of 3,902m²
- Costs are calculated at real costs, i.e. there is no allowance for inflation and increased costs included in the projected figures.
- Calculated costs exclude allowances for Client management costs for the operation of the building, or the overheads and profits of a Facilities Management Contractor.

5.2 General assumptions include:

- Economically sized competitive replacement contracts are placed
- All contract areas to be empty of staff and public, and to be safe to allow for replacement access
- No unreasonable restrictions on working hours
- All workmanships/installations/maintenance etc. are in accordance with manufacturers' recommendations
- Like for like replacements

5.3 General exclusions include:

- Decant costs that may be applicable to enable the works to be undertaken
- Structural works
- Out of hours working premium
- ICT equipment
- Professional fees
- Tenant works
- Catering equipment, specialist equipment, and the like
- Temporary roofs
- Damage caused through vandalism
- Effects of future legislation on Building Regulations
- Value Added Tax

5.4 Calculations

- The exact replacement of components is not known. Therefore the replacement cycles inputted into the model have been 'smoothed' across a range of years.

Year	Yr -2	Yr -1	Yr	Yr +1	Yr +2	Total
Smoothing	10%	20%	40%	20%	10%	100%

- The costs associated to years 56-60 have been tailed-off. This represents the reduced expenditure on maintenance and operation towards the end the building's life cycle.

FULL BUSINESS CASE FOR FOREST OF DEAN COMMUNITY HOSPITAL

COST FORM FB1

TRUST : GLOUCESTERSHIRE HEALTH & CARE NHS FOUNDATION

SCHEME : FOREST OF DEAN COMMUNITY HOSPITAL

VERSION : 09-Jul-21

OPTION : 1

CAPITAL COST SUMMARY

		COMMUNITY HOSPITAL		
		Cost Exc. VAT £	VAT £	Cost Incl. VAT £
1.	Departmental Costs (from Form FB2)	13,890,270	2,778,054	16,668,324
2.	On-Costs (from Form FB3)	2,657,200	531,440	3,188,640
3.	Works Cost Total (Tender Price index level 1995 = 100 base)	16,547,470	3,309,494	19,856,964
4.	Provisional location adjustment (if applicable)	0	0	0
5.	Sub Total	16,547,470	3,309,494	19,856,964
6.	Fees 6.77% of Works Cost	1,120,000	224,000	1,344,000
7.	Non-Works Costs (from Form FB4)			
	LAND	0	0	0
	OTHER	600,000	0	600,000
8.	Equipment Cost (from FB2) 4.68%	650,000	130,000	780,000
9.	Planning Contingencies 4.94%	816,667	163,333	980,000
	VAT Reclaim		(340,000)	(340,000)
10.	Sub Total	19,734,137	3,486,827	23,220,964
	Land / Property Purchase	0	0	0
11.	Optimism Bias 0.00%			0
12.	TOTAL (for approval purposes)	19,734,137	3,486,827	23,220,964
13.	Inflation Adjustments	581,347	116,269	697,616
14.	FORECAST OUTTURN BUSINESS CASE TOTAL		£	23,918,580

Cash Flow :- Year	SOURCE			£
	EFL	OTHER GOVERNMENT	PRIVATE / CHARITY	
'2020/2021				0
'2021/2022				0
'2022/2023				0
'2023/2024				0
				0
			Total Cost (as 12 above)	0

This form completed by : NHS Property

Telephone No :

Address :

Date : Jul-21

Authorised by : Project Director

Reference :

FULL BUSINESS CASE FOR FOREST OF DEAN COMMUNITY HOSPITAL

COST FORM FB2

TRUST : GLOUCESTERSHIRE HEALTH & CARE NHS FOUNDATION

SCHEME : FOREST OF DEAN COMMUNITY HOSPITAL

OPTION : 1

CAPITAL COST : DEPARTMENTAL COSTS AND EQUIPMENT COSTS

Functional Content	Function Units/Space Requirements	N/A/C	Capital Investment Version 2.1 £	Equipment Cost Version 2.1 £
ACCOMMODATION				
Main Building	3,802 M2	N	13,890,270	650,000
Less abatement for transferred Equipment if applicable				£ 650,000
				0
Departmental Costs and Equipment Costs to Summary (Form FB1)		3,802.0 M2	£ 13,890,270	£ 650,000

Notes :

Cost allowances should be based on Departmental Cost Allowances where appropriate and include allowances for essential complimentary accommodation and optional accommodation and services where details not available.

Identify separately any proposed adjustment (over or under cost allowances) justifiable in value for money terms (details to be provided)

1. State area and rate if departmental cost allowance not available
2. Insert :
 - N for new build,
 - A for adaptations for alternative use or
 - C for upgrading existing building retaining current use
3. Insert relevant version number of CONCISE 4 database listing of Departmental Cost Allowances and Equipment Cost Allowances
4. Provide details where appropriate

Reference :

FULL BUSINESS CASE FOR FOREST OF DEAN COMMUNITY HOSPITAL COST FORM FB3

TRUST : GLOUCESTERSHIRE HEALTH & CARE NHS FOUNDATION

SCHEME : FOREST OF DEAN COMMUNITY HOSPITAL

OPTION : 1

CAPITAL COSTS : ON-COSTS

	Estimated Cost (exc. VAT)	Percentage of Departmental Cost
£		%
1. Communications		
a. Space		
b. Lifts	£ 130,000	0.94%
2. "External" Building Works		
a. Drainage	460,000	3.31%
b. Roads, paths, parking	1,798,200	12.95%
c. Site layout, walls, fencing, gates	64,000	0.46%
d. Builders work for engineering services outside buildings	70,000	0.50%
3. "External" Engineering Works		
a. Steam, condensate, heating, hot water and gas supply mains		
b. Cold water mains and storage	35,000	0.25%
c. Electricity mains, sub-stations, stand-by generating plant	100,000	0.72%
d. Calorifiers and associated plant		
e. Miscellaneous services		0.00%
4. Auxiliary Buildings	£	0.00%
5. Other on-costs and abnormals		
a. Building		
b. Engineering		
Total On-Costs to Summary FB1	£ 2,657,200	19.13%

Notes: Must be based on scheme specific assessments/measurements; attach details to define scope of works as appropriate.

Identify separately any proposed additional capital expenditure justifiable in value for money terms (details to be provided).

(1) "External" to Departments

(2) Identify any enabling or preliminary works to prepare the site in advance e.g. demolitions; service diversions; decanting costs; site investigations and other exploratory works.

(3) To be read in conjunction with construction risk analysis tables in appendix E

This form completed by : NHS Property

Telephone No :

Date : Jul-21

Reference :

FULL BUSINESS CASE FOR FOREST OF DEAN COMMUNITY HOSPITAL

COST FORM FB4

TRUST : GLOUCESTERSHIRE HEALTH & CARE NHS FOUNDATION

SCHEME : FOREST OF DEAN COMMUNITY HOSPITAL

OPTION : 1

CAPITAL COSTS : FEES AND NON-WORKS COSTS

	£	Percentage of Works Cost %
1. Fees (including "in-house" resource costs)		
a. Architects	inc in Works Cost	
b. Structural Engineers	inc in Works Cost	
c. Mechanical Engineers	inc in Works Cost	
d. Electrical Engineers	inc in Works Cost	
e. Quantity Surveyors		
f. Project Management		
g. NHS Team		
h. NHS Team		
i. Legal Fees		
j. Site Supervision		
j. Others (Specify)		
1) Site specialist and other surveys		
2) Planning Consultant		
3) Healthcare Planning		
4) Building Control		
5) Decant Management		
6) Principal Designer		
7) BREEAM Assessors		
8) Highways Consultant and Traffic Assessment		
9) Equipment Scheduling and associated Consultant Fees		
10) Acoustic Consultant		
11) Fire Assessor		
	1,120,000	
Total Fees to Summary (FB1)	£ 1,120,000	0.00%

	£	£
2. Non-Works Costs		
a. Land Purchase legal fees		
b. Statutory and Local Authority charges		
c. Building Regulation and Planning Fees		
d. Other (specify) - Decommissioning Costs		
Site acquisition (Non VATable)	420,000	
Skate Park / MUGA works - financial transfer	180,000	
Non-Works Costs to Summary (FB1)	£ 600,000	0.00%

This form completed by : NHS Property

Telephone No :

Date : Jul-21

Reference :

TRUST : GLOUCESTERSHIRE HEALTH & CARE NHS FOUNDATION
 SCHEME : FOREST OF DEAN COMMUNITY HOSPITAL

FULL BUSINESS CASE
SUMMARY

Option 1
SOA MA
 Version 09-Jul-21

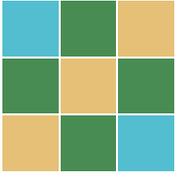
PROJECTS / DIRECTORATES	Category	New Refurb. Redec.	N A C	GFA	Departmental			On-Costs		Works Cost (Location Factor)	Fees Non-Works Costs - OBC	Fees Non-Works Costs - FBC	Fees Non-Works Costs - Const	Equipment	IT	Planning Contingencies	Inflation Adjustments	VAT	VAT Reclaim (on fees)	SUB-TOTAL	Land / Property Purchase	Optimism Bias	TOTAL COST	TOTAL COST OUTTURN	OUTTURN
					Area	Rate	Cost	Cost	%																
				m2	m2	£/m2	£	£	%	£	£	£	£	£	£	£	£	£	£	£	£	£	£	£	£
Main Building			N	3,802		3,653	13,890,270	2,657,200		16,547,470	0	1,720,000	0	650,000	0	816,667	581,347	3,943,096	(340,000)	23,918,580	0	0	23,918,580	23,918,580	
TOTAL DEVELOPMENT					0		13,890,270	2,657,200		16,547,470	0	1,720,000	0	650,000	0	816,667	581,347	3,943,096	(340,000)	23,918,580	0	0	23,918,580	23,918,580	

£/m2 GFA #DIV/0!

TRUST : GLOUCESTERSHIRE HEALTH & CARE NHS FOUNDATION SCHEME : FOREST OF DEAN COMMUNITY HOSPITAL	OUTLINE BUSINESS CASE	Option	1
		Revision	MA
	NOTES	Version :	09-Jul-21

CAPITAL COSTS

- N.01 All Capital costs have been prepared at base date 2Q21
- N.02 No adjustment has been taken for a location factor as the costs included are already based upon the actual location of the project.
- N.03 Works costs have been based upon a measured Elemental Cost Plan
- N.04 On-Costs for External Works etc. have been based upon a measured cost plan
- N.05 Value Added Tax has been calculated at 20% on all new build elements.
- N.06 VAT reclaim has been included as per advice received by the Trust.
- N.07 All design and Trust fees are as per actual fee submissions received to date and included within the fee schedule held by the Project Manager.
- N.08 Allowance for site acquisition costs and a financial transfer to the Council for a Skate Park / MUGA have been included
- N.09 The allowance for Equipment has been based upon calculated at 7% of the Works Cost
- N.10 Scheme contingencies and risk allowances have been calculated as approximately 4.9% of the value of the Works cost, Fees, Non-Works and Equipment Costs.
- N.11 A cashflow has not been prepared
- N.12 A 60 year Life Cycle cost exercise has been prepared



COTSWOLD
TRANSPORT
PLANNING

Gloucestershire NHS
Foundation Trust

Cinderford Community Hospital

Travel Plan

May 2021

DRAFT



DOCUMENT REGISTER

CLIENT:	GLOUCESTERSHIRE NHS FOUNDATION TRUST
PROJECT:	CINDERFORD COMMUNITY HOSPITAL
PROJECT CODE:	21-0239

REPORT TITLE:	TRAVEL PLAN		
PREPARED BY:	JONATHAN SENKBEIL	DATE:	MAY 2021
APPROVED BY:	JAMIE MATTOCK	DATE:	MAY 2021

REPORT STATUS:	DRAFT 01
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List of Contents

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4	Objectives and Targets	13
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Appendices

- APPENDIX A: Site Location Plan
- APPENDIX B: Development Proposals (Architect's Layout)
- APPENDIX C: Bus Timetable Information
- APPENDIX D: Accessibility Index Calculations
- APPENDIX E: Staff Travel Surveys
- APPENDIX F: Example Travel Survey



1 Introduction

- 1.1 Cotswold Transport Planning Ltd (CTP) has been instructed by the Gloucestershire NHS Foundation Trust to prepare a BREEAM compliant Travel Plan (TP) in support of a planning application concerning the construction of a new community hospital on land north-east of Steam Mills Road (A4151), Cinderford, Forest of Dean, Gloucestershire.
- 1.2 Full planning permission is sought for a new community hospital with associated parking for both staff and visitors, infrastructure, landscaping with a reconfigured access off Steam Mills Road (A4151). The site will also include drop-off zones, ambulance drop-off / pick up point and a small delivery area with associated building services accommodation.
- 1.3 The proposed development will be called Cinderford Community Hospital (CCH).
- 1.4 This TP has been prepared to assist the promotion of sustainable travel modes, primarily amongst staff, for travel to and from the application site but will also prove beneficial in encouraging patients, visitors, local community, and other stake holders to the site to utilise sustainable modes of travel.

Site Location and Development Proposals

- 1.5 The application site is located on land north-east of Steam Mills Road (A4151) within the town of Cinderford, which is situated within the Forest of Dean district of Gloucestershire and is located approximately 5km to the south-west of Mitcheldean and 16km to the north of Lydney.
- 1.6 The site location plan is attached at **Appendix A** and the development proposals are attached at **Appendix B**.
- 1.7 **[Parking - WILL BE UPDATED ONCE PARKING NUMBERS ARE CONFIRMED]**
- 1.8 Pedestrian access to the application site shall be achieved via an active travel corridor on the northern side of the reconfigured access with Steam Mills Road (A4141).
- 1.9 Vehicular access to the site is achieved via an improved access in the form of a simple priority junction from Steam Mills Road (A4151). The proposed junction will be incorporated into the right turn ghost island junction into Valley Road, thereby forming a staggered ghost island right turn facility for the proposed development and for Valley Road.



Travel Plans

- 1.10 TPs detail the means by which sustainable travel to / from the site by staff, patients, visitors and other stakeholders is encouraged. This may be achieved through the reduction in the number of individual private vehicle trips; and / or the encouragement of public transport, walking and cycling as travel alternatives. Success in this respect will help to mitigate the impact of additional traffic attracted by the proposed development, reducing carbon footprint, boosting the surrounding economy, and contributing to a fitter workforce.
- 1.11 The principal objective of the TP is to promote and provide alternative sustainable modes of transport and to ensure staff, and where possible patients and visitors, are fully aware of the sustainable travel options available to them.
- 1.12 The aims of the TP include:
- i) Reductions in single occupancy car use;
 - ii) Increase walking and cycling awareness and safety;
 - iii) Increase in public transport awareness; and
 - iv) To achieve high awareness of the TP with staff, and where possible patients and visitors.
- 1.13 The structure of the remainder of the TP is as follows:
- i) **Section 2:** Travel Plan Context - sets the scene and details the policy context;
 - ii) **Section 3:** Baseline Sustainability Audit - provides a site assessment in relation to sustainable transport modes;
 - iii) **Section 4:** Objectives and Targets - provides detailed objectives and targets of this Travel Plan;
 - iv) **Section 5:** Travel Plan Management and Measures - details the management structure in place to deliver the TP;
 - v) **Section 6:** Travel Plan Action Plan - detailed list of measures and initiatives that will be implemented to achieve the objectives and targets of this TP.
 - vi) **Section 7:** Monitoring and Review - details the monitoring and review of the TP; and
 - vii) **Section 8:** Funding - provides detail of the funding of the TP.
- 1.14 Travel Plans have the ability to create more sustainable developments, which will assist the development to comply with national, regional and local planning policies.



BREEAM Compliance

- 1.15 The Building Research Establishment Environmental Assessment Method (BREEAM), is the world's leading sustainability assessment method for master-planning projects, infrastructure and buildings. BREEAM measures sustainable value in a series of categories, ranging from energy to transport.
- 1.16 CCH will be BREEAM compliant and therefore the TP has been produced in accordance with the requirements of BREEAM UK New Construction scheme (2018) and the requirements of Tra 01 within the Transport section of the assessment.
- 1.17 The BREEAM guidelines for Travel Plans are at Tra 01. It states that the aim is to 'reward awareness of existing local transport and identify improvements to make it more sustainable'.
- 1.18 The following is required to demonstrate compliance:
- i) During the feasibility and design stages, develop a travel plan based on a site-specific travel assessment or statement;
 - ii) The Site-specific travel assessment or statement covers as a minimum (provided at **Section 3** of this report):
 - a. Existing travel patterns and opinions of existing building or site users towards cycling and walking identifying constraints and opportunities, if relevant;
 - b. Travel patterns and transport impact of future building users;
 - c. Current local environment for walkers and cyclists (accounting for visitors who may be accompanied by young children);
 - d. Reporting of the number and type of existing accessible amenities within 500m of the site;
 - e. Disabled access (accounting for varying levels of disability and visual impairment);
 - f. Calculation of the existing public transport accessibility Index (AI); and
 - g. Current facilities for cyclists.
 - iii) The travel plan includes proposal to increase or improve sustainable modes of transport and movement of people and good during the building's operation and use;
 - iv) If the occupier is known, involve them in the development of the Travel Plan; and
 - v) Demonstrate that the Travel Plan will be implemented post construction and be supported by the building's management in operation.



1.19 A Transport Assessment has been submitted under separate cover.

DRAFT



2 Travel Plan Context

Introduction

- 2.1 A TP is a long-term management strategy built on a package of site-specific measures that seeks to deliver sustainable transport objectives, with an emphasis on reducing reliance on single occupancy car journeys and facilitating travel by sustainable modes, which is articulated in a document that is regularly reviewed.
- 2.2 To be successful, it is crucial that the TP be a dynamic process that grows and develops with time. The TP will need to be flexible to allow for changes to be made in line with the performance of the plan, changing circumstances of the site and environment in which it works and to tailor it to the needs of the future users of the site. The flexibility of the TP will ensure that the targets and measures at any one time reflect and respond to current travel patterns.

Benefits of a Travel Plan

- 2.3 TPs help to reduce the cost of travel for individuals and reduce the impact of travel on the local highway network as well as the environment. They also help to:
- i) Inform the design and operation of development;
 - ii) Improve the health of all users on-site through promoting walking and cycling measures;
 - iii) Create improvements for public transport, pedestrians and cyclists;
 - iv) Reduce reliance on the car through facilitating and promoting sustainable transport initiatives;
 - v) Reduce the cost of travelling to and from the site through promotion of car sharing or alternative travel modes;
 - vi) Reduce congestion by minimising car use - thereby reducing local noise pollution and harmful vehicle emissions such as CO₂; and
 - vii) Save energy through reduced fossil fuel use.
- 2.4 In summary, TPs should identify the specific required outcomes, targets and measures, and set out clear future monitoring and management arrangements all of which should be proportionate. They should also consider what additional measures may be required to offset unacceptable impacts if the targets should not be met.



Policy

2.5 In developing this TP, care has been taken to ensure that full regard has been given to best UK practice methods and these have been applied. A number of key policy documents (national and local) have been taken into account to help deliver the maximum possible uptake of sustainable transport modes.

National Policy

2.6 The National Planning Policy Framework (NPPF) (February 2019) sets out the principal objective under Section 9: Promoting Sustainable Transport, which is to ensure that development is located where it is *'focused on locations which are or can be made sustainable, through limiting the need to travel and offering a genuine choice of transport modes'*. Developments should be located and designed, where practical, to:

- i) 'Accommodate the efficient delivery of goods and supplies;*
- ii) Give priority to pedestrian and cycle movements and have access to high quality public transport facilities;*
- iii) Create safe and secure layouts that minimise conflicts between traffic and cyclists or pedestrians, avoid street clutter and where appropriate establishing home zones;*
- iv) Incorporate facilities for charging plug-in and other ultra-low emission vehicles; and*
- v) Consider the needs of people with disabilities by all modes.'*

2.7 The NPPF promotes achieving sustainable development. Paragraph 111 states that development which generates significant amounts of movement should be required to provide a Travel Plan.

2.8 Paragraph 121 places material planning weight to the development of community facilities such as hospitals on land that has previously been developed.

"Local planning authorities should also take a positive approach to applications for alternative uses of land which is currently developed but not allocated for a specific purpose in plans, where this would help to meet identified development needs. In particular, they should support proposals to:

- a) use retail and employment land for homes in areas of high housing demand, provided this would not undermine key economic sectors or sites or the vitality and viability of town centres, and would be compatible with other policies in this Framework; and*



b) make more effective use of sites that provide community services such as schools and hospitals, provided this maintains or improves the quality-of-service provision and access to open space.”

- 2.9 The Government’s planning practice guidance, to the superseded NPPF (March 2012), was launched as a web-based resource by the Department for Communities and Local Government (DCLG) in March 2014. The category dealing with Travel Plans is contained in ‘Travel plans, transport assessments and statements in decision-taking’ (Reference ID: 42, Updated 06.03.2014).

Local Policy

- 2.10 Manual for Gloucestershire Streets (MfGS) published by Gloucestershire County Council (GCC) in July 2020 states that all developments that generate significant amounts of movement should be supported by a Travel Plan.

- 2.11 MfGS provides indicative thresholds for the submission of a Travel Plan. Non-residential institutions i.e. Medical and health services comprising > 1,000sq.m should be supported by a Travel Plan.

- 2.12 MfGS states the following in relation to Travel Plan’s:

“Travel Plans are typically a package of practical measures to encourage residents, employees and visitors to consider their travel options or reduce the need to travel. Typical examples of measures include: personalised travel plans and welcome packs for residential use, and for commercial use, the provision of showers, lockers and changing facilities, car sharing schemes, flexible working schemes etc. Travel Plans should be bespoke to the development and applicants should not replicate generic targets. Travel plans can be a valuable tool in mitigating traffic impact and can look at the wider environment rather than just traditional traffic compensation measures.”

Summary

- 2.13 In summary, the requirement for a Travel Plan is recognised within both national and local policy and it is within the context that this Travel Plan is prepared.



3 Baseline Sustainability Audit

3.1 To ensure that the development can operate sustainably in terms of minimising the overall level of daily vehicular trips to and from the site, particularly single-occupancy vehicle trips, it is essential to consider what alternative sustainable travel opportunities are present to enable future staff, visitors and patients to choose to travel by non-car modes.

Proximity to Local Services and Amenities

3.2 CCH is well located to allow future staff, patients and visitors to travel to the site by modes other than the private car or to link a private car trip with a nearby trip associated with a neighbouring land use.

3.3 Within 30m of the site, future staff, patients and visitors can access the bus stops located along Steam Mills Road (A4151), named 'corner of Valley Road' and 'after Valley Road'.

3.4 A review of the local area indicates that the following local services and amenities are located within 800m of the site. **Table 3.1** demonstrates the approximate distances and journey times to these locations.

Facility / Amenity	Approx. Distance	Walking Time		Cycling Time	
		IHT	Google	RB	Google
Bus Stop (Valley Road)	30m	1 minute	1 minute	1 minute	1 minute
Gulf Petrol Station (Local Shop)	50m	1 minute	1 minute	1 minute	1 minute
Applegreen Petrol Station (Local Shop / Subway)	260m	3 minutes	3 minutes	1 minute	1 minute
Cinderford Medical Centre	280m	3 minutes	3 minutes	1 minute	1 minute
Supermarket	650m	8 minutes	9 minutes	3 minutes	3 minutes
Cinderford Town Centre	800m	10 minutes	11 minutes	3 minutes	4 minutes

Table 3.1: Nearby Facilities and Amenities

3.5 For robustness, the distances and their corresponding journey times have been measured from the centre of the application site, whilst they were calculated via two methods; firstly, in accordance with Institution of Highways and Transportation (IHT) and 'Road Bike' (RB) guidelines for walking speed (1.4m/s) and cycling speed (4m/s) respectively, and secondly, via Google Maps, which additionally accounts for the gradient of the route when undertaking such journeys.

3.6 These local services and amenities minimise the need for future staff, patients or visitors to travel by car, or to combine private car journeys into linked trips thus minimising the number of 'new' vehicular trips on the local highway network.



Walking and Cycling

- 3.7 The IHT guidance document 'Providing for Journeys on Foot' (2000) suggests an acceptable walking distance of 1km for commuting purposes and a preferred maximum walking distance of 2km.
- 3.8 Walking is the most important mode of travel at the local level and offers the greatest potential to replace short car journeys, particularly those under 2km. In addition, the Department for Transport (DfT) National Travel Survey of 2019 confirms that 80% of all trips less than a mile (1.6km) are carried out on foot.
- 3.9 The Local Transport Note 1/20 (July 2020): Cycle Infrastructure Design, produced by the DfT, states the following at paragraph 2.2.2:
- 'Two out of every three personal trips are less than five miles (8km) in length, an achievable distance to cycle for most people'.*
- 3.10 Cycling has the potential to substitute for short car trips, further facilitating sustainable travel, particularly those trips under five miles (8km) and trips of 30 - 40 mins are considered acceptable for commuting purposes.

Infrastructure

- 3.11 In terms of pedestrian access, within proximity to the site, there are a network of footways of varying width providing connectivity to / from the town centre. The footways are serviced with street lighting provision and dropped kerbs, with tactile paving in some instances, to facilitate pedestrian crossing movements.

Steam Mills Road (A4151)

- 3.12 Footways of varying width are present along both sides of Steam Mills Road, which provide connections to pedestrian routes to and from Steam Mills to the north and High Street and the town centre to the south. An uncontrolled pedestrian crossing with associative dropped kerbs, tactile paving, refuse island and bollards is present at the existing access to the site.
- 3.13 On the eastern side of Steam Mills Road (A4151), a 1.4m footway is present along the site frontage terminating at the existing pedestrian crossing. On the western side, a continuous footway is provided that varies in width between 1.4m and 3.3m along its length. To the south it provides pedestrian connections to the existing Bus Stop 'Corner of Valley' adjacent to its junction with Valley Road.



Valley Road

- 3.14 Valley Road benefits from continuous footway provision along the eastern side of the carriageway. Along the western side of the carriageway the footway provision terminates 25m from the ghost island right turn priority arrangement with Steam Mills Road (A4151) and High Street. No formal crossing facilities are provided for pedestrians to cross to the eastern side of Valley Road.

High Street (A4151)

- 3.15 High Street (A4151) benefits from continuous footway provision of varying width along both sides of the carriageway toward the town centre. Along its length it benefits from informal dropped kerb crossing points and, in some instances, associated tactile paving.
- 3.16 Inspection of GCC's online mapping portal confirms that there are PROWs within the vicinity of the site.
- 3.17 National Cycle Network (NCN) Route 42 can be accessed 850m to the south of the site and runs to the centre of Cinderford along Station Street, Valley Road and into the Forest of Dean. NCN Route 42 is on-road along Station Street and Valley Road and then traffic free through the Forest of Dean.
- 3.18 There are no designated cycleways or formal cycling infrastructure within the vicinity of the application site.

Propensity to Cycle Tool (PCT)

- 3.19 In accordance with Manual for Gloucestershire Streets (MfGS), a review of the potential to cycle within the local area has been undertaken via the Propensity to Cycle Tool (PCT) (pct.bike). It demonstrates that the average percentage of people cycling to work in Gloucestershire is 4.2%. The development site is located in the MSOA of Forest of Dean 004, which has an average percentage of people cycling to work of approximately 1.0%.
- 3.20 **Figure 3.1** shows an extract from PCT demonstrating the cycling commuting level in the MSOA Forest of Dean 004 and in the wider context of Gloucestershire.

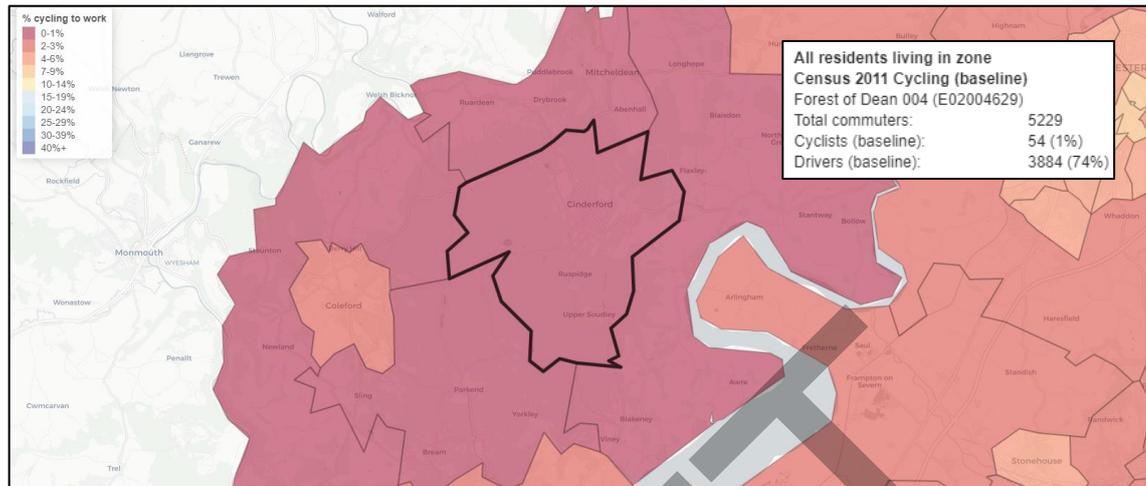


Figure 3.1: Map of Cycling Commuting Levels in Forest of Dean 004

Source: <https://www.pct.bike/>

Public Transport Provision

- 3.21 In reviewing the level of public transport provision, it is noted that there are bus stops situated along Steam Mills Road (A4133) adjacent to the site, which provide access to bus routes 22, 24, 25, 711, 746, GR4 and GR5 for north-west and south-east bound travel respectively.
- 3.22 Bus stops 'corner of Valley Road' and 'after Valley Road' are both formal stops. Bus Stop 'corner of Valley Road' consists of a shelter, timetable provision, lay-by and 'BUS STOP' cage markings embossed on the carriageway and bus stop 'after Valley Road' consists of a post and flag.
- 3.23 **Table 3.2** provides a summary of bus service 22, which is the most frequent and suitable for commuting / visitor purposes that serves the bus stops. Full timetable information for bus service 22 and services 24, 25, 711, 746, GR4 and GR5 is provided at **Appendix C**.

Note: Information taken from www.travelinesw.co.uk May 2021

Service Number	Operator	Route / Destinations Served	Days	Approximate Frequency		
				First service	Approx. Frequency	Last Service
22	Stagecoach West	Gloucester - Cinderford - Lydney - Coleford	Mon - Fri	07:29	60 mins	23:42
			Sat	08:44	60 mins	23:42
			Sun	11:14	2 hours	17:14
22	Stagecoach West	Coleford - Lydney - Cinderford - Gloucester	Mon - Fri	05:55	60 mins	22:24
			Sat	06:29	60 mins	22:24
			Sun	09:29	2 hours	17:29

Table 3.2: Bus Services and Frequencies



- 3.24 The 22 service provides transportation to Gloucester and Coleford and given the nature of the application site the bus service provision is considered suitable for commuting and travelling purposes for both staff and visitors.
- 3.25 Calculation of the public transport Accessibility Index (AI) for the site indicates that it has a rating of 2.29. The calculations are provided at **Appendix D**.

Summary

- 3.26 CTP assesses the site to be sustainably located with accessibility to suitable services and amenities, supplied by suitable pedestrian linkages and public transport services.
- 3.27 In summary, the site is considered to be suitably located in terms of being able to offer a range of sustainable travel choices to future employees, patients and visitors, as an alternative to travel to the site by car.

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4 Objectives and Targets

Objectives

- 4.1 It is important that the TP has a focus and direction in what it is trying to achieve. This can be accomplished through the identification of TP objectives, which are realistic and site specific.
- 4.2 The aim of this TP is to determine a range of actions and targets to encourage staff of the proposed development to use more sustainable transport modes to access the site. The principle objectives of the TP are set out below:
- i) To raise awareness of transport issues amongst future staff, patients and visitors and to reduce the impact of traffic to and from CCH on the local environment and air pollution;
 - ii) To achieve the minimum number of single occupancy car traffic movements to and from the proposed development;
 - iii) To reduce the need to travel to and from the site;
 - iv) To maximise the proportion of journeys to and from the proposed development by sustainable modes of transport;
 - v) Address the access needs of site users; and
 - vi) Provide adequately for those with mobility difficulties.
- 4.3 These objectives will be implemented through a package of measures that are discussed in **Section 5**.

Targets

- 4.4 Targets enable progress to be measured against aims and objectives and will be challenging to ensure continual improvement in managing development travel demand. The TP will need to be monitored to ensure it is still relevant, up-to-date and influencing sustainable travel use on the site, which is discussed in **Section 7**.
- 4.5 Monitoring of the TP will be the responsibility of the Travel Plan Co-ordinator (TPC). The TPC will supply GCC with updated statistical data showing how staff travel to and from the site, along with details of the measures employed to encourage sustainable travel.
- 4.6 A baseline travel survey will be undertaken within 3 months CCH is constructed and fully operational. Due to its scale, it is considered that a survey of the whole development would provide a more accurate interpretation of travel habits as opposed to a smaller percentage of staff.



- 4.7 Surveys will then be undertaken in the first, third, and fifth years following the baseline survey to ascertain modal splits and see if the targets and objectives of this TP are being met.
- 4.8 The introduction of a range of measures to support sustainable travel in favour of travel by private car, in particular single occupancy car journeys, will result in modal shift.
- 4.9 Targets for the scale of modal shift against which the success of the TP can be measured will accord with the following SMART principles:
- i) **Specific** (identify what is to be achieved);
 - ii) **Measurable** (over the target period);
 - iii) **Achievable** (linked to overall objectives and aims);
 - iv) **Realistic** (must be achievable over time allocated); and
 - v) **Time-bound** (a defined action plan including dates for achievement).
- 4.10 Accurate modal split targets will be identified once the baseline travel survey has been undertaken once CCH is constructed and fully operational. Initial modal split targets have been set based on likely future method of travel to work data been obtained from existing staff in April 2021, via online travel surveys, at the Dilke Memorial Hospital and Lydney Community Hospital.
- 4.11 The staff surveys received a total of 90 responses and the full results of the online staff survey are provided at **Appendix E**.
- 4.12 GCC Travel Plan Guide for New Developments reiterates guidance contained within 'Smarter Choices: Changing the Way We Travel' by stating 'basic travel plans can expect to achieve a 6-10% reduction in car use'.
- 4.13 On this basis, **Table 4.1** sets out initial modal split targets based on a 10% reduction in single occupancy car journeys.



Mode of Travel	Baseline Modal Split Proposed Travel Mode (%) - CCH	Modal Split Year 1 Target	Modal Split Year 3 Target	Modal Split Year 5 Target
Car (on my own)	88.89%	87.11%	83.55%	80.00%
Car share with a co-worker	0.00%	0.00%	0.00%	0.00%
Car share with a friend / family	1.11%	1.31%	1.70%	2.10%
Bus	1.11%	1.31%	1.70%	2.10%
Walk	6.67%	7.86%	10.23%	12.60%
Cycle	1.11%	1.31%	1.70%	2.10%
Other method of travel to work	1.11%	1.11%	1.11%	1.11%

Table 4.1: Percentage Modal Shift Targets

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5 Travel Plan Management and Measures

5.1 The TP will be implemented and managed by a TPC, in accordance with this TP. The TPC will be appointed prior to occupation to guarantee the most effective implementation of the TP.

Travel Plan Co-ordinator (TPC)

5.2 It will be the responsibility of the developer to ensure the appointment and funding of a suitably qualified person to perform the role of the TPC, in order to ensure compliance with the TP. A TPC shall be appointed three months prior to occupation.

5.3 The TPC will be responsible for:

- i) The operation of the plan;
- ii) Acting as a point of contact;
- iii) Marketing and promoting the TP;
- iv) Providing sustainable travel information to staff;
- v) Arranging for travel surveys to be undertaken for staff; and
- vi) Liaising with the Local Authority Travel Plan team with regards to the TP.

5.4 The TPC will make all staff aware of the TP and its objectives. Awareness will be raised via team meetings and promotional material in colleague staff areas.

Travel Plan Working Group

5.5 The TPC could set up a Travel Plan Working Group. This could include other members of staff, patients and members of the local community. The Travel Plan Working Group will initially meet on a monthly basis to discuss progress towards targets, plan promotional events and discuss what has or has not been successful in the implementation of the TP. Over the lifetime of the TP, the Working Group may be able to reduce the frequency of their meetings to bimonthly or quarterly.

Travel Plan Measures

5.6 The TP is effectively a set of measures, directed at employees, patients and visitors and intended to maximise sustainable travel for journeys to / from CCH. The proposed TP measures focus on maximising the site's accessibility and sustainability as part of the development proposals.



Travel Plan Noticeboards

- 5.7 Noticeboards will be installed centrally within CCH, for example within reception areas, to promote current sustainable travel initiatives and provide up-to-date public transport timetables, which will benefit staff, patients and visitors.

Pedestrians / Cyclists

- 5.8 The internal site will accommodate an active travel corridor on the northern side of the reconfigured access with Steam Mills Road (A4141). The active travel corridor will lead directly from the access and extend internally through the site and provide a shared route for both pedestrians and cyclists to / from the entrance to CCH.
- 5.9 Information will be provided to all staff giving details of safe walking and cycling routes to and from CCH and they will be made aware of walking and cycling initiatives, such as livingstreets.org.uk and sustrans.org.uk.
- 5.10 Showers, lockers and changing room facilities will be provided staff.
- 5.11 Secure, covered and convenient cycle parking will be provided for staff, patients and visitors.

Public Transport Information

- 5.12 CCH will provide information relating to the availability and frequency of local bus services and other public transport infrastructure and local amenities to staff, patients and visitors.

Car Users

- 5.13 The TPC will encourage car sharing amongst staff and will assist in finding suitable partners for those wishing to take up this option through the promotion of the car share scheme <https://liftshare.com/uk/community/gloucestershire>. The scheme allows users to identify other car drivers travelling to the same destination, as well as providing details on cost savings. The car share scheme and its benefits will be promoted and publicised by the TPC.
- 5.14 In accordance with NPPF guidance and Manual for Gloucestershire Streets (MfGS) vehicle charging points will be provided in safe, accessible and convenient locations to enable charging of plug-in and other ultra-low emission vehicles. The development includes the provision of **XX** electric vehicle charging spaces.

AWAITING CONFIRMATION OF EVCP SPACES



Guaranteed Ride Home

- 5.15 Those staff who choose to travel to work by foot, cycle, public transport or car share will be guaranteed a free ride home in the event that they are unable to get home, for example buses or trains being cancelled or car share partner being unavailable. This is likely to be provided by taxis.

Consolidate Deliveries, Servicing

- 5.16 Where possible, managers, clinicians, administration, and maintenance staff will aim to consolidate operational vehicles to and from the site such as deliveries, callouts, if required, and servicing trips.

Patient / Visitor Information

- 5.17 Whilst the TP has been tailored primarily towards staff, measures will be put in place to encourage both patients and visitors to arrive at CCH by modes other than the car. Information, detailing public transport links and nearest bus stops will be made available for all patients and visitors.
- 5.18 The TPC will ensure that all visitors information is maintained as being relevant and up to date.

Key Travel Resources

- 5.19 Sustainable travel opportunities are supported locally. **Table 5.1** provides a summary of the key travel resources available for staff, patients and visitors.

Resource	Description	Details
Living Streets	National organisation for supporting pedestrians	www.livingstreets.org.uk
Cycle Street	Online cycling journey planner	www.cyclestreets.net
Better By Bike	Cycle information	https://betterbybike.info
Sustrans	The national sustainable transport charity	www.sustrans.org.uk
Traveline	Online Journey Planner	www.traveline.info
TravelWest	Information and journey planner for the South West	https://travelwest.info
Thinktravel	Information and journey planner	https://www.thinktravel.info

Table 5.1: Key Travel Resources



6 Action Plan

6.1 Key to the success of the TP is the identification of viable transport alternatives and these can be identified through the Travel Plan Action Plan. This is the package of site-specific measures that will encourage a shift away from single occupancy car use and increase accessibility to and from the site.

6.2 This section outlines measures that will be implemented as part of this TP. These measures will include making best use of the current facilities, as well as creating further incentive for staff, patients and visitors to use sustainable transport modes of travel. The implementation of the TP and the measures contained within it will be flexible.

Action Plan

6.3 A comprehensive set of initiatives and measures are set out on the following pages. The recommended measures have been drawn from best practice, Travel Plan guidance and case studies throughout the UK.

6.4 The Action Plan has been broken down into four main strategy sections relating to the scope of the TP, which are, walking and cycling, public transport, car users and TP support measures. The measures and initiatives identified in this aim to influence staff principally. However, some of the measures could also have an influence on patients and visitor trips to the site and where this is the case, this has been identified in each strategy section.

6.5 Measures contained within the Action Plan also indicate where the responsibility lies for their completion, a timeframe, and estimated costs.



Walking and Cycling Strategy

	Measure	Action	Staff	Visitors / Patients	Timeframe / Frequency	Success Monitoring / Evaluation	Responsibility	Cost
WC1	Implement Cycle Parking Facilities	The quantum of cycle parking is in line with local planning guidance	✓	✓	Prior to occupation	Usage of cycle facilities observed by TPC / feedback	Developer	As part of build costs
WC2	Noticeboard	Maintain staff and visitor noticeboard with up-to date walking and cycling information	✓	✓	Annually	Feedback from staff, patients and visitors	TPC	TPC
WC3	Active Travel Corridor	Provision of active travel corridor from the entrance to the building to Steam Mills Road / Valley Road junction	✓	✓	Prior to occupation	Usage of active travel corridor facilities observed by TPC / feedback	Developer	As part of offsite build costs
WC4	Changing Facilities	Showers, lockers and changing room facilities will be provided for staff	✓		Prior to occupation	Usage of facilities	Developer	As part of build costs
WC5	Promote Walking / Cycling Routes	Information will be provided to all staff giving details of safe walking and cycling routes. Staff will be made aware of walking and cycling initiatives	✓		Annually	Feedback from staff	TPC	TPC



Public Transport Strategy

	Measure	Action	Staff	Visitors / Patients	Timeframe	Responsibility	Cost
PT1	Promotion of Bus Services	Up to date bus information to be provided to staff, patients and visitors	✓	✓	Annual	TPC	TPC's Time
PT2	Noticeboard	Maintain noticeboard with up-to-date public transport information	✓	✓	Annually	Feedback from staff, patients and visitors	TPC

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Car Users Strategy

	Measure	Action	Staff	Visitors / Patients	Timeframe	Responsibility	Cost
CU1	Promoting Car Sharing Websites	Information included on staff noticeboard and online with details on car sharing https://liftshare.com/uk/community/gloucestershire	✓		Lifetime of the TP	Number of people registered on site and feedback from staff	TPC
CU2	Reduce Single Occupancy Car Travel	Reduce the level of single occupancy car travel through the promotion of this TP and on-going monitoring	✓	✓	Lifetime of the TP	Modal split targets attained	TPC
CU3	Provide Electric Vehicle Charging	Electrical vehicle charging to be provided	✓	✓	Prior to occupation	Developer	Construction costs
CU4	Guaranteed Ride Home	Staff who choose to travel to work by foot, cycle, public transport, or car share will be guaranteed a free ride home in the event that they are unable to get home	✓		Lifetime of the TP	TPC	TPC / Travel Cost



Travel Plan Support Measures

	Measure	Action	Staff	Visitors / Patients	Timeframe	Responsibility	Cost
TP1	Transport Noticeboards	Install noticeboards detailing sustainable travel information around CCH	✓	✓	Prior to occupation	Developer	Cost of signage
TP2	Consolidate Deliveries & Servicing	Where possible, managers, clinicians, administration, and maintenance staff will aim to consolidate operational vehicles to and from CCH	✓		Lifetime of the TP	TPC	TPC

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7 Monitoring and Review

7.1 An effective monitoring and review process is important to establish how successful the TP has proved to be. Monitoring involves collecting data and information, and the review process involves the consideration of these details to determine whether or not the TP targets have been met.

7.2 As set out in **Paragraph 5.2**, the TPC will be appointed three months prior to occupation of the proposed development and will liaise with the relevant travel plan officers at GCC. Based on the monitoring and review process, it will then be necessary for the TPC, in conjunction with GCC, to decide what, if any, amendments are required to the TP. As part of the monitoring process, it is important to establish the baseline conditions.

7.3 The TP will be actively managed and monitored by the TPC for a period of five-years, after initial occupation following the baseline surveys. On appointment, at least three months prior to first occupation, contact details would be provided to GCC to ensure that clear dialogue is possible from inception of the TP.

Monitoring

7.4 For the on-going management of the TP to be successful and to deliver the desired outcomes, it is important that the parties involved in the delivery of the TP, which means the Developer/TPC and GCC, work effectively in partnership to achieve the desired results.

7.5 Monitoring of travel patterns over time, to ascertain whether the initiatives of the TP are proving successful and whether there has been a shift to more sustainable modes of transport, requires on-going travel surveys to be undertaken.

7.6 The monitoring of the TP is important in order to understand if the proposed objectives and modal split targets have been met. Follow up travel surveys will be undertaken in the first, third, and fifth years following the baseline travel surveys as shown in **Table 7.1**.

7.7 A sample questionnaire sheet has been attached as **Appendix F** to this report.

7.8 The information gathered will be analysed to confirm the definition of targets and to act as a benchmark against which progress in meeting targets will be measured.

7.9 New staff members will receive the travel questionnaires on commencement of employment and their results will be entered onto a database. Colleagues leaving employment will be removed from the database. All data will be treated confidentially.



7.10 The results of the initial surveys will be used to inform targets, objectives and measures and the monitoring surveys will be used to assess the progress of the TP against the objectives and targets and help the TPC make budget decisions and review targets and objectives.

	Baseline (Full Occupation)	Year 1	Year 2	Year 3	Year 4	Year 5
Travel Survey	✓	✓		✓		✓

Table 7.1: Programme for Monitoring

7.11 Following the completion of each survey, a summary report will be prepared and provided to GCC within one month of the data being made available.

Implementation Plan

7.12 An implementation plan sets out the commitments and timescales required to effectively implement the TP. This includes timescales to appoint a TPC, deliver proposed measures, commission surveys for monitoring and a schedule for the effective monitoring and review of the TP.

7.13 The implementation plan covers the lifetime of the TP, which is five years from occupation.

7.14 **Table 7.2** sets out the implementation plan for CCH. The plan indicates which measures and actions are required prior to occupation and during the construction of CCH.

Task	Details	Proposed Timescale for Implementation
Appointment of TPC	Responsible for promoting the TP and implementing measures.	Three months prior to occupation
Travel Plan Action Plan	Implement all measures as set out in the Action Plan.	As per the timescales set out in the Travel Plan Action Plan
Surveys and Monitoring	Travel surveys will be undertaken to determine the travel patterns of staff to the site, which will influence any amendments or refinements to be made to the Travel Plan.	In the first, third, and fifth years following occupation
Review of TP Performance	Following completion of the surveys, the TPC will be required to provide a review report to GCC	Within one month of the data being made available

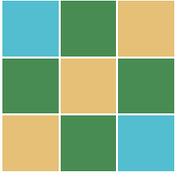
Table 7.2: TP Implementation Plan.



8 Funding

- 8.1 The funding of all aspects of the TP, including the introduction of measures, employing of Travel Plan Co-ordinator, monitoring and reporting will be the responsibility of the developer. This responsibility will be maintained for the full life of the TP.

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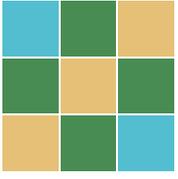


COTSWOLD
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Appendix A

Site Location Plan

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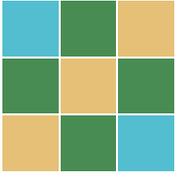


COTSWOLD
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Appendix B

Development Proposals
(Architect's Layout)

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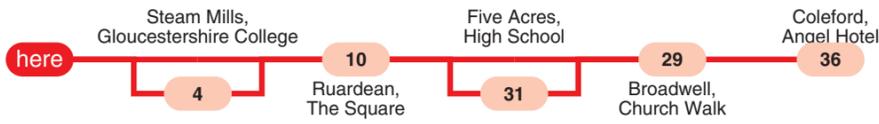
COTSWOLD
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Appendix C

Bus Timetable Information

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22 Gloucester - Cinderford - Lydney - Coleford Stagecoach West 



24 Cinderford - Ruspidge - Blakeney - Lydney - Chepstow Stagecoach West 



24 Chepstow - Lydney - Blakeney - Ruspidge - Cinderford Stagecoach West 



The numbers circled indicate approximate timings in minutes from Cinderford, Valley Road

Mondays to Fridays Bus times as at 14th May 2021

Time	Service Note														
0729	22 SH	0836	22 2,Sch	1044	22	1344	22	1549	22	1639	22 2,Sch	1736	24 C,Sch	1942	22
0729	22 1,Sch	0844	22 SH	1144	22	1444	22 SH	1616	24 C,Sch	1719	22 SH	1759	22	2112	22
0821	24 S,Sch	0944	22	1244	22	1444	22 1,Sch	1639	22 SH	1719	22 2,Sch	1854	22	2342	22

Saturdays Bus times as at 15th May 2021

Time	Service Note														
0844	22	1044	22	1244	22	1444	22	1634	22	1754	22	1942	22	2342	22
0944	22	1144	22	1344	22	1544	22	1714	22	1849	22	2112	22		

Sundays Bus times as at 16th May 2021

Time	Service Note						
1114	22	1314	22	1514	22	1714	22

Notes: Sch - Gloucestershire School Days 1 - serves Five Acres, High School C - towards Chepstow S - towards Steam Mills
SH - Gloucestershire School Holidays 2 - serves Steam Mills, Gloucestershire College

Times shown in italics are approximate times

BY SMS

Bus times by text message



Get the times of the next four buses from this stop on your phone

Scan the QR code or send the stop code below to:

84268

Return texts cost up to 25p, plus normal text messaging charge. Normal mobile internet charges apply.

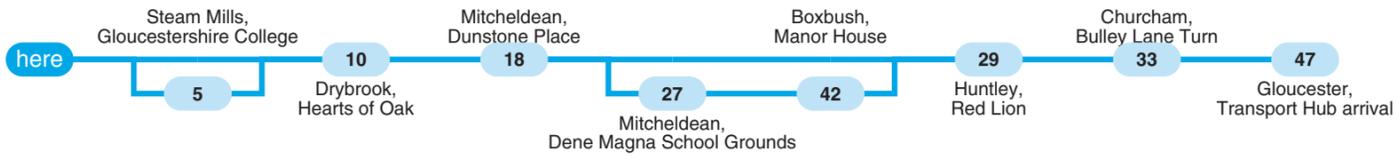
Code for this stop: gloajgt

NextBuses

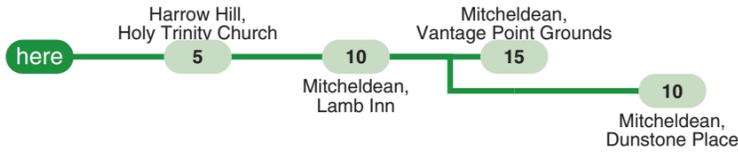
Bus times by mobile browser



24 Cinderford - Gloucester Stagecoach West 



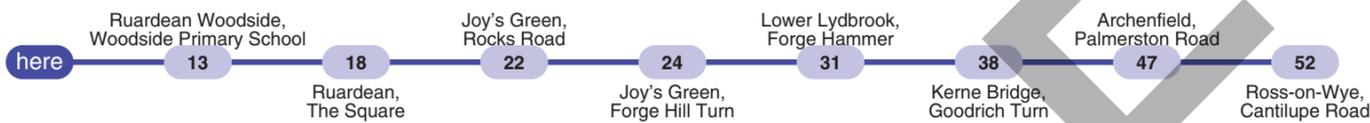
25 Coleford - Broadwell - Cinderford - Harrow Hill - Mitcheldean Stagecoach West 



711 Ruspidge - Cinderford - Brierley - The Pludds Stagecoach West 



746 Ross-on-Wye - Mitcheldean - Cinderford - Joy's Green - Ross-on-Wye Stagecoach West 



The numbers circled indicate approximate timings in minutes from Cinderford, Valley Road

Mondays to Fridays Bus times as at 14th May 2021

Time	Service	Note												
0625	25	4	1018	24		1218	24		1346	711	3	1508	24	2,Sch
0658	24	be	1106	711		1230	25		1418	24		1518	24	SH
0740	25	be	1124	746	5	1309	746		1430	25	be	1628	24	SH
												1630	24	1,Sch
												1724	746	
												1758	24	
												2018	24	
												2223	24	

Saturdays Bus times as at 15th May 2021

Time	Service	Note												
0658	24		1106	711		1218	24		1324	746		1418	24	
1018	24		1124	746	5	1230	25		1346	711	3	1430	25	
												1518	24	
												1628	24	
												1758	24	
												2018	24	
												2218	24	

Sundays Bus times as at 16th May 2021

Time	Service	Note	Time	Service	Note	Time	Service	Note
0838	24		1038	24		1238	24	
						1438	24	
						1638	24	

Notes: Sch - Gloucestershire School Days
 SH - Gloucestershire School Holidays
 1 - serves Steam Mills, Gloucestershire College
 2 - serves also from Mitcheldean, Dene Magna School Grounds to Boxbush, Manor House
 3 - terminates at Brierley, Swan Inn
 4 - terminates at Mitcheldean, Dunstone Place
 5 - terminates at Ruardean, The Square
 be - to 31.12.21

Times shown in italics are approximate times

BY SMS
Bus times by text message



Get the times of the next four buses from this stop on your phone

Scan the QR code or send the stop code below to:

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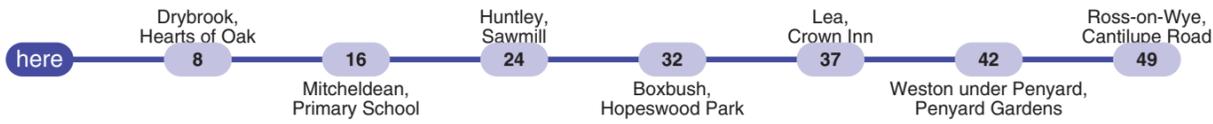
Return texts cost up to 25p, plus normal text messaging charge. Normal mobile internet charges apply.

Code for this stop: **gloajgt**

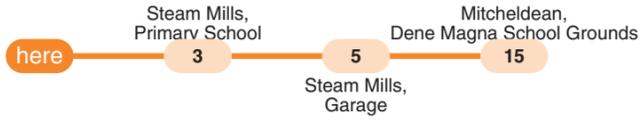
NextBuses
Bus times by mobile browser



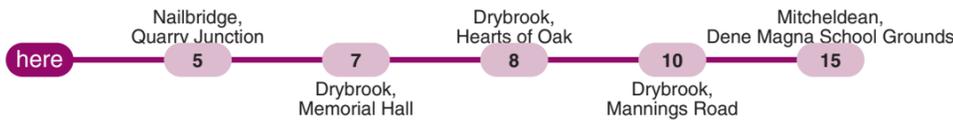
746 Lydbrook - Cinderford - Mitcheldean - Ross-on-Wye Stagecoach West 



GR4 Cinderford - Littledean - Steam Mills - Dene Magna School Grindles Coaches



GR5 Cinderford - Nailbridge - Drybrook - Dene Magna Grindles Coaches



The numbers circled indicate approximate timings in minutes from Cinderford, Valley Road

Mondays to Fridays Bus times as at 14th May 2021

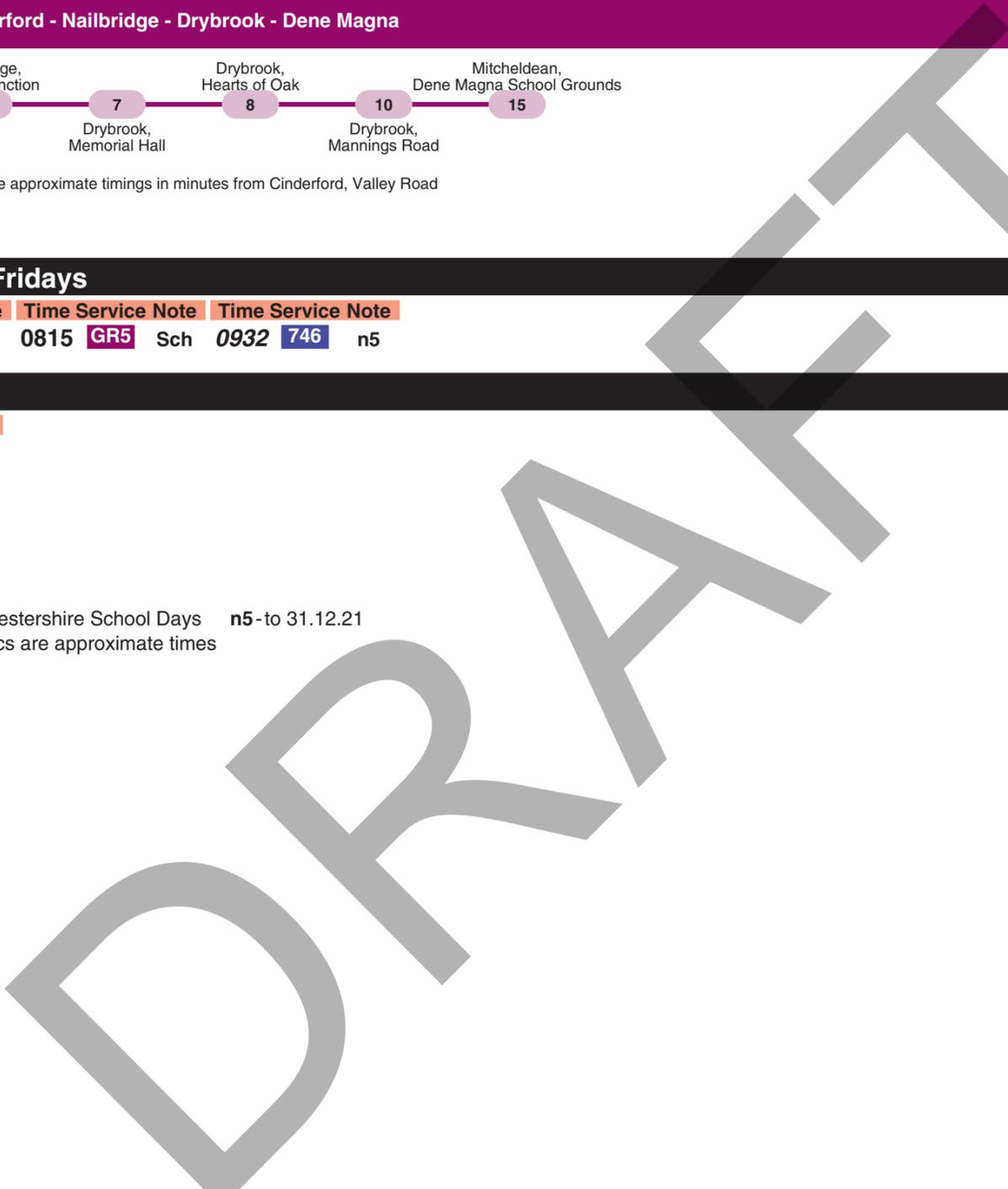
Time Service Note | **Time Service Note** | **Time Service Note**
0815 **GR4** Sch 0815 **GR5** Sch 0932 **746** n5

Saturdays Bus times as at 15th May 2021

Time Service Note
0932 **746**

Sundays
No Service

Notes: Sch - Gloucestershire School Days n5 - to 31.12.21
Times shown in italics are approximate times



BY SMS
Bus times by text message



Get the times of the next four buses from this stop on your phone
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Code for this stop: gloajgt



NextBuses
Bus times by mobile browser



22 Coleford - Lydney - Cinderford - Gloucester Stagecoach West 



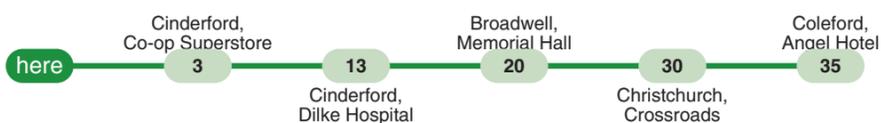
24 Chepstow - Lydney - Blakeney - Ruspidge - Cinderford Stagecoach West 



24 Gloucester - Cinderford Stagecoach West 



25 Mitcheldean - Harrow Hill - Cinderford - Broadwell - Coleford Stagecoach West 



27 Cinderford - Parkend - Whitecroft - Yorkley - Viney Hill - Lydney Stagecoach West 



The numbers circled indicate approximate timings in minutes from Cinderford, Valley Road

Mondays to Fridays Bus times as at 14th May 2021

Time	Service	Note																						
0555	22		0807	24	SH	1007	24		1229	22		1429	22		1615	25	1,SH	1707	24		1939	22		
0639	22		0829	22	SH	1029	22		1304	24		1504	24		1627	24		1724	24		2009	24		
0647	24		0839	22	Sch	1104	24		1315	25		1534	22	SH	1631	27	Sch	1734	22		2214	24		
0648	24		0915	25	cx	1129	22		1329	22		1536	22	Sch	1634	22	SH	1804	24		2224	22		
0729	22		0929	22	cx	1207	24		1407	24		1604	24		1637	22	Sch	1917	24		2349	24		

Saturdays Bus times as at 15th May 2021

Time	Service	Note																							
0629	22		0929	22		1207	24		1407	24		1615	25	1	1729	22		2209	24						
0729	22		1007	24		1229	22		1429	22		1617	24		1804	24		2224	22						
0807	24		1029	22		1304	24		1504	24		1629	22		1917	24		2349	24						
0829	22		1104	24		1315	25		1529	22		1707	24		1939	22									
0915	25		1129	22		1329	22		1604	24		1709	24		2009	24									

Sundays Bus times as at 16th May 2021

Time	Service	Note												
0929	22		1129	22		1329	22		1529	22		1729	22	
1024	24		1224	24		1424	24		1624	24		1824	24	

Notes: Sch - Gloucestershire School Days SH - Gloucestershire School Holidays 1 - terminates at Cinderford, Co-op Superstore cx - to 31.12.21
Times shown in italics are approximate times

BY SMS
Bus times by text message



Get the times of the next four buses from this stop on your phone

Scan the QR code or send the stop code below to:

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Code for this stop: gloajgmp

NextBuses
Bus times by mobile browser



35A Monmouth - Staunton - Coleford - English Bicknor - Mitcheldean - Cinderford Forest Community Transport



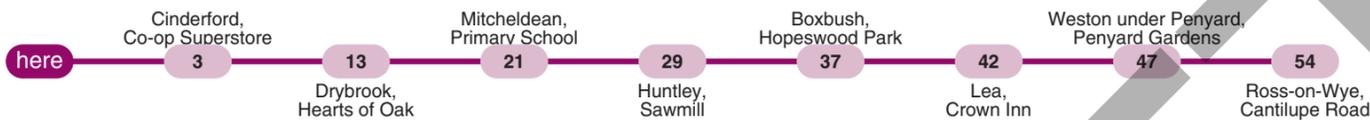
711 The Pludds - Brierley - Cinderford - Ruspidge Stagecoach West 



746 Ross-on-Wye - Mitcheldean - Cinderford - Joy's Green - Ross-on-Wye Stagecoach West 



746 Lydbrook - Cinderford - Mitcheldean - Ross-on-Wye Stagecoach West 



The numbers circled indicate approximate timings in minutes from Cinderford, Valley Road

Mondays to Fridays Bus times as at 14th May 2021

Time	Service	Note												
0927	746	R,n5	0928	711	C	1117	746	1,R	1128	711		1302	746	C
												1457	746	C
												1717	746	C
												1852	35A	G

Saturdays Bus times as at 15th May 2021

Time	Service	Note	Time	Service	Note	Time	Service	Note
0927	746	R	0928	711		1117	746	1,R
						1128	711	
						1457	746	C

Sundays

No Service

Notes: C - Concessionary passes valid on this journey. 1 - terminates at Cinderford, Co-op Superstore n5 - to 31.12.21 C - towards Cinderford R - towards Ross-on-Wye
G - Supported by Gloucestershire County Council
Times shown in italics are approximate times

BY SMS

Bus times by text message



Get the times of the next four buses from this stop on your phone

Scan the QR code or send the stop code below to:

84268

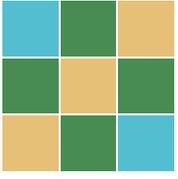
Return texts cost up to 25p, plus normal text messaging charge. Normal mobile internet charges apply.

Code for this stop: gloajgmp

NextBuses

Bus times by mobile browser





COTSWOLD
TRANSPORT
PLANNING

Appendix D

Accessibility Index Calculations

DRAFT

BREEAM 2018 Tra01/02 Accessibility Index calculator

Using the drop down boxes make the relevant selections and press the 'Select' button

Building type

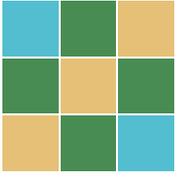
No. nodes required

Select

NODE 1

Public transport type	Bus										
Distance to node (m)	30										
Average frequency per hour	Service 1	Service 2	Service 3	Service 4	Service 5	Service 6	Service 7	Service 8	Service 9	Service 10	
	1.6	0.3	0.7	0.3	0.2	0.3					

Accessibility Index	2.29
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COTSWOLD
TRANSPORT
PLANNING

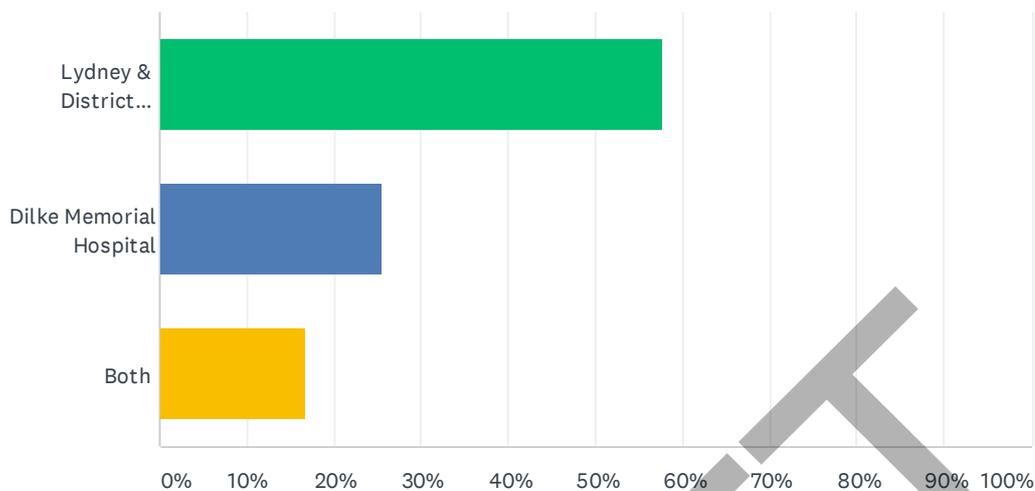
Appendix E

Staff Travel Survey

DRAFT

Q1 Which hospital are you currently based at?

Answered: 90 Skipped: 0

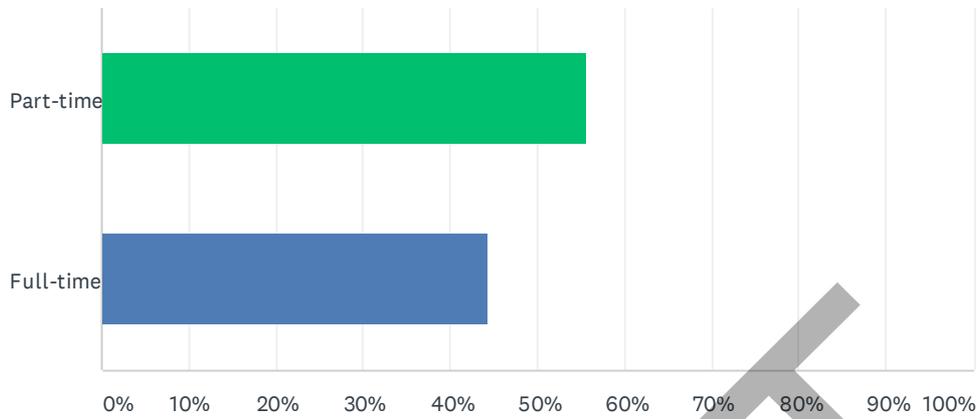


ANSWER CHOICES	RESPONSES	
Lydney & District Hospital	57.78%	52
Dilke Memorial Hospital	25.56%	23
Both	16.67%	15
TOTAL		90

DRAFT

Q2 Are you employed on a part-time or full-time basis?

Answered: 90 Skipped: 0

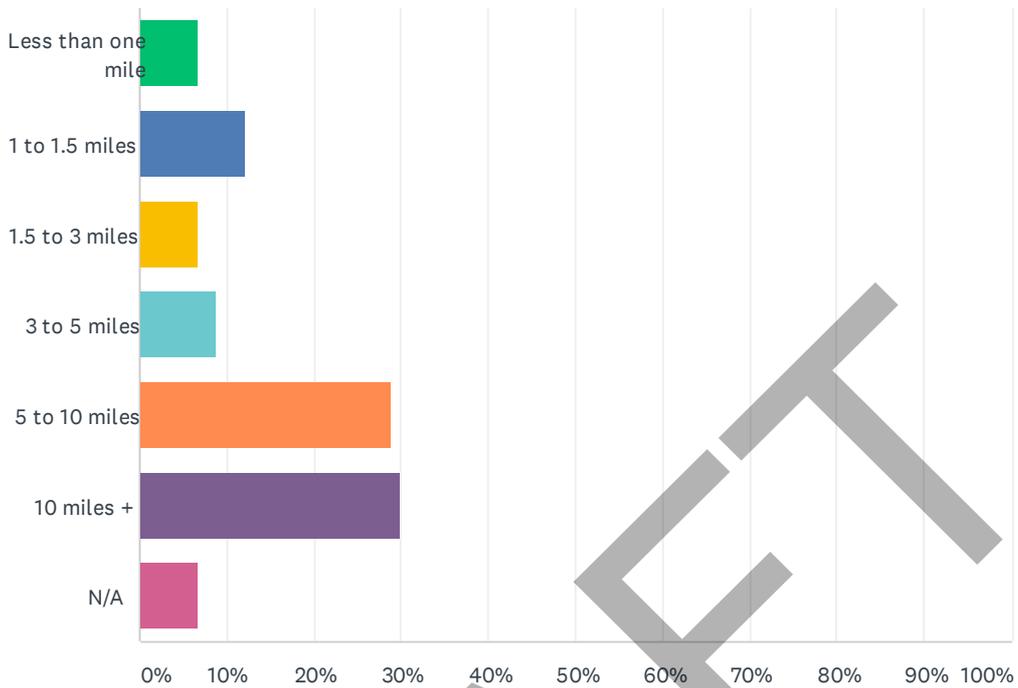


ANSWER CHOICES	RESPONSES	
Part-time	55.56%	50
Full-time	44.44%	40
TOTAL		90

DRAFT

Q3 How far is your current commute to Lydney & District Hospital?

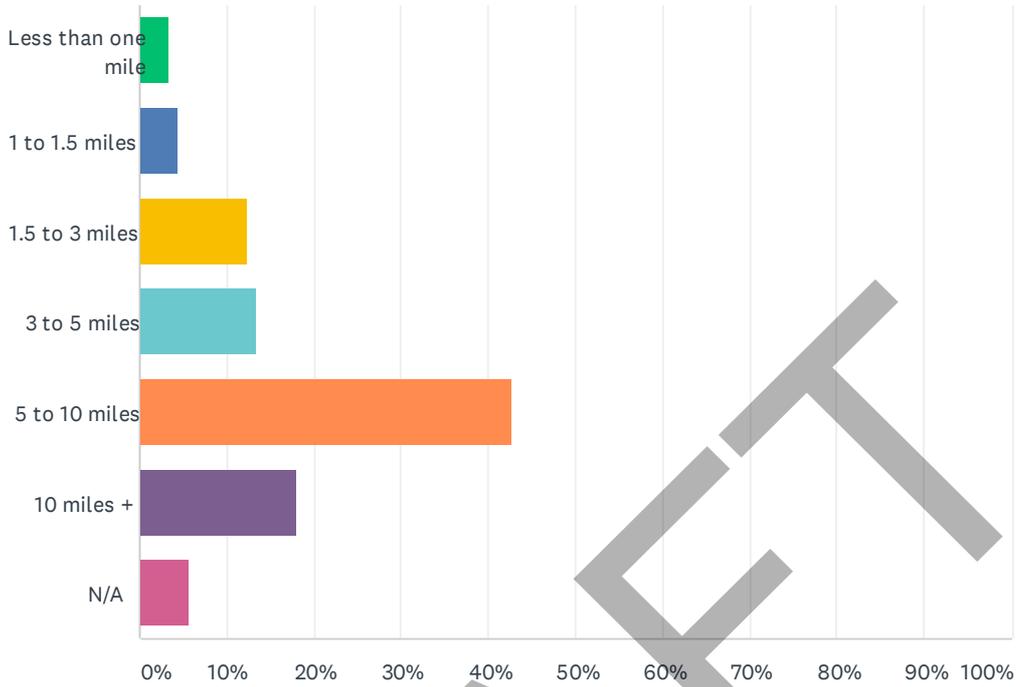
Answered: 90 Skipped: 0



ANSWER CHOICES	RESPONSES	
Less than one mile	6.67%	6
1 to 1.5 miles	12.22%	11
1.5 to 3 miles	6.67%	6
3 to 5 miles	8.89%	8
5 to 10 miles	28.89%	26
10 miles +	30.00%	27
N/A	6.67%	6
TOTAL		90

Q4 How far is your current commute to Dilke Memorial Hospital?

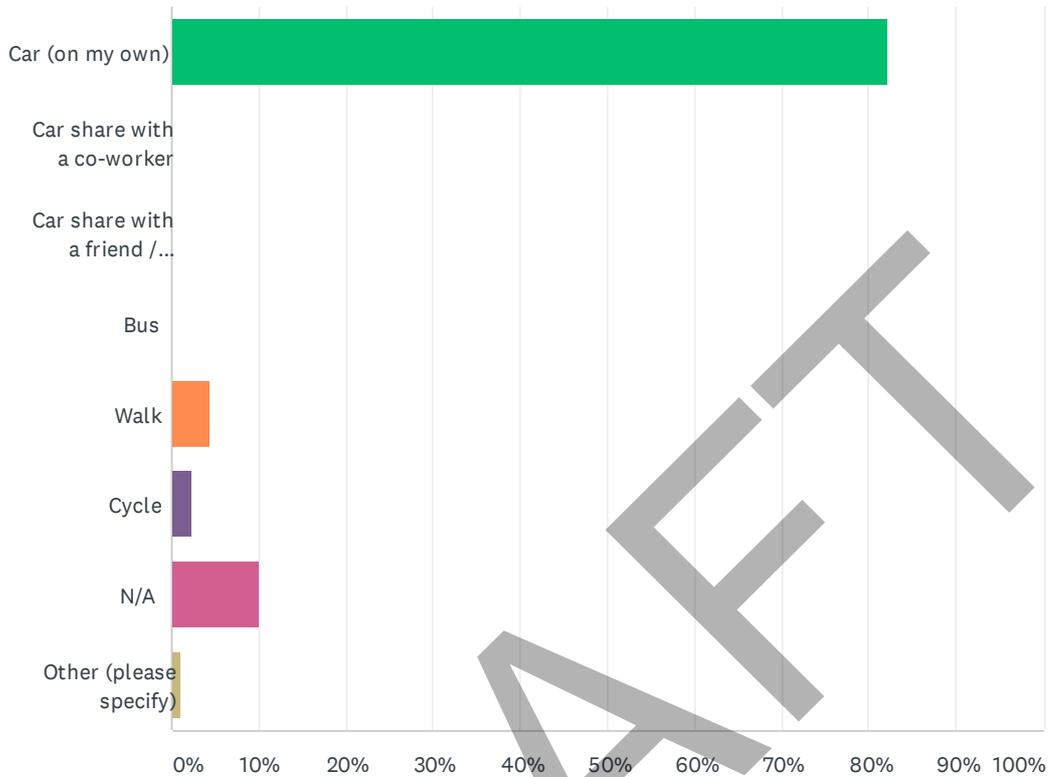
Answered: 89 Skipped: 1



ANSWER CHOICES	RESPONSES
Less than one mile	3.37% 3
1 to 1.5 miles	4.49% 4
1.5 to 3 miles	12.36% 11
3 to 5 miles	13.48% 12
5 to 10 miles	42.70% 38
10 miles +	17.98% 16
N/A	5.62% 5
TOTAL	89

Q5 How do you normally travel to Lydney & District Hospital? (outside of COVID-19 restrictions)

Answered: 90 Skipped: 0

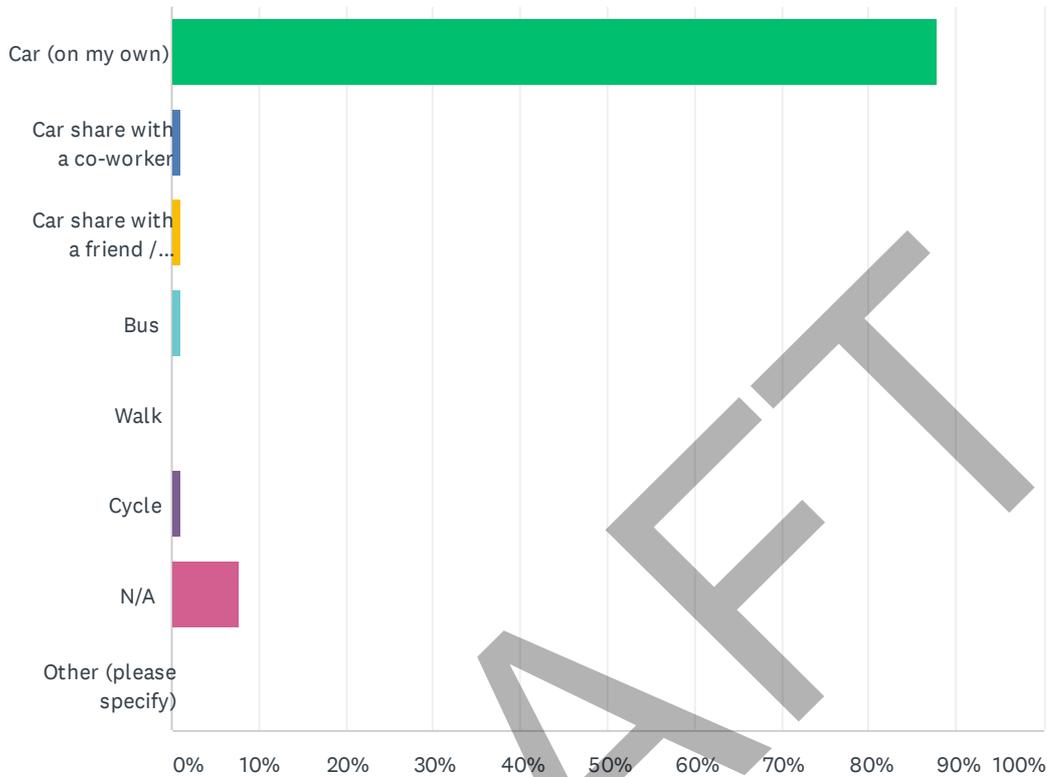


ANSWER CHOICES	RESPONSES	
Car (on my own)	82.22%	74
Car share with a co-worker	0.00%	0
Car share with a friend / family	0.00%	0
Bus	0.00%	0
Walk	4.44%	4
Cycle	2.22%	2
N/A	10.00%	9
Other (please specify)	1.11%	1
TOTAL		90

#	OTHER (PLEASE SPECIFY)	DATE
1	Train	4/20/2021 11:26 AM

Q6 How do you normally travel to Dilke Memorial Hospital? (outside of COVID-19 restrictions)

Answered: 90 Skipped: 0

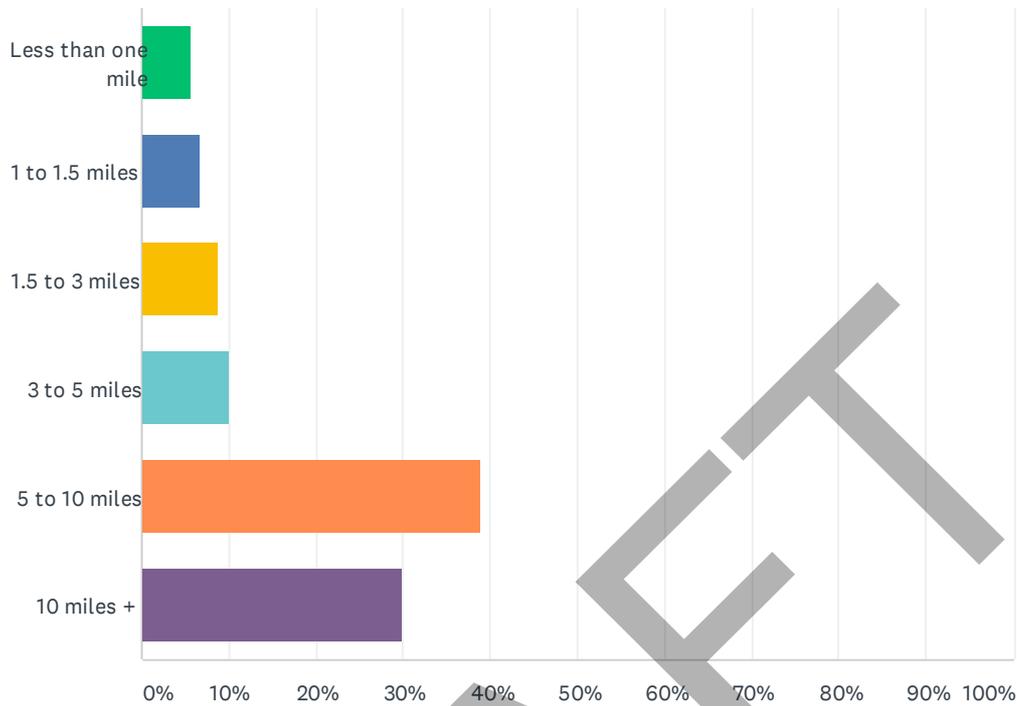


ANSWER CHOICES	RESPONSES	
Car (on my own)	87.78%	79
Car share with a co-worker	1.11%	1
Car share with a friend / family	1.11%	1
Bus	1.11%	1
Walk	0.00%	0
Cycle	1.11%	1
N/A	7.78%	7
Other (please specify)	0.00%	0
TOTAL		90

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q7 How far would your commute to the proposed new hospital be?

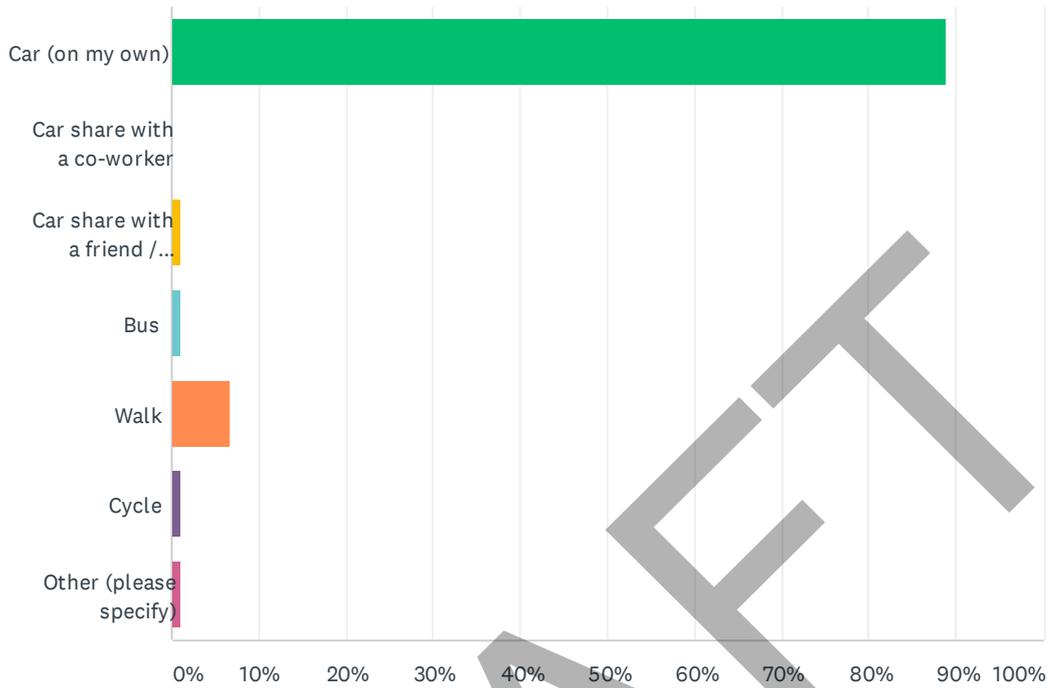
Answered: 90 Skipped: 0



ANSWER CHOICES	RESPONSES	
Less than one mile	5.56%	5
1 to 1.5 miles	6.67%	6
1.5 to 3 miles	8.89%	8
3 to 5 miles	10.00%	9
5 to 10 miles	38.89%	35
10 miles +	30.00%	27
TOTAL		90

Q8 How would you most likely travel to the new hospital? (outside of COVID-19 restrictions)

Answered: 90 Skipped: 0



ANSWER CHOICES	RESPONSES
Car (on my own)	88.89% 80
Car share with a co-worker	0.00% 0
Car share with a friend / family	1.11% 1
Bus	1.11% 1
Walk	6.67% 6
Cycle	1.11% 1
Other (please specify)	1.11% 1
TOTAL	90

#	OTHER (PLEASE SPECIFY)	DATE
1	CAR/WALK	4/19/2021 4:15 PM

Q9 If you opt to travel by car, what barriers prevent you from travelling by walking, cycling or public transport? (This could include distance, cost or convenience etc.)

Answered: 82 Skipped: 8

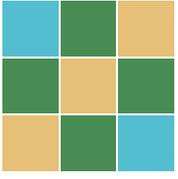
#	RESPONSES	DATE
1	Distance to new hospital / cost	5/8/2021 8:18 AM
2	Distance	4/30/2021 3:20 PM
3	Distance, public transport times and unreliable	4/30/2021 8:51 AM
4	Too far	4/29/2021 1:00 PM
5	distance and hills	4/28/2021 11:13 PM
6	For walking and cycling - the type of roads that I would need to travel on - I have no idea if a bus would go from my area to the new hospital?!	4/28/2021 5:55 PM
7	to far to walk and don't like rideing a bike and it is all up hill,	4/27/2021 7:22 AM
8	Distance and time.	4/25/2021 2:19 PM
9	distance + lack of public transport	4/25/2021 11:40 AM
10	Distance and convenience	4/25/2021 11:33 AM
11	too far and no appropriate bus times	4/24/2021 2:36 PM
12	distance	4/24/2021 8:11 AM
13	Walk - too long a distance Cycle - too long a distance too hilly roads to busy Public transport - Doesn't run around my hours	4/23/2021 3:46 PM
14	Distance, through the forest. Little public transport, certainly not regular enough.	4/23/2021 1:56 PM
15	It wold be possible for me to walk to work in bad weather as I live much closer. Due to Covid and the closing of Dilke MliU I have an hour added to my working day in travelling time and I use twice as much fuel. In bad weather it is impossible to get to Lydney as the roads are very bendy and in bad condition. The Forest of Dean covers a large area and the local residents are finding travelling to Lydney most inconvenient patients are forced to travel the bendy roads, which are lonely and very dark. I am very much in favour of the new hospital being located in Cinderford as I believe it is more accessible to a larger number of people in the Forest and surrounding areas, it is also much closer to GRH should transfer be needed.	4/23/2021 9:58 AM
16	The distance is too far	4/23/2021 8:37 AM
17	I need my car to travel to schools in the community to carry out School entry screening .	4/22/2021 9:13 AM
18	N/A	4/22/2021 9:08 AM
19	Distance and convenience	4/21/2021 7:14 PM
20	inclimate weather - snow etc would continue to influence staff ability to get to work - previous experience has closed Dilke MIIU to keep staff availability/access to manage Lydney MIIU - new location will not improve this	4/21/2021 4:28 PM
21	I don't think there are frequent services - if there was a train that was just as quick as driving and at appropriate times then would get the train.	4/21/2021 4:03 PM
22	Absolutely no transport to coincide with shift start and finish - too far to walk or cycle	4/21/2021 3:49 PM
23	extra time taken to travel Cost of travel shift timings - early starts, late finishes - sometimes waiting on an ambulance can finish very late, id be concerned I'd miss the last bus! i really don't enjoy driving through the forest at night, I worry I'll hit boar/deer etc, write off the car and need to call someone - but no phone signal, i really am dreading it. so much so - I may look for employment elsewhere once new hospital is built. I'd rather drive on the M4 to Southmead/Cwmbran/The Gwent than drive in the forest at night or in the snow.	4/21/2021 2:04 PM

Lydney & District and Dilke Memorial Hospital Survey

24	No convenient times for buses, too far to walk.	4/21/2021 12:40 PM
25	To far to walk, cycle. Public transport to unreliable.	4/21/2021 11:27 AM
26	Home to work commute is impractical by any other method of transport. I live in Bristol.	4/21/2021 10:39 AM
27	distance	4/21/2021 10:34 AM
28	No public transport available from where I live, and too far to walk or cycle.	4/21/2021 10:16 AM
29	distance is too far and too hilly to bike or walk and public transport from my house to work	4/21/2021 9:11 AM
30	childcare needing to drop children off prior to shift	4/21/2021 8:53 AM
31	convenience , need to carry work equipment , uniform etc. wouldnt want to walk after a late shift in the dark due to the area and types of people that hang around that area	4/20/2021 9:56 PM
32	Distance and convenience also shift patterns	4/20/2021 8:55 PM
33	Not able to walk to far and would not walk in the dark (shift work). Would not cycling in the dark (shift work). No public transport from where I live.	4/20/2021 7:34 PM
34	No public transport. muddy through woods and long way and unsafe road to walk. Hate cycling	4/20/2021 5:14 PM
35	Weather permitting I will walk.	4/20/2021 4:36 PM
36	distance + time main issue. outside work commitments.	4/20/2021 4:10 PM
37	no public transport available, or at the times to start and finish shifts, and costs. too far to cycle or walk.	4/20/2021 2:55 PM
38	Distance, carrying equipment and convenience	4/20/2021 2:49 PM
39	For safety and practical reasons i would use my car.	4/20/2021 11:44 AM
40	Walking, cycling = too far for me My initial impression is there is a lack of public transport into the new hospital, especially when i travel via train most of the time	4/20/2021 11:26 AM
41	distance - 30 miles	4/20/2021 10:52 AM
42	School run before and after work	4/20/2021 8:54 AM
43	Convince	4/20/2021 8:43 AM
44	Physical ability	4/20/2021 8:18 AM
45	distance	4/20/2021 7:19 AM
46	USING THE CAR WOULD BE CONVENIENCE	4/19/2021 4:15 PM
47	Time	4/19/2021 4:04 PM
48	because of shift work.and not on bus route	4/19/2021 4:00 PM
49	No effective public transport from where I live, especially with irregular working hours.	4/19/2021 3:43 PM
50	Distance, rural location & reliability of public transport.	4/19/2021 3:37 PM
51	Community worker, need car to carry out duties.	4/19/2021 3:26 PM
52	The bus hardly ever turns up or stops from previous experience of using public transport . Its to far to walk or cycle to work as its 5 to 10 miles away.	4/19/2021 3:24 PM
53	Too far to walk, especially in the winter and would not work well around child care. There are no regular buses on that route for me. If we had cycle lanes like the Dutch do, I would be more inclined to cycle more .	4/19/2021 3:14 PM
54	the weather and timings of the bus transport, will they cover shift patterns?	4/19/2021 2:37 PM
55	Too far to walk/cycle. Shift work does not allow for public transport	4/19/2021 2:21 PM
56	convenience	4/19/2021 1:32 PM
57	Too far to cycle. No buses from Walford, Herefordshire.	4/19/2021 1:21 PM
58	Distance Convenience	4/19/2021 1:21 PM
59	Distance, finishing in the dark	4/19/2021 1:04 PM

Lydney & District and Dilke Memorial Hospital Survey

60	Distance and too much equipment to carry	4/19/2021 12:53 PM
61	Public transport would not work to travel to the new Hospital	4/19/2021 12:39 PM
62	Couldn't work shifts and use public transport as none available at times required. Too far to walk. Too many cars on main roads if I had to ride a bicycle, which I wouldn't do due to shift times, weather, etc. Convenient to drive.	4/19/2021 12:36 PM
63	Too far to walk, public transport is a no as i do not have regular buses running to and from the area i live in.	4/19/2021 12:36 PM
64	Distance No public transport available	4/19/2021 12:33 PM
65	Distance is to far to walk, I work a variety of shifts and times do not always fit with bus timetable.	4/19/2021 12:27 PM
66	If working core hours 9-5pm I would need to complete the school run prior to work, if I walked I would be late for work	4/19/2021 12:26 PM
67	Distance	4/19/2021 12:12 PM
68	Distance, dangerous road in the winter, time restraints, no public transport	4/19/2021 11:30 AM
69	Public Transport is not good in whole of the Forest.	4/19/2021 11:13 AM
70	long walk (partly on unpaved road) to appropriate bus stop and not able to catch bus at appropriate times and too expensive as need to run a car anyway. Too far to walk or cycle	4/19/2021 10:56 AM
71	distance, used to cycle and would be good to have bike racks too, used to have to chain to rails. need access to shower before work too if cycling. thanks	4/19/2021 10:33 AM
72	the distance is too far to walk or cycle and there is no convenient bus.	4/19/2021 10:20 AM
73	Convenience	4/19/2021 10:14 AM
74	Distance and carrying too much equipment needed for clients appointments and staff training.	4/19/2021 9:58 AM
75	I live over 45 miles away.	4/19/2021 9:57 AM
76	Distance. Car needed for Community work. No public transport from rural location in Tintern vacinity to Cinderford	4/19/2021 9:56 AM
77	No buses at the right time of day, to or from Dilke and Lydney. Buses are very few and far between.	4/19/2021 9:52 AM
78	No public transport Not possible to walk	4/19/2021 9:49 AM
79	Public transport too infrequent and would require at last 3 buses to get to work. Too far to walk/cycle plus it would include mostly hills	4/19/2021 9:43 AM
80	My travel time would be greatly increased as I would have to walk quite a distance to get to a bus stop initially. I would only consider walking the whole distance in bad weather. I would not wish to ride a cycle; it would be all uphill on the way home!!!	4/19/2021 9:41 AM
81	Distance I live in Gloucester	4/19/2021 9:41 AM
82	Distance No available public transport	4/19/2021 9:27 AM



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Appendix F

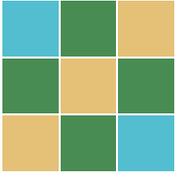
Example Travel Survey

DRAFT

EMPLOYEE TRAVEL SURVEY

1. Name: _____
Town: _____
Street: _____
Post Code: (optional) _____
2. Distance from Home to Work:
- Under - 1 mile
 - 1 mile - 3 miles
 - 3 miles - 10 miles
 - Over 10 miles
3. How do you normally travel to work?
(Please tick only one box):
- Walk
 - Cycle
 - Public Transport
 - Car Driver
 - Car Passenger
 - Other
4. Would you consider either walking or cycling to work as changing facilities, showers and cycle storage are available? YES NO
5. Would you consider using a bus to travel to work given the proximity of stops? YES NO
6. Would you consider car-sharing lift with someone if you could be guaranteed that arrangements could be made for you to have a lift home in an emergency? YES NO
7. If you drive a car to work, are there any special reasons why you have to drive to work?
(*ie. Are you disabled and cannot walk or use a bus?*)
8. Do you work a shift, which would make walking or catching a bus unsafe, or impractical? Please specify

All data will be handled with strictest confidentiality



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Cotswold Transport Planning Ltd

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Gleeds

**Forest of Dean Community
Hospital**

Phase 2 Survey Report

Issue | 12 July 2020

This report takes into account the particular instructions and requirements of our client.

It is not intended for and should not be relied upon by any third party and no responsibility is undertaken to any third party.

Job number 266394

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ARUP

Document verification

ARUP

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Sturgess Ecology (2019) Vegetation and Invasive Plant Survey Report

1 Introduction

1.1 Scope of the Report

Ove Arup and Partners Ltd (Arup) was commissioned by Gleeds to prepare a Preliminary Ecological Appraisal (PEA) report¹ for the potential development of the Forest of Dean Community Hospital, on Steam Mills Road in Cinderford. The Site, centred on approximate National Grid Reference (NGR) SO 65233 14883, is shown on Figure 1, along with the results of the Extended Phase 1 Habitat survey undertaken for the PEA.

Arup's PEA for the project identified that habitats on Site were potentially suitable for dormice (*Muscardinus avellanarius*), bats, reptiles, and badgers (*Meles meles*). As such, further surveys were undertaken for these species, as well as a botanical survey (National Vegetation Classification (NVC) methodology) of the semi-improved neutral grassland to the north and a survey across the whole Site for invasive species. This document reports the findings of these surveys that were carried out between the Spring and Autumn of 2019, in order to provide a baseline for an Ecological Impact Assessment (EcIA) report. An EcIA report will be required to support any future planning application and can be completed when the detailed design of the project is finalised.

This document also outlines potential appropriate mitigation and enhancement measures for inclusion within the design and construction methodology. These measures should be considered and added to as the project design progresses.

1.2 Description of the Site

The Site currently comprises a recreational sports field, with areas of scrub and woodland along the boundaries, and one area of bracken to the north. This Site is located at the edge of woodland habitat, which is part of the Forest of Dean forested area, bordering on the mixed residential, commercial and industrial area of Cinderford.

1.3 Survey Objectives

Survey objectives for the various specific species/groups undertaken on Site in 2019 are discussed in turn.

The objectives of the dormouse survey were to:

1. Determine the presence and distribution, or likely absence of dormice within the Site;
2. To provide sufficient information to inform the requirement for an EPS mitigation licence; and

¹ Arup, February 2019. Forest of Dean Community Hospital, Preliminary Ecological Appraisal (PEA) report for Gleeds.

3. To provide sufficient information to inform the assessment of impacts on dormice from the proposed development in any future EcIA report.

The objectives of the bat surveys were to:

1. Identify the potential presence of any bat roosts within or adjacent to the Site that may be impacted by the development;
2. Record and identify levels of bat activity, using static bat detectors at two different locations within the Site;
3. To identify the range of species present and their relative abundance in terms of activity levels at these locations;
4. The provide sufficient information to inform the requirement for an EPS mitigation licence; and
5. To provide sufficient information to inform the assessment of impacts on bats from the proposed development as part of any future EcIA and/or Habitats Regulations Assessment (in the case of lesser horseshoe (*Rhinolophus hipposideros*) and greater horseshoe bats (*Rhinolophus ferrumequinum*)).

The objectives of the reptile survey were to:

1. Identify and record the presence or likely absence of reptile species within the survey area;
2. Determine use of and distribution within the Site by reptiles (areas/habitats); and
3. To provide sufficient information to inform the assessment of impacts on reptiles from the proposed development as part of any future EcIA.

The objectives of the badger survey were to:

1. Identify and record the presence or likely absence of badger setts within the Site boundary, or within 30 metres of the Site boundary;
2. Determine use of and distribution within the Site by badgers;
3. To provide sufficient information to inform the requirement for a badger licence; and
4. To provide sufficient information to inform the assessment of impacts on reptiles from the proposed development as part of any future EcIA.

The objectives of the vegetation and invasive species survey were to:

1. Establish the importance of the grassland to the north of the Site; and
2. Identify and record the presence of any Schedule 9 plant species within the Site boundary.

1.4 Relevant Legislation and Biodiversity Framework

1.4.1 Dormouse

Dormice in the UK are afforded protection under both European and national law. Dormice are listed as a European Protected Species (EPS) under the provisions of the Conservation of Habitats and Species Regulations 2017 (as amended) (known as the 'Habitats Regulations'). The Habitats Regulations transpose the requirements of Council Directive 92/43/EEC on the Conservation of Natural Habitats and of Wild Fauna and Flora (the Habitats Directive) into law within England and Wales.

Additionally, dormice are afforded protection under Schedule 5 of the Wildlife and Countryside Act 1981 (as amended).

Together this legislation makes it an offence to:

- intentionally or recklessly kill, injure or capture a dormouse;
- intentionally or recklessly disturb a dormouse such as to affect its local distribution, or ability to survive, breed or rear its young;
- damage, destroy or obstruct access to a breeding site or resting place (e.g. shelter) used by a dormouse, or disturb dormice while they are using such a place; and
- possess or control a dead or live dormouse, or any part of a dormouse.

Dormice are also included within the list published in response to Section 41 of the Natural Environment & Rural Communities (NERC) Act 2006. Section 41 (S41) of the Act requires the Secretary of State for England to publish a list of habitats and species which are of principal importance for the conservation of biodiversity in England. The S41 list is used to guide decision makers such as public bodies, including local and regional authorities, in implementing their duty under Section 40 of the Act, to have regard to the conservation of biodiversity in England, when carrying out their normal functions.

Dormice are further listed on the Gloucestershire Biodiversity Action Plan (BAP), which contains Habitat and Species Action Plans to conserve and enhance biodiversity.

1.4.2 Bats

All UK bat species are afforded protection under both European and national law. All bats are listed as EPSs under the provisions of the Habitats Regulations. Additionally, all bat species are afforded protection under Schedule 5 of the Wildlife and Countryside Act 1981.

Together this legislation makes it an offence to:

- intentionally or recklessly kill, injure or capture a bat;
- intentionally or recklessly disturb a bat such as to affect its local distribution or ability to survive, breed or rear its young;

- damage, destroy or obstruct access to a breeding site or resting place (e.g. roost) used by a bat, or disturb bats while they are using such a place; and
- possess or control a dead or live bat, or any part of a bat.

Furthermore, Bechstein's bat (*Myotis bechsteinii*), barbastelle (*Barbastella barbastellus*), and lesser and greater horseshoe bats are protected under Annex 2 of the European Habitats Directive. Annex 2 species can be protected through the designation of a Special Area of Conservation (SAC).

Various bat species, including barbastelle, Bechstein's bat, noctule (*Nyctalus noctula*), soprano pipistrelle (*Pipistrellus pygmaeus*), brown long-eared bat (*Plecotus auritus*), and greater and lesser horseshoe bat are S41 Priority Species. Barbastelle, Bechstein's bat, pipistrelle species (*Pipistrellus spp.*), and greater and lesser horseshoe bats are further listed on the Gloucestershire BAP.

1.4.3 Reptiles

All UK native reptile species (adder (*Vipera berus*), grass snake (*Natrix helvetica*), smooth snake (*Coronella austriaca*), common lizard (*Zootoca vivipara*), slow-worm (*Anguis fragilis*) and sand lizard (*Lacerta agilis*)) are protected under Schedule 5 of the Wildlife and Countryside Act against deliberate or intentional killing, injuring and unlicensed trade. This legislation applies to all life stages of these species.

The sand lizard and smooth snake receive additional legislation as a result of their status as EPS and are therefore fully protected under Schedule 2 of the Habitats Regulations. This Regulation makes it an offence to: deliberately capture, injure or kill any wild animal of an EPS, deliberately disturb wild animals of such a species, deliberately disturb take of destroy the eggs of such a species; and damage or destroy a breeding site or resting place of such an animal. However, sand lizard and smooth snake are very restricted in their distribution and not expected to be found within the Site.

All six UK native reptile species are also S41 Priority Species.

1.4.4 Badgers

Badgers are protected by the Protection of Badgers Act 1992. This legislation makes it an offence to:

- wilfully kill, injure or take (dead or alive) a badger, or attempt to kill, injure or take (dead or alive) a badger;
- exhibit cruelty to badgers (as defined under the Act);
- interfere with a badger sett (including damaging, destroying, obstructing, disturbing, or allowing a dog to enter);
- sell or possess a live badger; and
- mark or ring a badger.

Actions that are prohibited by legislation laid out in Sections 1.4.1, 1.4.2 and 1.4.4 of this report can be made lawful on the approval and granting of relevant licences from Natural England (NE), subject to conditions.

1.4.5 Invasive species

Section 14 of the Wildlife and Countryside Act 1981 makes it an offence to plant, or otherwise cause to grow, any plant which is included in Part 2 of Schedule 9.

Under Part 2 Article 3 (2) of The Invasive Alien Species (Enforcement and Permitting) Order 2019², it is an offence to:

'release or allow to escape into the wild any specimen which is of a species of animal which (a) is not ordinarily resident in and is not a regular visitor to Great Britain in a wild state, or (b) is included in Part 1 of Schedule 2'.

It is also an offence under Part 2 Article 3 (3) to:

'plant or otherwise cause to grow in the wild any specimen which is of a species of plant which is included in Part 2 of Schedule 2'.

Part 1 of Schedule 4 of the Order also amends the Wildlife and Countryside Act 1981 to remove the animals and plants listed on Part 1, Schedule 2 of the Order from Schedule 9 of the Wildlife and Countryside Act.

Due to the location and context of the Site adjacent to residential gardens, there is the potential for invasive species to have established within the Site from garden escapes, such as cotoneaster species (*Cotoneaster spp.*), rhododendron species (*Rhododendron spp.*), Japanese knotweed (*Reynoutria japonica*) or Himalayan balsam (*Impatiens glandulifera*).

² The invasive plant survey was conducted prior to the introduction of the Invasive Alien Species (Enforcement and Permitting) Order 2019. However, species covered by the survey remain relevant to both the Invasive Alien Species (Enforcement and Permitting) Order 2019 and to Schedule 9 of the Wildlife and Countryside Act 1981.

2 Methodology

2.1 Desk Study

Biodiversity information was obtained from the Gloucestershire Centre for Environmental Records (GCER)³ on 6th February 2019. The search included information on dormice, bats, reptiles and badgers up to 2km from the Site centre point. An online search was also carried out using the Multi Agency Geographic Information for the Countryside (MAGIC)⁴, and the Joint Nature Conservation Committee (JNCC)⁵ website to identify European Sites within 30km of the Site boundary designated for the presence of Annex 2 bat species. The full desk study results from the previous 10 years are provided in the PEA report.

2.2 Field Surveys

2.2.1 Dormouse Survey

To confirm the presence or likely absence of dormice within the Site, a nest tube survey was undertaken in accordance with best practice guidance⁶. This comprised placing nest tubes within potential dormouse habitat within the study area. Nest tubes were constructed of stiff double-walled black plastic sheet, approximately 5x5 cm in cross sections and 25cm long. A small plywood tray was placed inside, projecting 5cm beyond the tubes entrance to allow the animals easy access. The opposite end of the tube was sealed with a wooden block mounted on the tray. Each tube was suspended by wire, fixed firmly underneath horizontal branches.

Nest tubes are used by dormice as an alternative to tree holes and other suitable nesting sites. Other species, such as wood mice (*Apodemus sylvaticus*), yellow-necked mice (*Apodemus flavicollis*) or birds, may also use the dormouse nest tubes. However, dormice build tightly woven nests which are usually readily distinguishable from the nests of other species.

A total of 50 nest tubes were deployed on the 16th May 2019, within suitable habitat at locations shown in Figure 2. This was approximately a month and a half prior to survey commencement to allow time for dormice to find and move into the tubes. Nest tubes were spaced between 15m and 20m apart, with entrance holes angled downwards and facing the centre of vegetation where possible. Tubes were numbered, and the location recorded by GPS on tablet devices to allow for repeatability of surveys and the positive location identification of any survey findings.

Nest tubes were inspected once a month (approximately every four weeks) between the 24th June and 15th November 2017 (dates shown in Table 1 below). The interior of each tube was visually inspected where possible, either directly or

³ <https://www.gcer.co.uk/datasearch.html> with data supplied 6th February 2019

⁴ <http://magic.defra.gov.uk/MagicMap.aspx> Accessed 23rd January 2019

⁵ <http://jncc.defra.gov.uk/> Accessed 23rd January 2019

⁶ English Nature, 2006. Dormouse Conservation Handbook, Peterborough

using a mirror. Where this was not possible or where vegetation was observed inside the tube, the open end of the tube was blocked with a cloth and the nest tray carefully withdrawn. The contents of the nest tube were documented and photographed if any signs of wildlife were observed.

Table 1: Survey schedule

Month	Visit	Date	Index of Probability (cumulative total)
May	Deployment	16/05/2019	-
Jun	1	24/06/2019	2 (2)
Jul	2	18/07/2019	2 (4)
Aug	3	23/08/2019	5 (9)
Sep	4	17/09/2019	7 (16)
Oct	5	15/10/2019	2 (18)
Nov	6	15/11/2019	2 (20)

Nest tube use by dormice varies through the year with peaks in May, August and September⁷. In accordance with the Dormouse Conservation Handbook, the survey effort provided a score of 20, indicating adequate survey effort using the probability index scores provided in Table 1. Surveys were all undertaken in suitable weather conditions for dormouse surveys (details of weather conditions are provided in Appendix A), by licenced surveyors and/or accredited agents.

2.2.2 Bat Surveys

Preliminary Roost Assessments

During the Extended Phase 1 Habitat survey Potential Roost Features (PRFs) were identified on two trees within/adjacent to the Site. These comprised two English oaks (*Quercus robur*), one located just within the western boundary of the Site with a crack on its southern side (T1), and one located outside of the eastern boundary with a hole (T2).

Both PRFs were at a height that could be accessed from the ground, and as such an inspection with an endoscope was conducted on the 1st July 2019 by Pete Wells CEnv MCIEEM (a bat specialist with over 20 years of experience in bat work, holder of an NE Class 2 licence: 2015-14791-CLS-CLS) assisted by Eloise Arif BSc (Hons) ACIEEM.

Furthermore, buildings immediately adjacent to the Site boundary were subject to an external assessment on the 16th May 2019, for their suitability to support roosting bats, in line with Bat Conservation Trust (BCT) guidelines⁸. The structures were examined externally from the ground for features that could

⁷ Chanin and Woods, 2003. Surveying Dormice using nest tubes: results and experiences from the South West Dormouse Project (English Nature Research Report No. 524). Peterborough, English Nature.

⁸ Collins, J., 2016. Bat Surveys for Professional Ecologists: Good Practice Guidelines, 3rd Edition, The Bat Conservation Trust, London.

support roosting bats and features that could lead to internal potential roost spaces, and were categorised as having high, moderate, low or negligible Bat Roosting Potential (BRP) accordingly. This assessment was conducted by Claire Pooley BSc (Hons) MSc MCIEEM, holder of an NE Class 2 licence: 2015-19288-CLS-CLS and an NRW 78418: OTH:CSAB:2018, assisted by Eloise Arif BSc (Hons) ACIEEM and Hannah Whitfield BSc (Hons).

Static Bat Activity Monitoring

Static bat detectors were used to record bat activity over a five-night period each month from April to October 2019 (inclusive). These surveys were undertaken in line with the aforementioned BCT guidelines. The dates of the monitoring periods in each month are shown in Table 2.

Table 2: Static bat activity monitoring periods

Month	Date of Deployment	Date of Collection
April	24/04/2019	30/04/2019
May	24/05/2019	30/05/2019
June	24/06/2019	01/07/2019
July	18/07/2019	24/07/2019
August	23/08/2019	04/09/2019
September	17/09/2019	23/09/2019
October	15/10/2019	28/10/2019

Two locations were selected on and within the Site boundary (shown on Figure 3). The locations were selected using professional judgement to provide a representative sample of the habitats present within the Site boundary, with the aim of identifying the relative importance of these. Location 1 was along the edge of the woodland to the east of the Site and Location 2 was along the treeline to the west of the Site.

Wildlife Acoustic Song Meter 2 Ultrasonic Bat Detectors (SM2+ BAT) with SMX-U1 microphones were used to record bat activity over the monitoring periods. The detectors were set up with the settings shown in Table 3 to record from half an hour before sunset, to half an hour after sunrise the following morning each month.

Table 3: SM2+ BAT settings used during static bat activity monitoring

Parameter	Setting
2.5V Microphone Bias	Off
Low noise filter	1kHz
Microphone pre-amp gain	12dB
Sample rate	354800
Monitoring schedule	Daily from 18:00
Monitoring duration	13hrs

The microphones used with the detectors during the course of the surveys were regularly checked and calibrated using a Wildlife Acoustics Calibration Unit to ensure that they were functioning properly. Microphones that were found not to be of sufficient sensitivity to the output of the calibration unit or which were damaged were replaced.

Data Processing and Analysis

The detectors recorded bat activity in Wildlife Acoustics Compression files (.wac). These were downloaded from the detectors and processed using Kaleidoscope Pro Software to produce audio files (.wav) and zero crossing files. The processing also included the automatic identification of bat species based on the classifiers developed by Wildlife Acoustics (Bats of Europe 5.1.0).

The files produced by the processing were then reviewed to ensure correct identification of species and to identify where possible the bat species for any calls which could not be recognised by the software. All calls identified as being either common pipistrelle (*Pipistrellus pipistrellus*) or soprano pipistrelle were not reviewed except where high levels of insect noise had been recorded leading to uncertainty over the accuracy of identification. All other calls were checked by Pete Wells CEnv MCIEEM.

The number of files (sound clips) recorded by the detectors each night was taken as a proxy value to the number of bat passes. This was then used to calculate a Bat Activity Index (BAI) for each species at each location during each session. The BAI was calculated on the first five nights recorded each month. In some cases, the detector also recorded data on the sixth and seventh nights. These additional nights have been excluded from the BAI as it could not be certain that the detector had recorded data for the entire night. However, where rarer or more notable species were recorded on these additional nights, they have been included to ensure their representation within the data in terms of species diversity.

The average BAIs for all species (sum of individual BAIs) at each location has been calculated over the active months from April to October 2019.

The time of recording of the first bat of each species, each night, and time of last recording were also compared to sunset and sunrise times obtained using Anasun software to infer the potential proximity of roost sites.

2.2.3 Reptile Survey

Habitat Suitability Assessment

During the initial Site walkover survey undertaken for the PEA in January 2019 the various habitats within the Site were assessed in terms of their ability to support reptile species.

British reptile species require feeding and resting locations such as thick, tussocky grassland and scrub habitat which supports their invertebrate prey, as well as suitable basking locations such as open, exposed south-facing banks where they

are able to bask in direct sunlight, or absorb heat retained in artificial/natural habitat features such as logs and tyres⁹.

The habitats which were considered suitable for further survey, assessed by an ecologist according to the criteria listed above, were identified and informed the placement of the artificial refugia.

Presence/Likely Absence Survey

A seven-visit reptile survey was carried out in accordance with standard best practice guidance¹⁰. This involved the placement of artificial refugia within the suitable reptile habitat identified during the habitat suitability assessment. The refugia used comprised pieces of roofing felt measuring approximately 1m x 0.5m with a placement density of at least 5-10 refugia per hectare.

Tablet devices were used to record the position of refugia and to collect data during the seven survey visits in order to improve efficiency and mapping precision. A total of 36 refugia were installed on the 24th April 2019 (shown on Figure 4). This was thirteen days prior to survey commencement, to allow reptiles to habituate to the refugia and begin using them. As per the guidance, seven survey visits were carried out over May and June 2019 by suitably qualified ecologists, with at least 48 hours between each visit. Any incidental observations of reptiles during site visits for other surveys were also recorded. Refugia were collected on the 15th November 2019 following completion of the last dormouse survey.

All survey visits were made in suitable weather conditions, within a temperature range of between 9°C and 18°C (weather conditions for each survey visit are provided in Appendix A).

Each refugia was lifted carefully to search for any reptile species. If present, details of the reptile species, sex, age class and condition were recorded where possible (sometimes individuals escaped too quickly to allow for identification of sex, age class or condition). Any pre-existing suitable artificial or natural refugia on Site were also checked as part of the survey. Once the reptiles had been allowed to escape, the refugia were replaced.

Additional signs of reptile presence such as sloughed skins were also recorded where evident and any live animals observed away from refugia were also recorded. Incidental records of reptiles on or under refugia were also recorded when the Site was visited for other surveys.

2.2.4 Badger Survey

Due to the lack of desk study records and the lack of badger signs identified during the Extended Phase 1 Habitat Survey within the Site, the PEA did not recommend a further badger survey.

⁹ Edgar, P., Foster, J. and Baker, J. (2010). Reptile Habitat Management Handbook. Amphibian and Reptile Conservation, Bournemouth.

¹⁰ Froglife. (1999). Reptile Survey: An Introduction to Planning, Conducting and Interpreting Surveys for Snake and Lizard Conservation. Froglife Advice Sheet 10. Halesworth: Froglife.

However, the Extended Phase 1 Habitat Survey was conducted in dry and frosty weather conditions in the winter of 2019. Badgers are less active in the winter, and dry/frosty weather conditions further restrict the presence of badger signs through limiting the amount badgers are able to forage in the ground for preferred food sources (such as earth worms or insect larvae)^{11;12}.

Subsequently, during a site visit on the 16th May 2019, a young injured female badger was found in the bracken area to the north of the Site. The badger was then rescued by a volunteer for the Vale Wildlife Hospital and Rehabilitation Centre. It was considered that the badger had been hit by a vehicle on the adjacent Steam Mills Road, and it unfortunately had to be euthanised due to the severity of the injuries. The volunteer was familiar with the sett that the badger had most likely come from and indicated that it was located more than 30m from the Site boundary in a north easterly direction.

As a precautionary approach following this incident, a walkover of the Site and the areas within approximately 30m of the Site boundary was conducted on the 16th and 24th May 2019 to search for signs of badger activity such as sett holes, footprints, latrines, hairs and paths, in line with best practice guidance¹³.

2.2.5 National Vegetation Classification (NVC) and Invasive Species Survey

Arup commissioned Sturgess Ecology to undertake an NVC survey of an area of semi-improved neutral grassland in the north of the Site, and a survey of invasive species across the whole Site. The survey work was undertaken on the 20th May 2019, in optimal weather conditions.

The vegetation survey followed standard NVC survey methodology and plant communities were described in terms of the published NVC communities¹⁴ by quadrat sampling. Plant species recorded within quadrats were compared with the communities within the published NVC classification, using the author's experience and professional judgment, assisted by Tablefit software¹⁵.

The invasive species survey was undertaken by a walk-over of the Site, passing through all the different vegetation types and carefully looking for any plant species included in the legislation relating to invasive species.

The full survey methodology is given in the vegetation and invasive plant survey report in Appendix C.

¹¹ Scottish Badgers (2018) Surveying for Badgers: Good Practice Guidelines. Version 1

¹² Badger Trust. Badgers in your garden. <http://www.badgergroup.org.uk/garden.pdf> [Accessed 29/06/2020]

¹³ Harris, S., Cresswell, P., and Jefferies, D. (1989) Surveying Badgers. The Mammal Society, London

¹⁴ Rodwell, J.S. (ed.) et al., (1991 - 2000). British Plant Communities. Volumes 1-5. Cambridge University Press, Cambridge.

¹⁵ Hill, M.O. (2015). TABLEFIT version 2.0 for identification of vegetation types. Wallingford: Centre for Ecology and Hydrology

2.3 Limitations and Assumptions

During the dormouse survey on the 18th July one of the surveyors fell in a hole associated with old mining activity, due to overgrown vegetation obstructing the hole from view. No injuries were sustained, however, approximately 15 tubes that could not be easily accessed (due to overgrown vegetation) were not checked following this incident, due to the risk that vegetation could be concealing health and safety hazards underfoot. In subsequent surveys, surveyors used large sticks and garden shears to safely reach tubes where the ground had been obscured by overgrown vegetation.

Furthermore, due to the dense growth of vegetation over the survey season, a small number of tubes could not be found each month until vegetation had died back again in November. Where tubes could not be found, replacement tubes were deployed in a more accessible location. The presence of dormouse was confirmed in multiple areas within the Site boundary and as such, these limitations are not considered to have significantly affected the survey results or the conclusions drawn.

The identification of bat calls can be highly subjective based on decisions on the shape and characteristics of the calls. Whilst every effort has been made to ensure the accurate identification of calls, given the number of bat passes recorded (in excess of 33,000 from static detectors) it has not been possible to differentiate between the *Myotis* species. Due to the subjective nature of bat call analysis it is possible that other ecologists may differ in opinion on the identification of calls, however current reference works¹⁶ have been used along with BatExplorer software which also includes species identification functions.

There is also the potential that some calls may be overlooked principally due to the fact that the automatic species identification systems cannot identify multiple species within the same sound clip. However, with the exception of files identified as common or soprano pipistrelle by the software, all other files have been checked and all species recorded within those files included within the results set out in this report.

Whilst effort was made to programme and undertake surveys during suitable weather conditions, the nature of the static activity monitoring surveys, undertaken over a five-night recording session and including surveys in April and October, means that on some occasions these surveys included nights during which there were lower temperatures, periods of rainfall and strong winds.

However, the recordings provide an indication of bat activity levels within the Site during these different weather conditions.

Only a limited number of artificial reptile refugia were placed along the western boundary of the sports field, despite suitable habitat being present. There is a skate park located adjacent to the western boundary with a footpath running up to the skate park from the car park in the south. The artificial refugia were not placed

¹⁶ Russ, J. (2012). *British Bat Calls: A Guide to Species Identification*. Exeter: Pelagic Publishing, and Middleton, N., Froud, A., & French, K. (2014). *Social Calls of the Bats of Britain and Ireland*. Exeter: Pelagic Publishing.

within close proximity to this path or the skate park due to the increased risk of the refugia being tampered with by members of the public.

Reptile presence has been confirmed in areas of similar habitat elsewhere in the Site, and it is therefore assumed that these reptile species will also be present in similar volume along the western boundary. As such, this limitation is not considered to significantly affect the survey results or the conclusions drawn.

No limitations specific to the badger survey, NVC survey or invasive species survey were encountered.

It should be stressed that the findings presented in this study represent those at the time of survey and reporting, and data collected from available sources.

Ecological surveys are limited by factors which affect the presence of species, such as weather conditions, movement patterns and behaviour.

Nevertheless, these surveys were conducted at an appropriate time of year and using appropriate methods. Every effort has been made to ensure that the findings of the study present as accurate an interpretation as possible of the status of target species within the study area.

3 Results

3.1 Desk Study

3.1.1 Bat Special Areas of Conservation

The search using MAGIC highlighted two bat SACs within 30km of the Site boundary (shown on Figure 5):

- The Wye Valley and Forest of Dean Bat Sites SAC, designated for the presence of lesser and greater horseshoe bats, located approximately 1.59km north east of the Site; and
- The Wye Valley Woodlands SAC, designated for the presence of lesser horseshoe bat, located approximately 7.3km west of the Site.

3.1.2 Protected and Notable Species

GCER provided data on protected and notable species on 6th February 2019. The GCER search was carried out up to 2km from the Site centre (NGR SO 65233 14883). The data summarised below are those records of bats, dormice and reptiles provided from the previous 10 years (2009 to present). No records of badger were provided by GCER.

Table 4: Summary of protected bat, reptile and dormouse records within 2km of the Site centre point. Data are from 2009 onwards. Distances are approximate.

Species/Group	Scientific Name	Status ¹⁷	Summary of Records	Most Recent Record
Dormouse				
Hazel dormouse	<i>Muscardinus avellanarius</i>	EPS, WCA, S41	Three records of dormouse were returned, the closest of which was a characteristic gnawed nut, which was found in 2019, approximately 1.3km from Site in woodland that connects to the Site.	2019
Bats				
Barbastelle	<i>Barbastella barbastellus</i>	EPS, WCA, S41	One record of barbastelle was returned, at Cinderford Linear Park KWS approximately 780m north west. There were no records of roosts.	2011

¹⁷ EPS = European Protected Species as listed under Schedule 2 of the Conservation of Habitats and Species Regulations (2010)

WCA = Species protected under Schedule 5 (animals) or Schedule 8 (plants) of the Wildlife and Countryside Act (1981) as amended

S41 = Species protected under Section 41 of the 2006 Natural Environment and Rural Communities (NERC) Act

Species/Group	Scientific Name	Status ¹⁷	Summary of Records	Most Recent Record
Brown long-eared bat	<i>Plecotus auritus</i>	EPS, WCA, S41	One record of brown long-eared bat was returned, at Cinderford Linear Park KWS approximately 780m north west. There were no records of roosts.	2011
Common pipistrelle	<i>Pipistrellus pipistrellus</i>	EPS, WCA, S41	Six records of common pipistrelle bats were returned, the closest of which was a sighting approximately 400m south.	2017
Soprano pipistrelle	<i>Pipistrellus pygmaeus</i>	EPS, WCA, S41	Three records of soprano pipistrelle bats were returned, but none were roosts. The closest of these records was of a high level of foraging/commuting activity approximately 740m south east.	2017
Daubenton's bat	<i>Myotis daubentonii</i>	EPS, WCA, S41	One record of Daubenton's bat was returned, at Cinderford Linear Park KWS approximately 780m north west. There were no records of roosts.	2011
Greater horseshoe bat	<i>Rhinolophus ferrumequinum</i>	EPS, WCA, S41	One record of greater horseshoe bat was returned, at Cinderford Linear Park KWS approximately 780m north west. There were no records of roosts.	2011
Lesser horseshoe bat	<i>Rhinolophus hipposideros</i>	EPS, WCA, S41	Three records of lesser horseshoe bats were returned, the closest of which was located approximately 780m north west at Cinderford Linear Park KWS. One roost was identified approximately 1.5km north-west of the Site.	2011
Natterer's bat	<i>Myotis nattereri</i>	EPS, WCA, S41	One record of Natterer's bat was returned, at Cinderford Linear Park KWS approximately 780m north west. There were no records of roosts.	2011
Noctule bat	<i>Nyctalus noctula</i>	EPS, WCA, S41	Three records of noctules bats were returned, none were of roosts. The closest of these records was of a high level of foraging/commuting activity approximately 740m south east.	2017
Serotine bat	<i>Eptesicus serotinus</i>	EPS, WCA, S41	One record of serotine bat was returned, at Cinderford Linear Park KWS approximately 780m north west. There were no records of roosts.	2011
Whiskered bat	<i>Myotis mystacinus</i>	EPS, WCA, S41	One record of whiskered bat was returned, at Cinderford Linear Park KWS approximately 780m north west. There were no records of roosts.	2011
Long-eared bat species	<i>Plecotus</i> spp.	EPS, WCA, S41	Two records of long-eared bats were returned, including a record of droppings in Forest High School,	2017

Species/Group	Scientific Name	Status ¹⁷	Summary of Records	Most Recent Record
			approximately 740m south-east of the Site.	
Unidentified bat species	<i>Chiroptera</i>	EPS, WCA, S41	Three records of unidentified bats were returned including two roosts. The closest of these records was of a roost located approximately 590m south east.	2014
Reptiles				
Adder	<i>Vipera berus</i>	WCA, S41	31 records of adder were returned, including adults and juveniles and a hibernation site.	2015
Common lizard	<i>Zootoca vivipara</i>	WCA, S41	38 records of common lizard were returned, including adults and juveniles and a breeding pair.	2017
Grass snake	<i>Natrix helvetica</i>	WCA, S41	11 records of grass snakes were returned, including adults and juveniles.	2017
Slow-worm	<i>Anguis fragilis</i>	WCA	14 records of grass snakes were returned, including adults and juveniles.	2017

3.2 Field Surveys

3.2.1 Dormouse Survey

Dormice or signs of dormice were encountered on a total of 16 occasions, within ten of the nest tubes during the course of the survey. This included two nests with live dormice inside: tubes 21b and 47.

Tube 21b contained one adult male dormouse in October. On two occasions, dormice were seen to run out of tube 47 and come to rest on adjacent branches when surveyors approached the tube. It was therefore decided not to take down and open tube 47 on these occasions, so as not to disturb the dormice further. In October, at least three individuals were observed running out of tube 47 and breeding is therefore considered confirmed on Site.

Due to the connecting habitats around the Site which would allow movement of dormouse, it is assumed that this species would be present in all suitable habitat within the Site, i.e. woodland, scrub and hedgerows.

Wood/yellow-necked mice or signs of wood/yellow-necked mice were encountered on eight occasions, within seven of the nest tubes during the survey. In November wood/yellow-necked mice had destroyed and occupied some of the nests previously built and occupied by dormice. In order to minimise any distress caused when these species were encountered, they were not handled. As such, it was not possible to determine whether they were wood mice or yellow-necked

mice, as a clear view of either the yellow/orange streak (wood mice), or the unbroken yellow band (yellow-necked mice) on their chest could not be obtained.

The results of the survey are shown on Figure 6 and detailed further, including photographs, in Appendix B.

3.2.2 Bat Surveys

3.2.2.1 Preliminary Roost Assessments

The previously identified PRFs on T1 and T2 were both inspected using an endoscope, and the extent of the PRFs were examined, with neither being particularly deep. No roosting bats were identified within the PRFs at the time of the endoscope inspection. Following the endoscope inspection, the initial assessments of BRP were considered accurate (i.e. T1 – low and T2 – moderate).

No buildings were located within the survey boundary, but thirteen buildings adjacent to the Site boundary were subject to external assessments for BRP. These comprised residential houses, garages, and site office/storage units.

One apparently disused garage/out-house building (B4) was assessed as having moderate/high BRP due to the gaps under the ridge, at the window frames, and in the windowpanes. One house was assessed as having moderate BRP due to hanging tiles and gaps at the flashing. Seven buildings were assessed as having low BRP and four buildings were assessed as having negligible BRP. At the time of these surveys, the project design was in preliminary stages, and the extent of the construction boundary and nature of construction activities was unknown. As such, no further surveys were conducted on the nine buildings assessed as having potential (Buildings 3, 4, 5, 6, 7, 10, 11, 12a and 12b).

The results of these assessments are given in greater detail, along with photographs, in Appendix B2, and shown on Figure 7.

3.2.2.2 Static Bat Activity Monitoring

The results of the static detector surveys are summarised in Table 5 below, which shows the total BAIs for all species at each location. The two monitoring locations are displayed in Figure 3 and described above in the methodology Section 2.2.2.

Table 5: BAIs (average bat passes (equivalent) per night) for all species

All Species	Location 1	Location 2
April	1.2	20.8
May	6.2	327.6
June	6	200
July	6.2	492.6
August	9.8	1460.8
September	9.2	56
October	2.2	11.6

Average	5.8	367.1
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Key:

High bat activity level
Moderate bat activity level
Low bat activity level

Significantly higher levels of activity were recorded at Location 2 along the western boundary of the Site, than at Location 1 along the eastern boundary, with Location 2 recording the maximum activity level of 1460.8 bat passes (equivalent) per night in August 2019.

Common pipistrelle were the most commonly recorded bat species across the monitoring period at Location 1. Noctule bats were the most commonly recorded bat species across the monitoring period at Location 2, followed by common pipistrelle. Relative to these species, all other species were recorded at a relatively low level. This included Annex II greater and lesser horseshoe bats (described in further detail below), Nathusius' pipistrelle (*Pipistrellus nathusii*), and soprano pipistrelle. Some calls could not be identified to species-level, including those of long-eared bats, *Myotis spp.*, and *Pipistrellus spp.*. The relative activity levels of each species recorded at each location across the months of monitoring are displayed in Chart 1 and Chart 2.

Chart 1: Relative activity levels of species recorded at Location 1

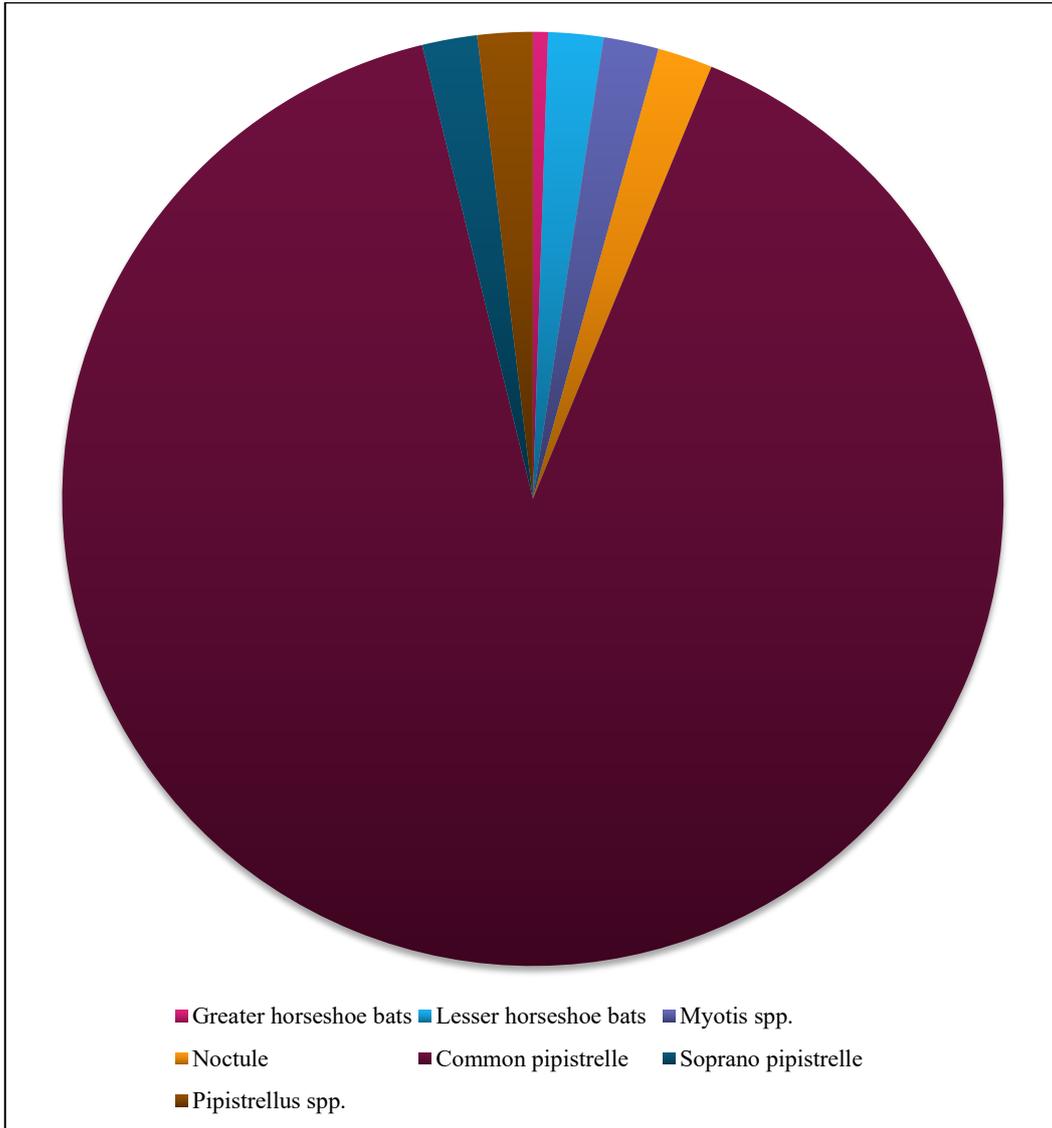
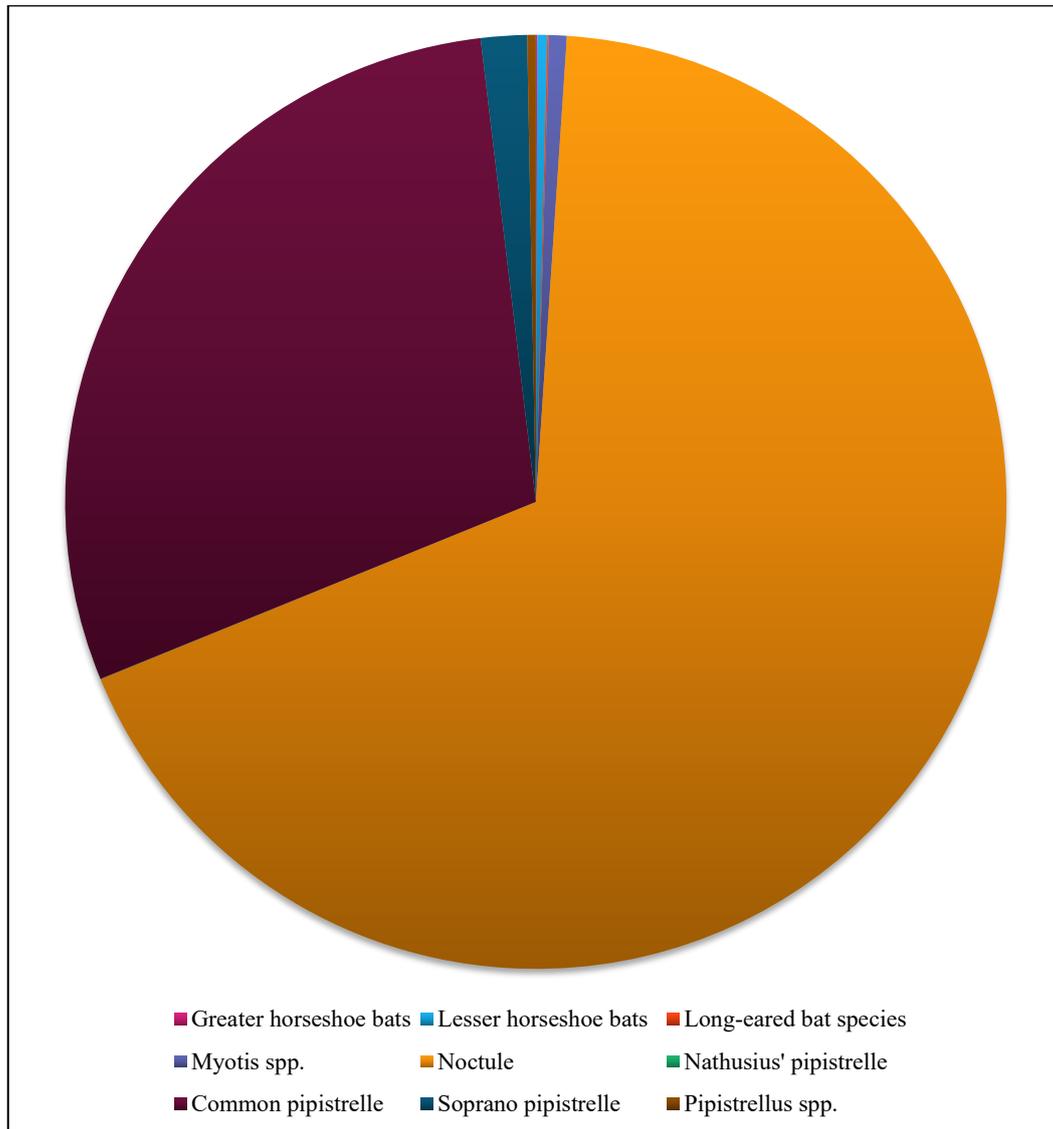


Chart 2: Relative activity levels of species recorded at Location 2



Greater horseshoe bats were recorded in May at Location 1 (single pass) and Location 2 (two passes), and in August at Location 2 (four passes). Lesser horseshoe bats were recorded in August (one pass), September (one pass) and October (two passes) at Location 1 and in May (6 passes), June (two passes) and August (36 passes) at Location 2. The relatively low level of activity and the times at which these passes were recorded generally indicate that these individuals were passing through the Site, as opposed to spending a prolonged period foraging around the Site, with the exception of the 36 passes of lesser horseshoe bat in August. It is possible that these individuals came from roosts for which the Wye Valley and Forest of Dean Bat Sites SAC and the Wye Valley Woodlands SAC are designated.

Six passes of barbastelles were recorded at Location 2 on the 29th May. As described within the methodology section, due to this being outside of the five-night monitoring window for that month, these passes have not been included within the BAI calculations, but have been noted here due to barbastelle being a rarer and more notable species.

An analysis of the earliest recordings of each species at each location in each month was undertaken to indicate how closely different species may be roosting to the Site. This analysis indicated that common pipistrelles, soprano pipistrelles and noctule bats may be roosting within 250m of the Site, whilst the roosts of other species (including Annex II species) are likely to be at least 500m from the Site.

3.2.3 Reptile Survey

Habitat Suitability Assessment

Habitat identified as suitable for reptiles within the Site included an approximately 0.3ha area of bracken to the north, and the long grassland margins around the edge of the amenity grassland sports field.

Presence/Likely Absence survey

Common lizard and/or slow-worm were recorded on all seven survey visits throughout the Site, and incidentally during other surveys at the Site. This included a breeding slow-worm pair under refugia 29 on the 16th May (shown on Photograph 13), and juveniles of both slow-worm and common lizard. The presence of breeding populations of both species are therefore confirmed on Site.

Common lizard were frequently recorded basking on top of the artificial refugia, and often ran away too quickly for identification of sex or life stage. On the 20th May, a common lizard was recorded basking on a wooden fence post in the car park to the south of the Site.

The peak counts of each species were 11 slow-worm on the 24th June, comprising 6 adult males, 3 adult females and 2 juveniles, and 7 common lizards on the 30th May. Figure 8 displays the species distribution and peak counts around the Site, and the results are detailed further, with some photographs provided, in Appendix B.

3.2.4 Badger Survey

No badger setts were recorded within the Site or within 30m of the Site boundary. Possible badger latrines, pathways and snuffle holes were recorded within and adjacent to the Site boundary, but it was difficult to establish whether these were badger, or other mammals such as wild boar (*Sus scrofa*), deer, or dogs (*Canis lupus familiaris*).

The habitats present on Site are considered to provide suitable habitat for badgers to use for both foraging and sett building. Locations of possible badger signs are shown on Figure 9 and some photographs are provided in Appendix B.

3.2.5 NVC and Invasive Species Survey

The NVC survey established that the target grassland in the north of the Site was in a state of transition from unimproved acid grassland, which is a Gloucestershire BAP habitat, to mesotrophic grassland. In terms of NVC, the vegetation can be

described as a transition from U1 *Festuca ovina* – *Agrostis capillaris* – *Rumex acetosella* grassland, to MG1 *Arrhenatherum elatius* grassland. The bracken area is best described as a very species-poor example of U20 *Pteridium aquilinum* – *Galium saxatile* community.

The invasive species survey identified only two Schedule 9 invasive species, as follows:

- Himalayan cotoneaster (*Cotoneaster simonsii*) growing in the shade of large willow trees to the north-east of the car-park.
- Entire-leaved cotoneaster (*Cotoneaster integrifolius*), not rooted within the study area but growing over the boundary wall from an adjacent garden.

Several other species were observed during the survey that have likely established from garden waste tipping, discarded refuse, or self-seeded from nearby gardens, mainly near to the roads at the northern and western boundary. These included horseradish, gooseberry, red currant, apple, butterfly bush, rose of Sharon and daffodil. However, these are not considered to be a significant threat to the wild flora in this location.

The results of this survey are described in further detail within the survey report in Appendix C.

4 Conclusions and Recommendations

4.1 Survey Conclusions

The surveys carried out at the Site between April and November 2019 have confirmed the presence of breeding dormice, foraging/commuting bats, breeding slow-worm and common lizard, and foraging/commuting badgers within and/or adjacent to the Site.

The surveys also identified suitability within and adjacent to the Site for badger setts and roosting bats.

4.2 Mitigation Recommendations

As described within Section 1.1, the mitigation measures given below are broad recommendations for inclusion within the design and construction methodology, which should be re-assessed for their appropriateness and added to as the project design progresses.

4.2.1 Dormice

A dormouse EPS mitigation licence will need to be obtained from NE for any clearance of hedgerows, trees, woodland or scrub within the Site, including any clearance that may be required for ground investigation works.

All vegetation clearance and earthworks should be conducted following Method Statements, in line with any licences obtained, to avoid harm to animals, including habitat manipulation methods and staged vegetation clearance. For dormice, this may be including cutting vegetation to stump level over winter when dormice are hibernating, followed by a finger-tip search for dormouse hibernation nests, with stump removal taking place in April when dormice are once again active. If dormouse habitat is to be lost due to the works, then replacement habitat (either like-for-like or enhanced) is likely to be required.

Toolbox talks and ecological watching briefs by an Ecological Clerk of Works (ECoW) should be conducted to move any remaining animals, if found, into safe areas.

Night-time construction and operational lighting should be avoided where possible. If it cannot be avoided, lighting should be directed away from dormouse habitats and designed to reduce light spill.

4.2.2 Bats

Due to the presence of greater and lesser horseshoe bat, a Habitats Regulations Assessment will be required to allow the Competent Authority to grant planning consent within the requirements of the Habitat Regulations. A statement to Inform an Appropriate Assessment will need to be included within any planning application for the proposed development, to assess the implications of the project

on the designated interest features of the Wye Valley & Forest of Dean Bat Sites SAC and the Wye Valley Woodlands SAC.

If there are any works required within 30m or piling located within 60m of the tree identified as having moderate suitability for roosting bats (T2), or if it requires removal or pruning as part of the proposed works, further surveys should be conducted to confirm the presence/likely absence of roosting bats. If T2 is confirmed as a bat roost, a bat mitigation licence should be obtained from NE and any removal/pruning or activities that could cause disturbance should be conducted in line with the requirements of this licence.

No further surveys are required for the tree identified as having low suitability for roosting bats (T1), however, if this tree requires removal or pruning as part of the proposed works, this should be carried out under the supervision of a bat-licensed ecologist.

Based on the preliminary project design, it is considered unlikely that any of the nine buildings (Buildings 3, 4, 5, 6, 7, 10, 11, 12a and 12b) assessed as having bat roosting potential would be subject to disturbance impacts (including the blocking of bat access routes to foraging habitats). This is due to the presence of the Forest of Dean to the north and east, and the substantial buffer proposed between the hospital development and the forest edge.

However, if there are any works required within 30m or piling located within 60m of these buildings, further surveys should be conducted to confirm the presence/likely absence of roosting bats. If any of these buildings are confirmed as bat roosts, a bat mitigation licence should be obtained from NE and any activities that could disturb should be conducted in line with the requirements of this licence.

Due to the high level of bat activity recorded, particularly along the western boundary of the site, habitat connectivity should be retained for as long as possible in the works programme. Dead hedges¹⁸ could be used to allow bats to continue using key commuting routes to maintain connectivity to adjacent foraging habitats. An appropriate buffer should be maintained between any dead hedges and construction activities, with limits to lighting in these areas, in order to minimise disturbance impacts to commuting and foraging bats.

Night-time construction and operational lighting should be avoided where possible. If it cannot be avoided, lighting should be directed away from bat foraging and commuting habitats and designed to ensure no light spill over 0.5 Lux.

¹⁸ When a scheme involves the temporary removal of edge habitat such as woodland edges, hedgerows or tree lines, temporary structures 'dead hedges', can be used to provide connectivity and allow protected species, such as dormice and bats, to continue along severed habitat and flight paths for bats during construction. Such dead hedges for dormice and bats use brash from cut and cleared vegetation piled in a line in a similar shape and function as a hedgerow. For bats only dead hedges may comprise a line of Heras fencing panels or similar with hessian stretched across them to provide a solid structure along which bats can commute. Such structures are only suitable to maintain connectivity for bats over relatively short distances. The structures can be moved during the day to accommodate construction activities, and then put back before dusk so that the mitigation is effective between dusk and dawn every night.

4.2.3 Reptiles

The areas that have been confirmed as supporting reptiles (i.e. the long grass margins around the recreational field, and the bracken and grassland area to the north), as well as the habitat which links these populations, should be retained wherever possible in any future development planning. This would avoid the need for a detailed mitigation and translocation proposal (and the associated cost and programme implications) and is therefore strongly recommended.

Where avoidance is not considered to be possible, mitigation for reptiles would involve a period of translocation in advance of development, which aims to translocate as many individuals as possible to a safe receptor site within the local area. The receptor site should be a location where suitable reptile habitat is being retained but should first be enhanced for reptiles to increase its carrying capacity (the number of reptiles that the habitat is able to support).

All vegetation clearance and earthworks should be conducted following site specific Method Statements produced by ecologists to avoid harm to animals, including habitat manipulation methods and staged vegetation clearance. Toolbox talks and ecological watching briefs by an ECoW should be conducted to move any remaining animals, if found, into safe areas.

4.2.4 Badgers

Due to the suitability of the Site for badger sett creation, pre-construction surveys for badger should be conducted within three months of the commencement of the proposed works. If any setts are identified within 30m of the proposed works or within 60m of any piling, a licence to disturb badgers setts for development purposes should be obtained from NE, with Site clearance being conducted in line with the requirements of this licence.

Night-time construction and operational lighting should be avoided where possible. If it cannot be avoided, lighting should be directed away from badger foraging and commuting habitats and designed to reduce light spill.

Any holes/excavations created during the construction period which badgers, or other mammals could fall into must be covered at night or a ramp provided for escape.

4.2.5 Invasive Plant Species

Pre-construction surveys should be conducted within the Site boundary for invasive species. Only two invasive species were identified within the car park to the south of the Site, although it is feasible that others may be introduced prior to development due to apparent ongoing tipping of garden-waste at various locations along the track next to the northern boundary.

Where possible, any invasive species within/adjacent to the Site should be fenced off, with construction activities maintaining an appropriate buffer distance. Where this is not possible, an Invasive Species Management Plan should be produced and adhered to, to ensure their safe removal.

4.2.6 General

It will be necessary to include provisions within any design for the hospital for the compensation of existing habitat which will be lost. The project should cause no-net-loss of habitat and should ideally obtain a net-gain.

As described above, any vegetation clearance will need to be conducted in line with the requirements of any licences obtained/agreed method statements and should include habitat manipulation methods and staged vegetation clearance, along with toolbox talks and ecological watching briefs to avoid harm to target species. These methods are also suitable to avoid impacts to other species that may be present, such as hedgehog (*Erinaceus europaeus*).

As described within the PEA for the project, the Site has been confirmed as suitable for breeding birds and is likely to support a typical range of species during the breeding season. Given the relative abundance of the Schedule 1 species goshawk within the Forest of Dean, and the potential for other Schedule 1 species such as crossbill, a pre-works check of the site and within a 500m buffer of the adjacent forest is recommended to ensure no disturbance to rare breeding species. In addition, the following mitigation is proposed:

Construction works that involve vegetation clearance within the breeding bird season (March to August inclusive) should be avoided. In practice, this would mean clearing scrub, tall grassland and any trees that may be removed as part of the development outside of this period. Should vegetation clearance occur during the breeding bird season, a pre-works check by an ECoW should be undertaken to look for bird nests. Should an active nest be found, a suitable exclusion zone of at least 5m should be set up and no works can occur in that area until the chicks have fledged and the nest is no longer in use.

4.3 Enhancement Recommendations

Potential ecological enhancements to the Site could include the following, and should be discussed amongst the project design team as the work progresses:

- Safe removal and eradication of Schedule 9 invasive species from the car park/retained areas;
- Provision of bird and bat boxes on retained trees;
- Creation of log piles/areas of brash to enhance the hibernacula habitat for reptiles and amphibians;
- Installation of insect hotels to enhance habitat for invertebrates, including pollinators, within the Site;
- Creation of a pond to enhance the biodiversity of the Site;
- Creation of a green roof or living wall to increase foraging habitat for pollinators, and reduce the impact of the urban heat island effect;
- Management to reduce the dominance of bracken and coarse grasses within the unimproved acid grassland habitat to the north;
- Management to reduce the depth of the dead bracken litter in the bracken area;

- Inclusion of native, locally sourced and appropriate plants in any landscaping proposals; and
- Inclusion of a footpath with interpretation boards for the education of hospital patients, visitors and staff on the ecological value of the Site, whilst also providing a benefit to wellbeing of hospital patients.

The report has been written as the result of survey efforts undertaken between April and November 2019. This report refers within the limitations stated, to the condition or proposed development of the Site at the time of inspections. Changes in legislation, guidance, best practice, etc. may necessitate a re-assessment/re-survey. It is also advised that if there is a delay of over two years in undertaking the proposed works, update surveys may be required. No warranty is given as to the possibility of future changes in the condition of the Site.

This report is produced solely for the benefit of Gleeds and no liability is accepted for any reliance placed on it by any other party. This report is prepared for the proposed uses stated in the report and should not be used in a different context.

Figures

Figure 1 Site boundary and Phase 1 map

Figure 2 Dormouse survey tube locations

Figure 3 Static bat activity monitoring locations

Figure 4 Location of reptile refugia

Figure 5 Bat SACs within 30km of the Site boundary

Figure 6 Dormouse survey results

Figure 7 Bat Roosting Potential (BRP) – external assessments

Figure 8 Reptile survey results

Figure 9 Locations of badger signs



Legend

- Site boundary
- Target note
- + Dense scrub (A2.1)
- x Scattered scrub (A2.2)
- Scattered broadleaved trees (A3.1)
- ◐ Scattered mixed trees (A3.3)
- Scattered broadleaved tree line (A3.1)
- Running water (G2)
- Introduced shrub (J1.4)
- Fence (J2.4)
- Semi-natural broadleaved woodland (A1.1.1)
- Coniferous plantation woodland (A1.2.2)
- Semi-natural mixed woodland (A1.3.1)
- Dense/continuous scrub (A2.1)
- Scattered broad-leaved trees (A3.1)
- Semi-improved neutral grassland (B2.2)
- Improved grassland (B4)
- Continuous bracken (C1.1)
- Tall ruderal (C3.1)
- Amenity grassland (J1.2)
- Gravel and concrete (J5)
- Tarmac (J6)

F1	2020-07-12	EA	PW	PC
Issue	Date	By	Chkd	Appd



ARUP

Client

Gleeds

Job Title

Forest of Dean Community Hospital

Site boundary and Phase 1 map

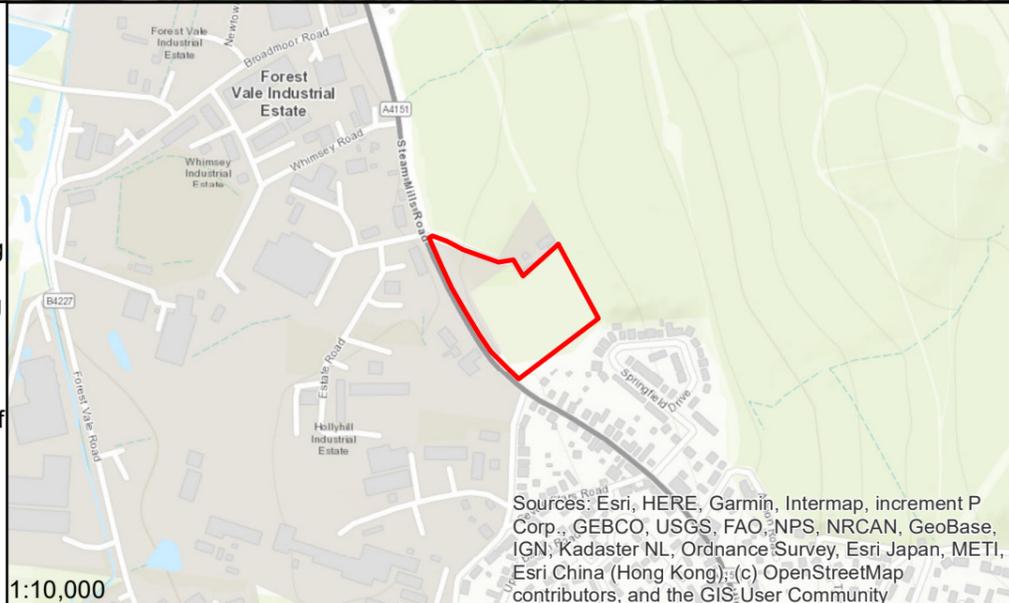
Scale at A3

1:1,200

Job No 266394-30	Drawing Status For Issue
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Drawing No 001	Issue F1
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- Target Notes**
- TN1: Patch of buddleia with willow
 - TN2: Frequent mounds within grassland - possibly ant hills
 - TN3: Embankment around skate park with improved grassland and patches of bare ground
 - TN4: Tall ruderal on steep embankment
 - TN5: Multiple areas of boar damage within field
 - TN6: Skate park
 - TN7: Car park
 - TN8: English oak with crack on southern side at head height. Unable to tell if the crack leads anywhere. Low bat roosting suitability
 - TN9: English oak covered with ivy. Crack at waist height on eastern side, which continues up. Moderate bat roosting suitability
 - TN10: Reptile potential within this area of bracken/tall ruderal
 - TN11: Multiple pathways throughout area of bracken (possibly boar)
 - TN12: Mammal path (possibly boar) which continues north through bracken. Boar damage present within field to east of mammal path
 - TN13: Possible boar droppings
 - TN14: Multiple areas of boar damage within woodland
 - TN15: Multiple areas of boar damage within woodland
 - TN16: Possible deer droppings
 - TN17: Area of mole hills



1:10,000

Sources: Esri, HERE, Garmin, Intermap, increment P Corp., GEBCO, USGS, FAO, NPS, NRCAN, GeoBase, IGN, Kadaster NL, Ordnance Survey, Esri Japan, METI, Esri China (Hong Kong), (c) OpenStreetMap contributors, and the GIS User Community

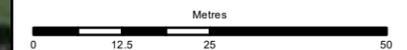


Legend

- Site boundary
- Dormouse tube locations

F1	2020-07-12	EA	PW	PC
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Issue	Date	By	Chkd	Appd



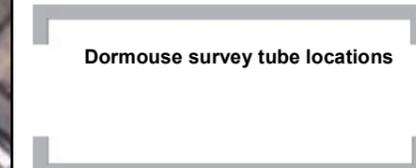
ARUP

Client

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Job Title

Forest of Dean Community Hospital



Scale at A3

1:1,000

Job No	Drawing Status
266394-30	For Issue

Drawing No	Issue
002	F1

Source: Esri, DigitalGlobe, GeoEye, Earthstar Geographics, CNES/Airbus DS, USDA, USGS, AeroGRID, IGN, and the GIS User Community

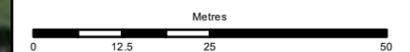


Legend

- Site boundary
- Bat static monitoring locations

F1	2020-07-12	EA	PW	PC
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Issue	Date	By	Chkd	Appd



ARUP

Client

Gleeds

Job Title

Forest of Dean Community Hospital

**Static bat activity
monitoring locations**

Scale at A3

1:1,000

Job No	Drawing Status
266394-30	For Issue

Drawing No	Issue
003	F1

Source: Esri, DigitalGlobe, GeoEye, Earthstar Geographics, CNES/Airbus DS, USDA, USGS, AeroGRID, IGN, and the GIS User Community

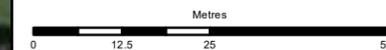


Legend

- Site boundary
- Artificial reptile refugia

F1	2020-07-12	EA	PW	PC
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Issue	Date	By	Chkd	Appd
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ARUP

Client

Gleeds

Job Title

Forest of Dean Community Hospital

**Reptile survey
artificial refugia locations**

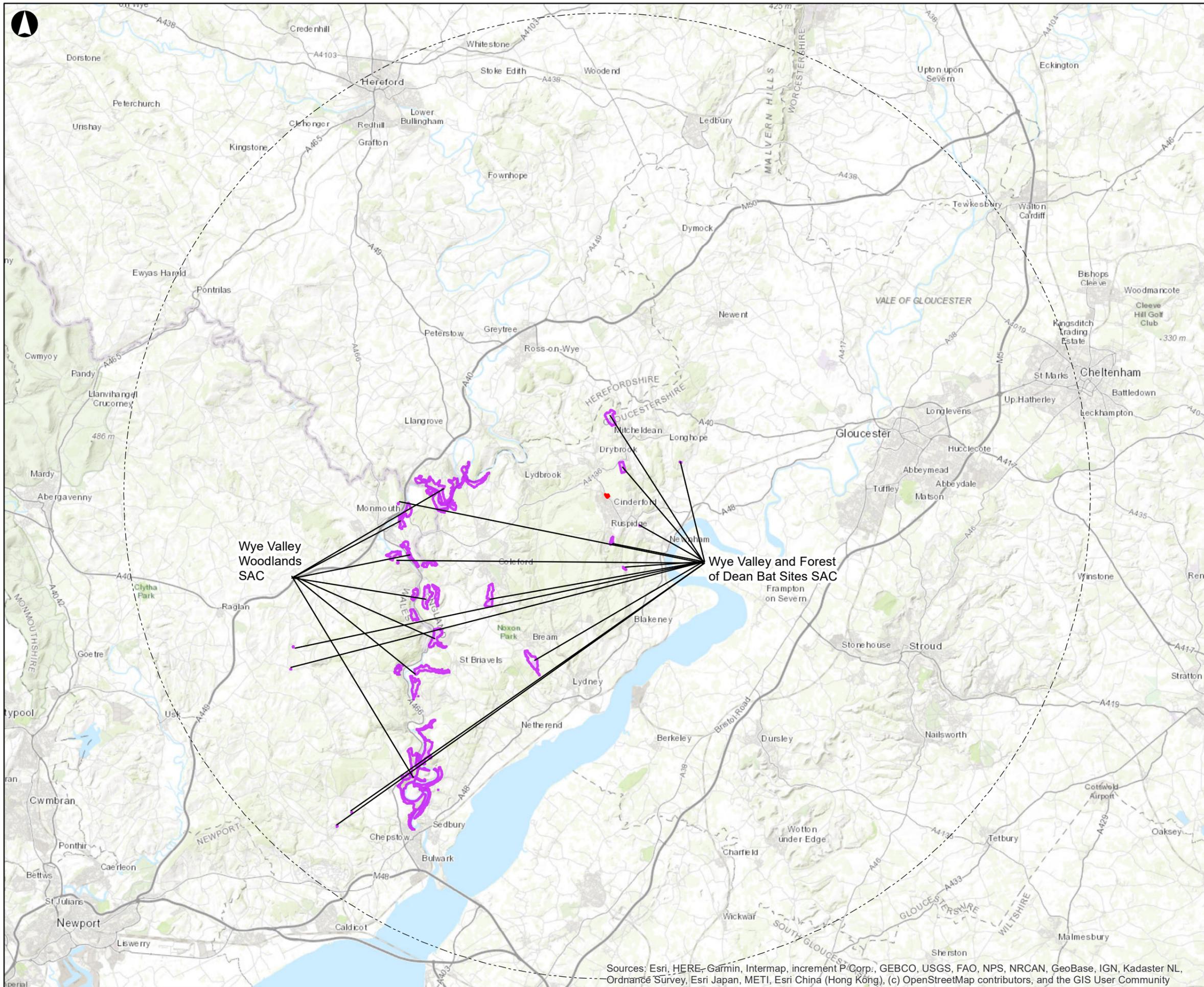
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Job No 266394-30	Drawing Status For Issue
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Drawing No 004	Issue F1
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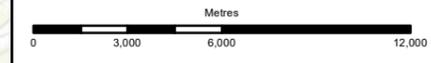
Source: Esri, DigitalGlobe, GeoEye, Earthstar Geographics, CNES/Airbus DS, USDA, USGS, AeroGRID, IGN, and the GIS User Community



Legend

- Site boundary
- 30km buffer
- Bat Special Areas of Conservation (SACs)

F1	2020-07-12	EA	PW	PC
Issue	Date	By	Chkd	Appd



ARUP

Client
Gleeds

Job Title
Forest of Dean Community Hospital

Bat Special Areas of Conservation (SACs) within 30km

Scale at A3
1:225,000

Job No 266394-30	Drawing Status For Issue
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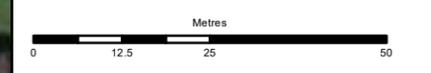
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Sources: Esri, HERE, Garmin, Intermap, increment P Corp., GEBCO, USGS, FAO, NPS, NRCAN, GeoBase, IGN, Kadaster NL, Ordnance Survey, Esri Japan, METI, Esri China (Hong Kong), (c) OpenStreetMap contributors, and the GIS User Community



- Legend**
- Site boundary
 - Dormouse nest
 - Dormouse nest taken over by wood mouse
 - Wood mouse nest

F1	2020-07-12	EA	PW	PC
Issue	Date	By	Chkd	Appd



ARUP

Client
Gleeds

Job Title
Forest of Dean Community Hospital

Dormouse survey results

Scale at A3
1:1,000

Job No 266394-30	Drawing Status For Issue
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Drawing No 006	Issue F1
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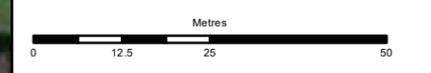
Source: Esri, DigitalGlobe, GeoEye, Earthstar Geographics, CNES/Airbus DS, USDA, USGS, AeroGRID, IGN, and the GIS User Community



Legend

- Site boundary
- Bat Roosting Potential**
- Low (Tree)
- Moderate (Tree)
- Low (Building)
- Moderate (Building)
- Moderate/High (Building)
- Negligible (Building)

F1	2020-07-12	EA	PW	PC
Issue	Date	By	Chkd	Appd



ARUP

Client
Gleeds

Job Title
Forest of Dean Community Hospital

Bat Roosting Potential (BRP) - external assessments

Scale at A3
1:1,000

Job No 266394-30	Drawing Status For Issue
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Drawing No 007	Issue F1
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Source: Esri, DigitalGlobe, GeoEye, Earthstar Geographics, CNES/Airbus DS, USDA, USGS, AeroGRID, IGN, and the GIS User Community

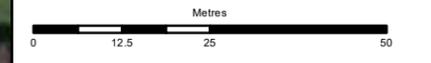


- Legend**
- Site boundary
 - Common lizard and slow-worm
 - Common lizard
 - Slow-worm

Peak counts of each species under each refugia

2	- 1 common lizard
3	- 1 male slow-worm, 2 common lizards (1 female, possibly pregnant)
6	- 1 common lizard
7	- 1 male slow-worm, 1 common lizard
8	- 1 juvenile slow-worm
10	- 1 juvenile slow-worm
11	- 1 female slow-worm
16	- 2 male slow-worms
19	- 1 female slow-worm
20	- 1 slow-worm, 1 common lizard
21	- 1 male slow-worm, 1 common lizard
23	- 1 common lizard
24	- 3 slow-worms, 3 juvenile common lizards
26	- 3 slow-worms (1 female, 2 juveniles), 1 juvenile common lizard
28	- 1 female slow-worm, 1 common lizard
29	- 2 female slow-worms, 2 common lizards
30	- 1 male slow-worm
34	- 1 common lizard

F1	2020-07-12	EA	PW	PC
Issue	Date	By	Chkd	Appd



ARUP

Client
Gleeds

Job Title
Forest of Dean Community Hospital

Reptile survey results

Scale at A3
1:1,000

Job No 266394-30	Drawing Status For Issue
Drawing No 008	Issue F1

Source: Esri, DigitalGlobe, GeoEye, Earthstar Geographics, CNES/Airbus DS, USDA, USGS, AeroGRID, IGN, and the GIS User Community

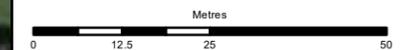


Legend

- Site boundary
- Injured badger
- Latrine
- Mammal pathway
- Snuffle holes

F1	2020-07-12	EA	PW	PC
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Issue	Date	By	Chkd	Appd



ARUP

Client

Gleeds

Job Title

Forest of Dean Community Hospital



Location of badger signs

Scale at A3

1:1,000

Job No	Drawing Status
266394-30	For Issue

Drawing No	Issue
009	F1

Source: Esri, DigitalGlobe, GeoEye, Earthstar Geographics, CNES/Airbus DS, USDA, USGS, AeroGRID, IGN, and the GIS User Community

Appendix A

Weather Conditions

A1 Weather Conditions

Table 6: Weather conditions during dormouse, bat and reptile surveys

Date	Survey Type and Visit Number	Temp. (°C)	Wind Speed (Beaufort Scale) and Direction	Cloud Cover (%)	Conditions
24/04/2019	Reptile refugia and bat static detector deployment	11	2 SW	100	Dry
30/04/2019	Bat static detector collection	N/A			
07/05/2019	Reptile survey visit 1	13	1 SE	90	Sunny
10/05/2019	Reptile survey visit 2	14	1 N	75	Sunny
16/05/2019	Reptile survey visit 3, bat external assessments and dormouse tube deployment	13	2 E	5	Sunny
20/05/2019	Reptile survey visit 4	13	1 E	75	Sunny
24/05/2019	Reptile survey visit 5, badger survey and bat static detector deployment	18	1 N	10	Sunny
30/05/2019	Reptile survey visit 6 and bat static detector collection	18	2 SW	75	Dry, slightly overcast
24/06/2019	Reptile survey visit 7, bat static detector deployment and dormouse survey visit 1	18	1 SE	100	Dry
01/07/2019	Tree 13 bat inspection, bat static detector collection and	16	2 E	95	Dry
18/07/2019	Dormouse survey visit 2 and bat static detector deployment	19	2 NW	25	Sunny
24/07/2019	Bat static detector collection	20	1 N	70	Sunny
23/08/2019	Dormouse survey visit 3 and bat static detector deployment	18	2 S	60	Sunny
04/09/2019	Bat static detector collection	17	4 W	50	Sunny
17/09/2019	Dormouse survey visit 4 and bat static detector deployment	13	2 N	0	Sunny
23/09/2019	Bat static detector collection	N/A			
15/10/2019	Dormouse survey visit 5 and bat static detector deployment	12	1 SE	100	Dry
28/10/2019	Bat static detector collection	7	2 NE	50	Sunny
15/11/2019	Dormouse survey visit 6	5	3 N	100	Dry

Appendix B

Detailed Survey Results and Photographs

B1 Dormouse Nest Tube Survey Results

Table 7: Results of nest tube surveys undertaken in 2019. Tubes not listed were found to be empty.

Month	Date	Visit	Tube No.	Results		
				Species	Comments	Photographs
May	16/05/2019	Deployment				
Jun	24/06/2019	1	All empty			
Jul	18/07/2019	2	All empty			
Aug	23/08/2019	3	47	Dormouse	Unoccupied nest – bark strips and green leaves, woven structure, cavity in centre	
			12	Wood/yellow-necked mouse	Nest and food cache	

Month	Date	Visit	Tube No.	Results		Photographs
				Species	Comments	
			19	Wood/yellow-necked mouse	Droppings – likely wood/yellow-necked mouse	
Sep	17/09/2019	4	5	Dormouse	Nest with cavity, lots of freshly cut green leaves	
			47	Dormouse	Live dormouse seen running out of tube on approach. Came to rest on tree that tube was attached to so decided not to open the tube so as not to disturb it further.	-

Month	Date	Visit	Tube No.	Results		Photographs
				Species	Comments	
			50	Dormouse	Structured nest with green fresh cut leaves.	
			3b	Wood/yellow-necked mouse	Food cache	
Oct	15/10/2019	5	14	Dormouse	Empty nest – very waterlogged	

Month	Date	Visit	Tube No.	Results		Photographs
				Species	Comments	
			15b	Dormouse	Beginnings of nest	
			21b	Dormouse	One adult male in nest	
			36b	Wood/yellow-necked mouse	Empty nest. Clean, dry and no odour but no woven structure or fresh green leaves.	

Month	Date	Visit	Tube No.	Results		Photographs
				Species	Comments	
			45	Dormouse	Empty nest	
			47	Dormouse	Live dormice seen running out of tube on approach. At least three individuals observed.	-
			49	Dormouse	Empty nest	
			22	Wood/yellow-necked mouse	Empty nest	-
Nov	15/11/2019	6	7	Dormouse	Possible incomplete dormouse nest but shelf had fallen out.	

Month	Date	Visit	Tube No.	Results		Photographs
				Species	Comments	
			14	Dormouse	Probable dormouse nest. Nest of bracken with moss. Some structure to it.	
			29	Dormouse	Unoccupied nest	
			45	Dormouse	Unoccupied nest	

Month	Date	Visit	Tube No.	Results		Photographs
				Species	Comments	
			47	Dormouse	Unoccupied nest	
			49	Dormouse	Unoccupied nest	
			36b	Wood/yellow-necked mouse	Unoccupied nest, no woven structure or fresh green leaves.	

Month	Date	Visit	Tube No.	Results		
				Species	Comments	Photographs
			15b	Wood/yellow-necked mouse	Occupied nest	-
			21b	Wood/yellow-necked mouse	Occupied nest (three wood/yellow-necked mice)	-

B2 Bat Survey Results

B2.1 Bat Roosting Potential Results

Table 8: Bat roosting potential of trees

Ref.	NGR	Date surveyed	Species	Age	PRF	Signs of bat-use	Comments	BRP
T1	SO 65210 14806	30/01/2019 and 01/07/2019	Oak	Mature	Crack	None	Crack on southern side at approx. 1.7m height	Low
T2	SO 65343 14931	30/01/2019 and 01/07/2019	Oak	Mature	Hole	None	Hole on eastern side at approx. 1.5m height continuing up. Above hole was covered in ivy.	Moderate

Table 9: Bat roosting potential of buildings

Ref.	NGR	Date surveyed	Type	Age (approx. yrs)	Height of eaves (m)	Pitch height (m)	Roof aspect	Roof complexion	Roof covering	PRFs	Signs of bat-use	Comments	BRP
1	SO 65365 14836	16/05/2019	House	<5 (new build)	4	8	N-S	Single ridge	Slates	None	None	Well-sealed new build. Same as adjacent building.	Negligible
2	SO 65381 14837	16/05/2019	House	60	2.5	6	N-S	Single ridge	Tiles	None	None	-	Negligible
3	SO 65359 14826	16/05/2019	House	30	2	3	NE-SW	Main section with extensions	Tiles	Gaps behind fascias;	None	Bungalow	Low

Ref.	NGR	Date surveyed	Type	Age (approx. yrs)	Height of eaves (m)	Pitch height (m)	Roof aspect	Roof complexion	Roof covering	PRFs	Signs of bat-use	Comments	BRP
4	SO 65284 14785	16/05/2019	House	90	2	3.5	NE-SW	Single ridge	Corrugated Sheets	Gaps behind fascias;	None	Appears unused. Gaps under ridge, at window frames and in window pane.	Moderate/High
5	SO 65270 14771	16/05/2019	House	50	8	10	NE-SW	Main section with extensions	Tiles	Gaps at flashing; Hanging tiles;	None	-	Moderate
6	SO 65296 14782	16/05/2019	Garage	50	2	2.5	NE-SW	Single ridge	Slates	Loose Tiles/slates; Gaps behind fascias;	None	-	Low
7	SO 65305 14782	16/05/2019	Garage	50	2	2.5	NE-SW	Single ridge	Slates	Loose Tiles/slates; Gaps behind fascias;	None	-	Low
8	SO 65346 14793	16/05/2019	House	20	2	4	NE-SW	Complex	Tiles	None	None	-	Negligible
9	SO 65348 14814	16/05/2019	House	30	2	4	NW-SE	Single ridge	Tiles	None	None	Appears well-sealed.	Negligible

Ref.	NGR	Date surveyed	Type	Age (approx. yrs)	Height of eaves (m)	Pitch height (m)	Roof aspect	Roof complexion	Roof covering	PRFs	Signs of bat-use	Comments	BRP
10	SO 65244 14932	16/05/2019	House	80	4.5	6	N-S	Single ridge	Slates	Loose tiles/slates; Gaps at flashing;	None	Roof looks new. Loose tiles above porch. Associated shipping containers all negligible.	Low
11	SO 65273 14971	16/05/2019	House	80	3.5	5	NW-SE	Single ridge	Slates	Gaps in fascias,	None	-	Low
12a	SO 65252 14956	16/05/2019	Garage	N/A	2	N/A	N/A	Flat	Corrugated sheet	Gaps	None	Gaps where wall meets corrugated sheet roof	Low
12b	SO 65244 14951	16/05/2019	Garage	N/A	2	N/A	N/A	Flat	Corrugated sheet	Gaps	None	Gaps where wall meets corrugated sheet roof	Low

B2.1.1 Bat Survey Photographs



Photograph 1: T1 PRF (crack)



Photograph 2: T2 PRF (hole)



Photograph 3: Building Ref. 1



Photograph 4: Building Ref. 2



Photograph 5: Building Ref. 4



Photograph 6: Building Ref. 5



Photograph 7: Building Ref. 5



Photograph 8: Building Ref. 6



Photograph 9: Building Ref. 7



Photograph 10: Building Ref. 8



Photograph 11: Building Ref. 10



Photograph 12: Building Ref. 11

B2.2 Static Bat Activity Monitoring Survey Results

Table 10: BAIs for greater horseshoe bats

Month	Location 1	Location 2
April	0	0
May	0.2	0.4
June	0	0
July	0	0
August	0	0.8
September	0	0
October	0	0
Average	0.03	0.17

Table 11: BAIs for lesser horseshoe bats

Month	Location 1	Location 2
April	0	0
May	0	1.2
June	0	0.4
July	0	0
August	0.2	7.2
September	0.2	0
October	0.4	0
Average	0.11	1.26

Table 12: BAIs for long-eared bat species

Month	Location 1	Location 2
April	0	0
May	0	0
June	0	0.2
July	0	0
August	0	1
September	0	0.2
October	0	0
Average	0	0.2

Table 13: BAIs for Myotis bat species

Month	Location 1	Location 2
April	0	0
May	0	0

June	0	0
July	0.4	0.2
August	0.2	15.4
September	0.2	0
October	0	0
Average	0.11	2.23

Table 14: BAIs for noctule bats

Month	Location 1	Location 2
April	0	18.8
May	0.4	273.8
June	0	154.2
July	0.2	413.4
August	0	843.6
September	0	34.8
October	0.2	2.2
Average	0.11	248.69

Table 15: BAIs for Nathusius' pipistrelles

Month	Location 1	Location 2
April	0	0
May	0	0
June	0	0
July	0	0
August	0	0.2
September	0	0
October	0	0
Average	0	0.03

Table 16: BAIs for common pipistrelles

Month	Location 1	Location 2
April	1.2	2
May	5.2	47.6
June	6	45
July	5.4	74
August	9	554.4
September	8.2	20.8
October	1.6	9.4
Average	5.23	107.6

Table 17: BAIs for soprano pipistrelles

Month	Location 1	Location 2
April	0	0
May	0	2.2
June	0	0
July	0.2	0.8
August	0.2	37.4
September	0.4	0.2
October	0	0
Average	0.11	5.8

Table 18: BAIs for pipistrelle bat species

Month	Location 1	Location 2
April	0	0
May	0.4	2.4
June	0	0.2
July	0	4.2
August	0.2	0.8
September	0.2	0
October	0	0
Average	0.11	1.09

B3 Reptile Survey Results

Table 19: Results of the reptile refugia survey undertaken in 2019, including incidental records

Survey No.	Date	Species	Sex/Life Stage	Number
1	07/05/2019	Slow-worm	Adult, male	2
		Common lizard	Adult	1
2	10/05/2019	Common lizard	Unknown	3
		Common lizard	Adult, female (possibly pregnant)	1
3	16/05/2019	Common lizard	Unknown	5
		Slow-worm	Sub-adult	1
		Slow-worm	Adult, male (breeding)	1
		Slow-worm	Adult, female (breeding)	1
4	20/05/2019	Common lizard	Unknown	6
		Slow-worm	Adult, male	3
		Common frog	Unknown	1
5	24/05/2019	Common lizard	Unknown	4
		Slow-worm	Adult, female	1
6	30/05/2019	Common lizard	Unknown	7
		Slow-worm	Adult, female	4
		Slow-worm	Sub-adult	1
		Slow-worm	Adult, male	2
		Common toad	Unknown	1
7	24/06/2019	Slow-worm	Adult, male	6
		Slow-worm	Adult, female	3
		Slow-worm	Juvenile	2
		Common lizard	Unknown	1
Incidental Records				
N/A	01/07/2019	Common lizard	Unknown	1
		Slow-worm	Juvenile	3
		Slow-worm	Adult female	1
		Slow-worm	Adult male	1
	18/07/2019	Common lizard	Unknown	1
		Slow-worm	Adult male	1
	23/08/2019	Slow-worm	Adult female	1
		Slow-worm	Juvenile	2
	17/09/2019	Common lizard	Juvenile	4

B3.1 Reptile Survey Photographs



Photograph 13 Breeding slow-worm under refugia 29 on the 16th May



Photograph 14 Common lizard on refugia 36 on the 20th May



Photograph 15 Common lizard at refugia 34 on the 24th May



Photograph 16 Female slow-worm under refugia 19 on the 30th May



Photograph 17 Adult female (lost tail) and juvenile slow-worm under refugia 24 on 1st July



Photograph 18 Adult male slow-worm under refugia 26 on 1st July

B4 Badger Survey Photographs



Photograph 19 Badger or wild boar latrine



Photograph 20 Mammal pathway along western boundary



Photograph 21 Badger or wild boar snuffle hole



Photograph 22 Badger or wild boar snuffle hole

Appendix C

Sturgess Ecology (2019)
Vegetation and Invasive Plant
Survey Report

Ove Arup and Partners

Land at Steam Mills Road, Cinderford, Forest of Dean

Vegetation and invasive plant survey



May 2019

Contents

1. Introduction.....	1
2. Survey method.....	2
3. Survey findings.....	3
4. Discussion.....	10
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6. References	11
Appendix 1. Plant species list	12
Appendix 2. Incidental fungi and fauna observations	16

Document reference: C252/D1/V1

Cover photographs: Left: grassland with anthills; Right: Himalayan Cotoneaster.

This document has been produced for Ove Arup and Partners by:

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Web: www.sturgess-ecology.co.uk

1. Introduction

Ove Arup and Partners have commissioned Sturgess Ecology to undertake a survey of vegetation and invasive species on land at Steam Mills Road, Cinderford (grid reference SO651149). The site is proposed for possible development as a community hospital and this study is being carried out as part of a range of ecological surveys which are being undertaken.

The key objectives for the study were as follows:

- To undertake a National Vegetation Classification (NVC) survey of an area identified as semi-improved neutral grassland in the north of the proposed site.
- To carry out a search for non-native invasive species across the whole site.

The study area boundary is shown by a red line on an aerial photograph background in Figure 1, and the grassland area for the NVC survey is highlighted in purple.



Figure 1. Overview of study area

This report presents an outline of the survey methodology, summarises the findings and provides discussion of their significance, and makes recommendations in relation to the proposed development.

The fieldwork and assessment were undertaken by Dr Peter Sturgess CEnv MCIEEM.

2. Survey method

Grassland National Vegetation Classification study

The focus for the study was an area of grassland that had been identified during an initial habitat survey as supporting potentially important unimproved grassland vegetation. The plant community within the area was examined in detail, using National Vegetation Classification (NVC) methods.

The survey work was carried out on 20 May 2019. The weather was dry and sunny, and considered ideal for this type of survey. The survey date was relatively early in the fieldwork season; it was chosen to improve the chances of recording any low-growing or early flowering plants that might be more difficult to spot later in the year when cover by tall grasses and Bracken is more developed.

The area of grassland was so small that for recording purposes only two plant communities were assessed; namely the grassland vegetation and the surrounding Bracken-dominated vegetation. These were described in terms of the published NVC communities (Rodwell, 1991, etc.) by quadrat sampling. Photographs were also taken to illustrate the vegetation types.

A total of 5 quadrats were recorded in each vegetation type. These involved recording every species within square 2x2m sample areas. The quadrat locations were selected as representative samples of the vegetation. The cover of every species within each quadrat was assessed using the Domin scale, as shown in Table 1. An estimate was also made of the percentage cover by vegetation and the approximate vegetation height (as an average through the quadrat).

Table 1. Domin scale for recording vegetation cover

Percentage cover	Domin score
91-100%	10
76-90%	9
51-75%	8
34-50%	7
26-33%	6
11-25%	5
4-10%	4
<4% - many individuals	3
<4% - several individuals	2
<4% - few individuals	1
Associate species (within 1m of a quadrat)	A

The quadrats recorded from each plant community were grouped together into floristic tables, giving each vegetation type its own table. Following NVC methodology, the occurrence of each species within the group of quadrats was assigned a constancy score as indicated in Table 2. The species within each table were then listed in order of their constancy score. Once the tables were completed, they were compared with the communities within the published NVC classification. The comparisons have generally been made based on the author's experience, assisted by Tablefit software (Hill, 2015).

Table 2. Constancy scores for quadrat data

Frequency within quadrats	Constancy Score
81 - 100%	V
61 - 80%	IV
41 - 60%	III
21 - 40%	II
1 - 20%	I
Associate species (A) only	

Invasive species survey

The invasive species survey was undertaken by a walk-over survey, passing through all the different vegetation types and carefully looking for plant species included in Schedule 9 of the Wildlife and Countryside Act 1981 (as amended). Much of the area supports dense Bracken and scrub, and this was surveyed by walking transects through the vegetation, aiming to pass within 5m of all potentially suitable habitat. Particular attention was given to searching through areas around the site boundary and near roads, especially where tipping of garden refuse has taken place.

3. Survey findings

A list of all the plant species recorded during the survey is presented in Appendix 1. This includes the scientific and common names for each species recorded within the study area. Incidental records of fungi and animal species are included in Appendix 2.

The locations of the NVC quadrats are shown in Figure 2, and the locations of non-native invasive species are shown in Figure 3.

3.1 National Vegetation Classification study

The quadrat locations are shown in Figure 2. Quadrats 1 to 5 are from the grassland vegetation, while quadrats 6 to 10 are from the surrounding dense Bracken vegetation. The aerial photograph background to figure 2 shows the Bracken as brown and the grassland as green, so it was not considered necessary to produce an additional map to distinguish between them.

Vegetation descriptions and quadrat data for the two plant communities are presented below. The quadrat data has been arranged into constancy tables, with species are arranged in order of frequency, as denoted by the constancy score in the right-hand column.



Figure 2. Location of quadrats.

Grassland quadrats

The grassland quadrat data is summarised in Table 3.

The vegetation appears to be in a state of transition from unimproved acid grassland, which is best represented by Quadrat 1, to mesotrophic grassland, evident from the dominance of False Oat-grass and other tall grasses in Quadrats 2 to 5.

In terms of the NVC, the vegetation can be described as a transition from U1 *Festuca ovina* – *Agrostis capillaris* – *Rumex acetosella* grassland, to MG1 *Arrhenatherum elatius* grassland.

The transition from one community to another is gradual, and some of the intermediate length sward and the grassland on the sides of the ant-hills, especially where Sweet Vernal-grass is frequent, is probably best described as U4 *Festuca ovina* – *Agrostis capillaris* – *Galium saxatile* grassland. However, the scale of the sampling and topographic variation due to the anthills makes it impractical to map the different stages of the transition. Even in the tall, dense MG1 grassland there are elements of the shorter, more open U1 grassland on the tops of the ant-hills.

Table 3. Quadrat data for grassland area

Species	1	2	3	4	5	Frequency
<i>Agrostis capillaris</i>	8	5	2	4	4	V
<i>Holcus lanatus</i>	2	4	2	2	4	V
<i>Rhynchospora squarrosus</i>	3	3	2	3	2	V
<i>Arrhenatherum elatius</i>	A	8	8	8	8	IV
<i>Brachythecium rutabulum</i>		2	4	4	3	IV
<i>Digitalis purpureus</i>	A	2	1	2	1	IV
<i>Galium saxatile</i>	5	4	A	2	5	IV
<i>Kindbergia praelonga</i>		4	2	2	2	IV
<i>Plantago lanceolata</i>	4	1		2	1	IV
<i>Pseudoscleropodium purum</i>	4	3	A	2	4	IV
<i>Senecio jacobaea</i>	1	2		1	2	IV
<i>Stellaria graminea</i>	1		1	2	3	IV
<i>Epilobium ciliatum</i>		1	1	2	A	III
<i>Festuca ovina</i>	9	4	A	A	2	III
<i>Festuca rubra</i>			2	4	2	III
<i>Galium aparine</i>	A	2	1	2		III
<i>Urtica dioica</i>		2	4	2		III
<i>Anthriscus sylvestris</i>		1	2		A	II
<i>Calliergonella cuspidata</i>		1	1	A		II
<i>Cardamine hirsuta</i>	A	2	2	A		II
<i>Ceratodon purpureus</i>	1	1	A			II
<i>Deschampsia flexuosa</i>	2		2	A		II
<i>Dryopteris filix-mas</i>		2	1	A	A	II
<i>Anthoxanthum odoratum</i>	A	A	1			I
<i>Cirsium arvense</i>			1	A		I
<i>Galium verum</i>			2			I
<i>Lophocolea bidentata</i>		4				I
<i>Myosotis discolor</i>	A	1		A		I
<i>Pilosella officinarum</i>	5					I
<i>Plagiomnium undulatum</i>		1				I
<i>Pseudephemerum nitidum</i>	1					I
<i>Pteridium aquilinum</i>		A		1		I
<i>Rumex acetosella</i>	4				A	I
<i>Veronica chamaedrys</i>	A		A	1	A	I
<i>Vicia hirsuta</i>	2					I
<i>Vicia sativa</i>	1	A	A			I
<i>Alnus glutinosa</i>			A			
<i>Geum urbanum</i>			A			
<i>Juncus effusus</i>			A			
<i>Poa pratensis</i>	A		A			
<i>Potentilla sterilis</i>			A			
<i>Quercus robur</i>	A	A				
<i>Rubus fruticosus</i>			A			
<i>Rumex acetosa</i>				A		
<i>Rumex crispus</i>			A			
<i>Rumex obtusifolius</i>						
<i>Rumex sanguineus</i>					A	
<i>Veronica arvensis</i>	A			A		
Species total	16	23	20	18	14	
Vegetation height (cm)	10	30	40	30	40	
Cover (%)	95	95	100	100	100	



Figure 3. Grassland vegetation, showing abundant tall grasses over most of the area (mostly False Oat-grass) and prominent ant-hills.



Figure 4. Grassland vegetation, showing shorter turf with open patches, mostly associated with ant-hills.

Bracken quadrats

The Bracken quadrat data is summarised in Table 4.

The vegetation is overwhelmingly dominated by bracken, with very few other species able to co-exist under the dense canopy or germinate through the thick layer of Bracken litter. Cleavers and Nettle are the most frequent associates, indicating a relatively fertile soil. Most other species are restricted to areas such as track edges where the Bracken litter is thinner, or subject to disturbance (e.g. by deer paths or Wild Boar feeding activity).

In terms of the NVC, the vegetation is best described as a very species-poor example of the U20 *Pteridium aquilinum* – *Galium saxatile* community.

Table 3. Quadrat data for Bracken area

Species	6	7	8	9	10	Frequency
<i>Pteridium aquilinum</i>	10	10	10	10	10	V
<i>Galium aparine</i>	2	5	5	7	6	V
<i>Urtica dioica</i>	A	4	5	5	4	IV
<i>Hyacinthoides non-scripta</i>		1			2	II
<i>Brachythecium rutabulum</i>				2	A	I
<i>Cardamine hirsuta</i>	1					I
<i>Holcus mollis</i>					4	I
<i>Kindbergia praelonga</i>				2		I
<i>Rubus fruticosus</i>		A	1			I
<i>Crataegus monogyna</i>				A		
<i>Digitalis purpureus</i>					A	
<i>Holcus lanatus</i>	A					
<i>Poa trivialis</i>	A					
<i>Rumex obtusifolius</i>	A					
<i>Veronica hederifolia</i>	A					
Species total	3	4	4	5	5	
Vegetation height (cm)	50	60	60	50	40	
Cover (%)	100	100	100	100	95	



Figure 5. Species-poor Bracken vegetation.

3.2 Invasive species survey

The survey only found two species of non-native invasive plants listed in Schedule 9 of the Wildlife and Countryside Act. These were the following:

- Himalayan Cotoneaster (*Cotoneaster simonsii*). Growing in the shade of large willow trees to the north-east of the car-park.
- Entire-leaved Cotoneaster (*Cotoneaster integrifolius*). Not rooted within the study area but growing over the boundary wall from an adjacent garden.

Their approximate locations are shown in Figure 6.

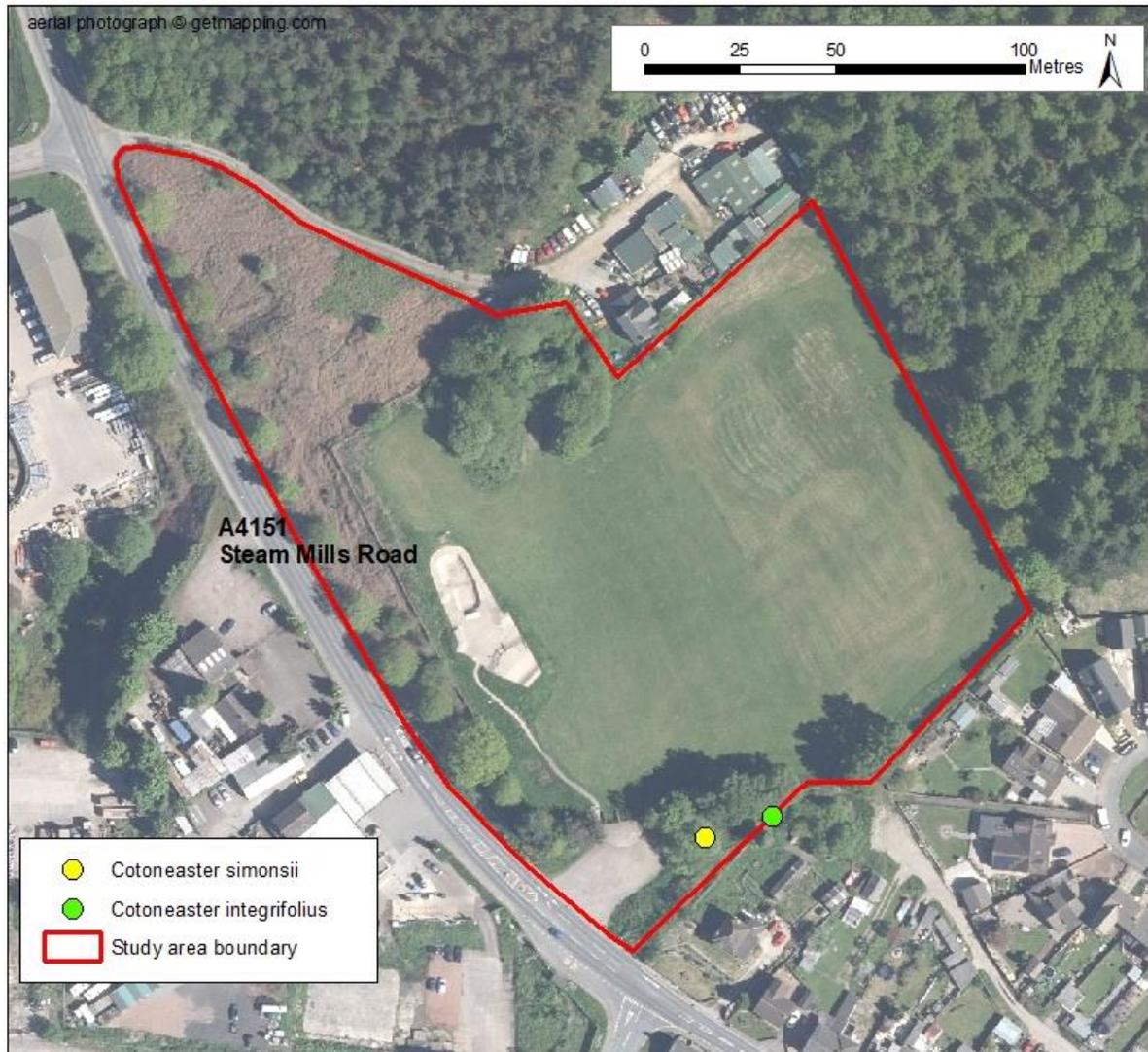


Figure 6. Location of non-native invasive species.

Several other species observed during the survey have probably established from garden throw-outs, discarded refuse, or self-seeded from nearby gardens, mainly near to the roads at the boundary. These included Horseradish, Gooseberry, Red Currant, Apple, Butterfly Bush, Rose of Sharon and Daffodil. However, these are unlikely to be a significant threat to the wild flora in this location so are not considered further.



Figure 7. Himalayan Cotoneaster in landscape planting near car-park.



Figure 8. Entire-leaved Cotoneaster at south-eastern boundary wall.

4. Discussion

4.1 National Vegetation Classification study

The timing of the NVC study has probably influenced some of the findings. It allowed the recording of some early flowering species that might have been harder to detect when the Bracken and coarse grasses had attained their full height, but may have under-recorded the cover by some species that peak later in the summer. It will also have recorded a lower vegetation height and cover than would be obtained by a survey later in the year. However, these are minor points that are unlikely to have had any significant bearing on the survey findings.

The grassland patch examined by the NVC study has not been subject to any obvious signs of agricultural improvement for at least several decades and this is evident by the range of species and the presence of numerous ant-hills. The vegetation appears to have developed on land that was formerly used for coal mining; several large depressions within the nearby Bracken areas appear likely to be the result of old bell-pit workings. An examination of old aerial photographs shows that the grassland patch used to be more extensive but has become smaller as it has been encroached on by Bracken. It is likely to have been grazed in the past, allowing the development of short grassland with ant-hills. However, there is no evidence of any management in recent years and the acid grassland element of the flora is in a state of transition to mesotrophic grassland as taller grasses become dominant. In the absence of grazing the current trend is likely to continue, and natural processes will result in the eventual loss of the acid grassland flora to mesotrophic grassland, Bracken and scrub.

The grassland patch is confirmed as being unimproved grassland, and it is of local interest for its flora and ant-hills. However, it is not considered sufficiently large or diverse to be considered important in a county context and does not support any especially rare plant species. If the grassland is to be retained in the long term it will require some form of management by cutting or grazing.

The Bracken vegetation also appears to have remained unmanaged for many years, as evidenced by the depth of dead Bracken litter. The dominance of the Bracken is very limiting to most other flora, and if this vegetation is likely to remain in the long term some form of management to reduce the density of the sward and depth of the litter would be beneficial for the flora diversity. The deep Bracken litter could be considered a fire risk in dry weather, so management would also reduce this possibility. In the short term, foraging by Wild Boar has created small pockets of disturbance within the Bracken, and in such a species-poor community this is likely to be beneficial for the plant diversity. (Other biodiversity is also likely to benefit, for example, several mining bees and solitary wasps were noted around areas of disturbed ground, but nowhere else within the dense Bracken.)

The grassland in the main field was examined briefly, and although much of it has been mown shortly before the survey there were a few areas where the flora was readily identifiable. Much of the grassland appears to be MG6b *Lolium perenne* – *Cynosurus cristatus* grassland, *Anthoxanthum odoratum* subcommunity. However, it is a relatively species-poor example of this vegetation.

4.2 Invasive species survey

The study found only two species of non-native invasive plants listed in Schedule 9 of the Wildlife and Countryside Act. Both are *Cotoneaster* species that are relatively common and widespread, being readily dispersed through seeds in bird-droppings, and often planted in gardens. They can be especially problematic in limestone areas but are unlikely to spread quickly within the current study area. The presence of these plants should be taken into account during any proposed development works as it would be unlawful to cause them to

spread in the wild. However, these are only present in small quantity and should be relatively straightforward to control.

It is feasible that other non-native invasive plants might be present in very small amounts not detectable at the time of the survey (e.g. if they had been present in the main grassland area that had been cut shortly before the survey). It is also possible that new invasive species could be introduced prior to any development commencing because there appears to be ongoing tipping of garden-waste at various locations along the track beside the northern boundary.

5. Recommendations

The unimproved grassland habitat and adjacent bracken vegetation is of limited diversity and nature conservation value, but if it is proposed to retain it in the long term (i.e. if it would not be affected by development proposals) it would be worth investigating some form of management to reduce the dominance of Bracken and coarse grasses, increase the botanical diversity and raise the value of the retained habitat for biodiversity and nature conservation. Management options might include occasional grazing (e.g. using electric fencing to enclose stock for a short period every year), or occasional cutting by strimming (removing the cuttings if possible, to prevent build up of leaf litter and nutrients). If the Bracken habitat is to be retained, it would be advantageous to reduce the depth of the dead Bracken litter, to reduce fire risk and enable more plant and animal species to thrive.

It is recommended to remove the non-native *Cotoneaster* species, to prevent any spread of them, either through possible development, or through seeds being dispersed by birds. Both species can be controlled by herbicide spraying, or by cutting down larger bushes and treating the stumps or regrowth with herbicide. In this case the Entire-leaved *Cotoneaster* is growing outside the site boundary from an adjacent garden, so it might not be possible to carry out any treatment other than trimming it back to the boundary unless permission is obtained from the adjacent landowner.

A final pre-construction check for non-native species is recommended, particularly at the site boundaries where there are problems with garden refuse tipping.

The habitats on this site are in a state of transition, and there are ongoing risks of invasive species being introduced from unauthorised tipping. It is therefore recommended that the lifespan of this survey report is limited to 12 months. After this time the survey findings may no longer be valid.

6. References

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Appendix 1. Plant species list

The following species were all identified within the wider study area on 20 May 2019. Due to the size of the site and nature of the sampling this should not be considered a comprehensive list of every plant species within the study area.

Species	Common Name
VASCULAR PLANTS	
<i>Acer campestre</i>	Field Maple
<i>Acer pseudoplatanus</i>	Sycamore
<i>Achillea millefolium</i>	Yarrow
<i>Agrimonia eupatoria</i>	Agrimony
<i>Agrostis capillaris</i>	Common Bent
<i>Alnus glutinosa</i>	Alder
<i>Alnus incana</i>	Grey Alder
<i>Anisantha sterilis</i>	Barren Brome
<i>Anthoxanthum odoratum</i>	Sweet Vernal-grass
<i>Anthriscus sylvestris</i>	Cow Parsley
<i>Arctium minus</i>	Lesser Burdock
<i>Armoracia rusticana</i>	Horse Radish
<i>Arrhenatherum elatius</i>	False Oat-grass
<i>Bellis perennis</i>	Daisy
<i>Betula pendula</i>	Silver Birch
<i>Brachypodium sylvaticum</i>	False Brome
<i>Bromopsis erecta</i>	Upright Brome
<i>Bromopsis ramosa</i>	Wood Brome
<i>Bromus hordeaceus</i>	Soft Brome
<i>Buddleia davidii</i>	Buddleia
<i>Capsella bursa-pastoris</i>	Shepherd's Purse
<i>Cardamine hirsuta</i>	Hairy Bittercress
<i>Cardamine pratensis</i>	Cuckoo Flower
<i>Carex flacca</i>	Glaucous Sedge
<i>Carex hirta</i>	Hairy Sedge
<i>Centaurea nigra</i>	Common Knapweed
<i>Cerastium fontanum</i>	Common Mouse-ear
<i>Chamaecyparis lawsoniana</i>	Lawson's Cypress
<i>Chamerion angustifolium</i>	Rose-bay Willowherb
<i>Chenopodium album</i>	Fat Hen
<i>Circaea lutetiana</i>	Enchanter's Nightshade
<i>Cirsium arvense</i>	Creeping Thistle
<i>Cirsium vulgare</i>	Spear Thistle
<i>Clematis vitalba</i>	Traveller's Joy
<i>Cornus sanguinea</i>	Dogwood
<i>Cornus cf sericea</i>	Red-osier Dogwood
<i>Corylus avellana</i>	Hazel
<i>Cotoneaster integrifolius</i>	Entire-leaved Cotoneaster
<i>Cotoneaster simonsii</i>	Himalayan Cotoneaster
<i>Crataegus monogyna</i>	Hawthorn
<i>Crepis cf capillaris</i>	Smooth Hawkbit
<i>Cytisus scoparius</i>	Broom
<i>Dactylis glomerata</i>	Cock's-foot Grass

Species	Common Name
<i>Deschampsia cespitosa</i>	Tufted Hair-grass
<i>Deschampsia flexuosa</i>	Wavy Hair-grass
<i>Digitalis purpurea</i>	Foxglove
<i>Dryopteris filix-mas</i>	Male Fern
<i>Epilobium ciliatum</i>	American Willowherb
<i>Epilobium montanum</i>	Broad-leaved Willowherb
<i>Epilobium parviflorum</i>	Hoary Willowherb
<i>Equisetum arvense</i>	Field Horsetail
<i>Erophila verna</i>	Common Whitlowgrass
<i>Euonymus europaeus</i>	Spindle
<i>Eupatorium cannabinum</i>	Hemp Agrimony
<i>Festuca ovina</i>	Sheep's Fescue
<i>Festuca rubra</i>	Red Fescue
<i>Ficaria verna</i>	Lesser Celandine
<i>Fragaria vesca</i>	Wild Strawberry
<i>Fraxinus excelsior</i>	Ash
<i>Galium aparine</i>	Cleavers
<i>Galium saxatile</i>	Heath Bedstraw
<i>Galium verum</i>	Lady's Bedstraw
<i>Geranium dissectum</i>	Cut-leaved Crane's-bill
<i>Geranium molle</i>	Dove's-foot Crane's-bill
<i>Geranium pyrenaicum</i>	Hedgerow Crane's-bill
<i>Geranium robertianum</i>	Herb Robert
<i>Geum urbanum</i>	Wood Avens
<i>Hedera helix sl.</i>	Ivy
<i>Heracleum sphondylium</i>	Hogweed
<i>Holcus lanatus</i>	Yorkshire Fog
<i>Holcus mollis</i>	Creeping Soft-grass
<i>Hyacinthoides non-scripta</i>	Bluebell
<i>Hypericum calycinum</i>	Rose of Sharon
<i>Hypericum maculatum</i>	Imperforate St. John's-wort
<i>Hypochaeris radicata</i>	Common Cat's-Ear
<i>Ilex aquifolium</i>	Holly
<i>Juncus effusus</i>	Soft Rush
<i>Lactuca serriola</i>	Prickly Lettuce
<i>Lapsana communis</i>	Nipplewort
<i>Lathyrus pratensis</i>	Meadow Vetchling
<i>Ligustrum vulgare</i>	Wild Privet
<i>Lolium perenne</i>	Perennial Rye-grass
<i>Lotus corniculatus</i>	Common Bird's-foot Trefoil
<i>Luzula campestris</i>	Field Woodrush
<i>Malus pumila</i>	Apple
<i>Medicago lupulina</i>	Black Medick
<i>Myosotis arvensis</i>	Field Forget-me-not
<i>Myosotis discolor</i>	Changing Forget-me-not
<i>Narcissus sp. (cultivar)</i>	Daffodil
<i>Pilosella officinarum</i>	Mouse-ear Hawkweed
<i>Pinus sylvestris</i>	Scot's Pine
<i>Plantago lanceolata</i>	Ribwort Plantain
<i>Plantago major</i>	Greater Plantain
<i>Poa annua</i>	Annual Meadow-grass

Species	Common Name
<i>Poa pratensis</i>	Smooth Meadow-grass
<i>Poa trivialis</i>	Rough Meadow-grass
<i>Polygonum aviculare</i>	Knotgrass
<i>Potentilla anglica</i>	Trailing Tormentil
<i>Potentilla anserina</i>	Silverweed
<i>Potentilla erecta</i>	Tormentil
<i>Potentilla reptans</i>	Creeping Cinquefoil
<i>Potentilla sterilis</i>	Barren Strawberry
<i>Prunella vulgaris</i>	Self-Heal
<i>Prunus avium</i>	Wild Cherry
<i>Prunus padus</i>	Bird Cherry
<i>Prunus spinosa</i>	Blackthorn
<i>Pteridium aquilinum</i>	Bracken
<i>Quercus coccinea</i>	Scarlet Oak
<i>Quercus petraea</i>	Sessile Oak
<i>Quercus robur</i>	Pedunculate Oak
<i>Ranunculus acris</i>	Meadow Buttercup
<i>Ranunculus bulbosus</i>	Bulbous Buttercup
<i>Ranunculus repens</i>	Creeping Buttercup
<i>Ribes cf rubrum</i>	Red Currant
<i>Ribes uva-crispa</i>	Gooseberry
<i>Rosa canina</i>	Dog Rose
<i>Rubus fruticosus</i>	Bramble
<i>Rumex acetosa</i>	Common Sorrel
<i>Rumex acetosella</i>	Sheep's Sorrel
<i>Rumex crispus</i>	Curled Dock
<i>Rumex obtusifolius</i>	Broad-Leaved Dock
<i>Rumex sanguineus</i>	Wood Dock
<i>Salix caprea</i>	Goat Willow
<i>Salix purpurea</i>	Purple Willow
<i>Salix cinerea</i>	Grey Willow
<i>Sambucus nigra</i>	Elder
<i>Schedonorus arundinaceus</i>	Tall Fescue
<i>Scorzonoides autumnalis</i>	Autumn Hawk-bit
<i>Senecio erucifolius</i>	Hoary Ragwort
<i>Senecio jacobaea</i>	Ragwort
<i>Silene dioica</i>	Red Campion
<i>Solanum dulcamara</i>	Bittersweet
<i>Sonchus oleraceus</i>	Smooth Sow-thistle
<i>Sorbus aucuparia</i>	Rowan
<i>Stachys sylvatica</i>	Hedge Woundwort
<i>Stellaria graminea</i>	Lesser Stitchwort
<i>Stellaria holostea</i>	Greater Stitchwort
<i>Symphoricarpos albus</i>	Snowberry
<i>Taraxacum sp.</i>	Dandelion
<i>Trifolium dubium</i>	Lesser Trefoil
<i>Trifolium pratense</i>	Red Clover
<i>Trifolium repens</i>	White Clover
<i>Tussilago farfara</i>	Colt's Foot
<i>Ulex europaeus</i>	Common Gorse
<i>Urtica dioica</i>	Nettle

Species	Common Name
<i>Valerianella carinata</i>	Keel-fruited Cornsalad
<i>Verbascum thapsus</i>	Greater Mullein
<i>Veronica arvensis</i>	Wall Speedwell
<i>Veronica chamaedrys</i>	Germander Speedwell
<i>Veronica hederifolia</i>	Ivy-leaved Speedwell
<i>Viburnum opulus</i>	Guelder Rose
<i>Vicia hirsuta</i>	Hairy Tare
<i>Vicia sativa</i>	Common Vetch
<i>Vicia sepium</i>	Bush Vetch
<i>Vicia tetrasperma</i>	Smooth Tare
<i>Viola riviniana</i>	Common Dog-Violet
BRYOPHYTES	
<i>Atrichum undulatum</i>	Common Smoothcap
<i>Brachythecium rutabulum</i>	Rough-stalked Feather-moss
<i>Calliergonella cuspidata</i>	Pointed Spear-moss
<i>Ceratodon purpureus</i>	Redshank
<i>Fissidens taxifolius</i>	Common Pocket-moss
<i>Kindbergia praelonga</i>	Common Feather-moss
<i>Lophocolea bidentata</i>	Bifid Crestwort
<i>Plagiomnium undulatum</i>	Hart's-tongue Thyme-moss
<i>Pseudephemerum nitidum</i>	Delicate Earth-moss
<i>Pseudoscleropodium purum</i>	Neat Feather-moss
<i>Rhytidiadelphus squarrosus</i>	Springy Turf-moss

Appendix 2. Incidental fungi and fauna observations

The following species were all recorded as incidental observations within the wider study area on 20 May 2019. They are not the result of any detailed study and should not be considered as exhaustive lists.

Species	Common Name
FUNGI	
<i>Kuehneola uredinis</i>	Pale Bramble Rust
<i>Monilinia johnsonii</i>	Hawthorn Leaf-blight
<i>Rhopoglyphus filicinus</i>	Bracken Map
INVERTEBRATES	
<i>Aglais urticae</i>	Small Tortoiseshell Butterfly
<i>Anthocharis cardamines</i>	Orange-tip butterfly
<i>Bombus hypnorum</i>	Tree Bumblebee
<i>Bombus pratorum</i>	Early Bumblebee
<i>Inachis io</i>	Peacock Butterfly
<i>Petrophora chlorosata</i>	Brown Silver-line
<i>Pieris napi</i>	Green-veined White Butterfly
AMPHIBIANS	
<i>Rana temporaria</i>	Common Frog
REPTILES	
<i>Anguis fragilis</i>	Slow Worm
<i>Zootoca vivipara</i>	Common Lizard
BIRDS	
<i>Carduelis carduelis</i>	Goldfinch
<i>Columba palumbus</i>	Wood Pigeon
<i>Corvus corone</i>	Carrion Crow
<i>Corvus monedula</i>	Jackdaw
<i>Dendrocopos major</i>	Great Spotted Woodpecker
<i>Erithacus rubecula</i>	Robin
<i>Parus caeruleus</i>	Blue Tit
<i>Parus major</i>	Great Tit
<i>Phylloscopus collybita</i>	Chiffchaff
<i>Pica pica</i>	Magpie
<i>Sylvia atricapilla</i>	Blackcap
<i>Troglodytes troglodytes</i>	Wren
<i>Turdus merula</i>	Blackbird
<i>Turdus viscivorus</i>	Mistle Thrust
MAMMALS	
<i>Sus scrofa</i>	Wild Boar (feeding signs/ tracks)

ROOM LIST

REF.	ROOM	Quantity	Area	AREA (m ²)	NOTES
PUBLIC ZONE & SUPPORT ZONES					
GF	Stairs			24.0	
GF	Lobby			14.0	
GF	Lift			6.0	
GF	Lift			6.0	
GF	Changing Places			11.7	
GF	WC			2.7	
GF	Baby Feed			3.7	
GF	Nappy change			7.6	
GF	Acc WC			5.0	
GF	Group Room			29.0	
GF	BEV Bay			7.8	
GF	Server			10.4	
GF	Cleaners Store			6.0	
GF	Staff WC			3.3	
GF	Multipurpose room			30.6	
GF	Disposal Hold			8.9	
GF	Cleaners St			5.6	
GF	Porter			8.7	
GF	Reception			16.5	
GF	Waiting			10.2	
GF	Interview			7.2	
GF	Stairs			25.7	
GF	General Store			12.9	
GF	FM Store				
FF	Lobby			11.9	
FF	Acc WC			4.5	
FF	Cleaners			2.2	
FF	Lobby			5.7	
URGENT CARE					
GF	Waiting			27.2	
GF	Cleaners Store			6.0	
GF	Paed Wait			10.2	
GF	Treatment (Paed)			15.0	
GF	Treatment	4	15	60.0	
GF	Treatment (Eye)			12.0	
GF	Resuc			18.0	
GF	Decon Shwr			2.8	
GF	Bev Bay			4.2	
GF	Dirty Utility			7.8	
GF	Store			9.9	
GF	Clean Utility			6.9	
GF	WC			2.7	
GF	Treatment (plster)			15.0	
GF	Staff Base			11.6	
GF	WC			2.7	
GF	Triage			12.8	
DIAGNOSTICS					
GF	Ultrasound			15.9	
GF	Acc WC			5.0	
GF	Change			2.9	
GF	A. Change			4.3	
GF	X Ray			28.9	
GF	Sub Wait			10.5	
GF	Office			10.2	
THERAPY					
GF	Wait			10.0	
GF	Therapy	5	10	50.0	
GF	Therapy/Large	2	12	24.0	
GF	Acc WC			5.7	
GF	Store			8.0	
GF	Activity Room			44.0	
STAFF ZONE					
GF	Meeting Room			15.0	
GF	6 Person Office			30.0	
GF	2 Person Office			10.0	
GF	8 Person Office (Perm)			32.0	
GF	8 Person Office (Hot Desk)			32.0	
GF	Staff Rest & Kitchen			31.4	
GF	Office Store			4.0	
GF	M Locker			9.1	
GF	M WC			3.2	
GF	M Shower			4.6	
GF	F WC	2	3.2	6.4	
GF	F Locker			13.4	
GF	F Shower			5.0	
FF	Bev			4.1	
FF	Store			16.1	
FF	Clinical Skills			28.4	
FF	Hot Desk (4p)			13.9	
FF	Matrons Office			9.3	
PEADIATRICS					
GF	PAED Consult 1			15.0	
GF	PAED Consult 2			15.0	
GF	PAED Consult 3			15.0	
GF	PAED Consult 4			15.0	
GF	Store			4.4	
GF	Nappy Change			5.0	
GF	ACC WC			5.2	
GF	PAED Wait			16.2	

ROOM LIST

REF.	ROOM	Quantity	Area	AREA (m ²)	NOTES
GF	Buggy Store			5.1	
GF	Store			3.8	
GF	Staff Base			9.9	
OUTPATIENTS					
GF	Waiting			24.3	
GF	Consult	7	15	105.0	
GF	Podiatry			15.0	
GF	Consult Leg	3	15	45.0	
GF	Dirty Ut			7.6	
GF	Staff WC			3.3	
GF	Cleaners Store			6.0	
GF	C/E Pod	3	5.3	15.9	
GF	Audiology			11.4	
GF	Store			13.5	
GF	Uro WC			4.8	
GF	Clean Utility			10.1	
GF	Staff Base			16.0	
GF	Physical Measure			8.4	
LofF					
GF	Shop & Store			20.2	
TREATMENT					
FF	Waiting			8.4	
FF	Change & WC	2	6	12.0	
FF	Store (Decon)			9.0	
FF	Dirty Utility			20.2	
FF	Clean Utility			15.8	
FF	Treatment (Endoscopy)	2	5	38.8	
FF	Recovery (Tr)			7.5	
FF	Recovery			10.0	
FF	Disposal Hold			8.8	
FF	Cleaners			6.8	
FF	Bev Bay			4.4	
FF	Consent			8.4	
FF	Prep Room			8.5	
DENTAL					
FF	Dirty St.			6.2	
FF	Clean St.			6.5	
FF	Dental Treatment (tipper)			18.1	
FF	Dental Treatment			15.4	
FF	Waiting Area			11.4	
INPATIENT					
FF	Bedroom	22	20.4	448.0	
FF	Ensuite	22	4.5	99.0	
FF	Touch Down	6	2.1	12.6	
FF	Reception Clerk			12.9	
FF	Resus	2	2.1	4.2	
FF	Staff WC			2.3	
FF	Interview			9.0	
FF	Cleaners			6.7	
FF	Disposal			10.5	
FF	Store			5.3	
FF	Mattress Store			9.9	
FF	Hoist			2.1	
FF	Linen			6.1	
FF	Touch Down			2.9	
FF	Clean Utility 1			9.8	
FF	Clean Utility 2			9.8	
FF	Office/Meeting Room			17.1	
FF	Ward Storage			17.1	
FF	Dirty Utility 1			8.4	
FF	Dirty Utility 2			8.4	
FF	Ward Gym			15.0	
FF	Staff Rest			15.0	
FF	Store			5.1	
FF	Day Store			4.5	
FF	Dining/Social Space			33.0	
FF	Bedroom (Bar)	2	22.3	44.6	
FF	Ensuite	2	4.5	9.0	
FF	Relatives Bedroom			16.5	
FF	Ensuite			4.5	
FF	Regen Kitchen			30.2	
SUB-TOTAL: NET AREA				2,511.7	
CIRCULATION / ENGINEERING / COMMUNICATION				1290.3	
TOTAL: GROSS INTERNAL AREA EXCLUDING PLANT				3,802.0	

Ratio: Gross/Net

1.51

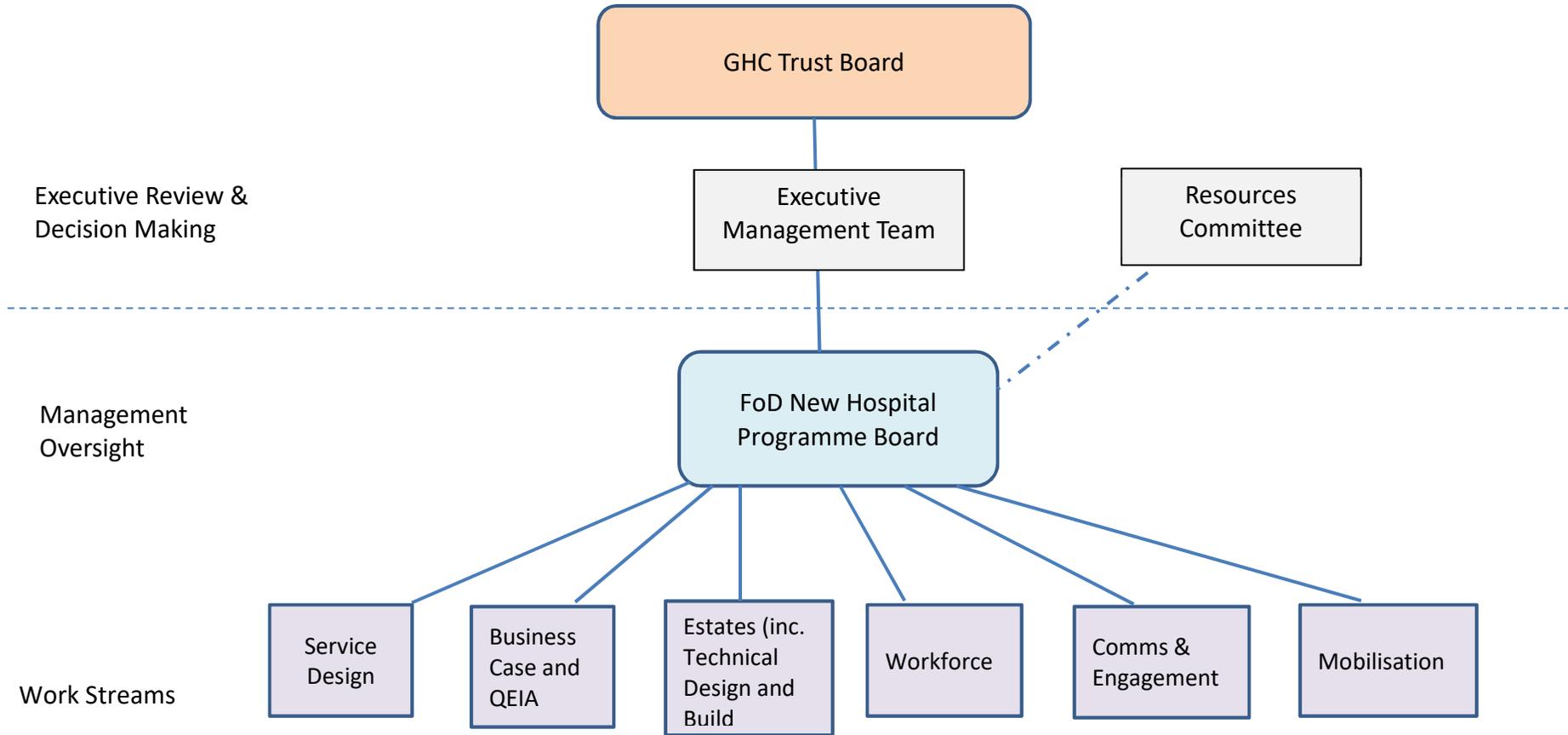
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Forest of Dean New Hospital Programme Board TERMS OF REFERENCE and MEMBERSHIP

1.	<p>Purpose</p> <p>The Forest of Dean (FoD) Programme Board is responsible for the management and delivery of the programme of work required to design, progress and deliver a new community hospital for the Forest of Dean in line with regulatory requirements.</p>
2.	<p>Membership</p> <ul style="list-style-type: none"> • Director of Strategy & Partnerships - Angela Potter (<i>Chair</i>) • Director of Nursing, Therapies and Quality - John Trevains • Director of Human Resources – Neil Savage • Associate Director of Estates, Facilities & Medical Equipment – Kevin Adams • Associate Director, Contracts and Planning – Lisa Proctor • Head of Programmes & Transformation – Des Gorman • Service Director, Hospitals – Julie Goodenough • Service Director for Urgent Care – Helen Mee • Head of Communications – Kate Nelmes • Community Partnerships Manager – Lisa Dervan • Matron, Forest Hospitals – Cheryl Haswell • Senior Project Manager – Fiona Smith • Strategic Project Manager – Andrew Paterson
3.	<p>Quorum</p> <p>This Board does not have a requirement for a quorum, as it is not a decision making Board.</p>
4.	<p>Reporting Arrangements and Relationships</p> <p>The FoD Programme Board is a management oversight group that reports to the Executive Management Team.</p> <p>It develops and monitors the programme of work as outlined below. It requires work stream leads to report monthly on progress and escalate any issues or concerns via the agreed channels.</p> <p>Following approval of the Full Business case it has delegated decision-making authority for implementation of the approved programme, except where additional funding may be required over and above agreed tolerances or a significant risk emerges (a risk score of greater than 12).</p> <p>A highlight report will be provided quarterly to be submitted to Execs, Resources Committee and the where appropriate to Trust Board.</p> <p>Governance and key linkages are illustrated in the attached appendix.</p>

5.	Powers
6.	Roles and Responsibilities
	<p>The Programme Board will be responsible for:</p> <ul style="list-style-type: none"> • Development of service models, accommodation requirements, financial modelling and associated activities in order to develop a robust Full Business Case for approval by Gloucestershire Health and Care Foundation NHS Trust (GHC) Trust Board • Establishing and resourcing an agreed programme of work to ensure timely progress is made and assisting in removing barriers to ensure work streams can deliver agreed milestones • Providing oversight and scrutiny to all the work streams ensuring key dependencies are clearly identified and understood • Receiving regular highlight reports from work streams and maintaining oversight of the programme risk and issue registers ensuring appropriate mitigations are in place • Escalating key issues and risks to the Gloucestershire Health and Care Foundation NHS Trust (GHC) Executive Team as appropriate • Ensuring there is timely internal and external communication and stakeholder engagement planning within the programme and responding to any FOI requests. • Allocating resources to the work streams as agreed within the financial parameters of the overall programme and monitoring capacity to deliver key outcomes • Monitoring the delivery of the programme within the agreed financial context. • Establishing links across community, partner and voluntary organisations to demonstrate community involvement in the design of the new hospital. • Ensuring that innovation and transformation is at the forefront of the new hospital development
7.	Frequency and Review of Meetings
7.1	The FoD New Hospital Programme Board will have regular monthly meetings and administration will be provided by the Programmes and Transformation Team.
7.2	These Terms of Reference will be reviewed annually (or set frequency longer if appropriate)

FoD New Hospital Governance





TERMS OF REFERENCE

Forest of Dean (FoD) Assurance Committee

1.	Purpose
1.1	The purpose of the FoD Assurance Committee is to receive and provide assurance to the Trust Board on the overarching delivery of the FoD Hospital programme, ensuring that the programme is delivered on time, to the agreed budget, and to a satisfactory quality.
2.	Membership
2.1	<p><u>Membership</u> Steve Brittan (Chair) Graham Russell (NED/Resources Committee Chair) Maria Bond (NED/Quality Committee Chair) Angela Potter (Director of Strategy and Partnerships) Sandra Betney (Director of Finance) Neil Savage (Director of HR&OD)</p> <p><u>In Attendance</u> Kevin Adams (Associate Director of Estates, Facilities & Medical Equipment) Andrew Paterson (Strategic Project Manager)</p> <p><u>In Attendance (at Request of Committee)</u> Alison Halmshaw (Gleeds) Adrian Speller (Speller Metcalfe)</p>
2.2	Other Officers or Directors of the Trust may attend at the discretion of the Chair.
3.	Quorum
3.1	<p>Three members, at least two of whom should be Non-Executive Directors and one should be an Executive Director.</p> <p>Where a member is unable to attend a meeting of the Committee, that member may, with the agreement of the Committee Chair, nominate a deputy who will count towards the quorum.</p>
4.	Reporting Arrangements
4.1	The FoD Assurance Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and issues requiring further consideration or decision by the Board.
4.2	The Committee will highlight any key issues or concerns to the Audit and Assurance Committee or the Resources Committee which require consideration by one or both of these committees.
5.	Powers
5.1	The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation shall apply to the FoD Assurance Committee.
6	Responsibilities
6.1	<p>The Committee will receive regular progress assurance reports from the FoD Project Board who are leading on the development of the Full Business Case</p> <p>The Committee will provide an oversight and assurance function on the delivery of the new hospital.</p> <p>The Committee will have oversight of the costing plan and will review and consider any significant changes to this. The Committee will also oversee and approve any value engineering recommendations.</p>

7.	Frequency and Review of Meetings
7.1	Committee meetings will be held monthly, commencing in February 2021. The Chair may agree further meetings if necessary. Virtual meetings, at the discretion of the Committee Chair, may take place using appropriate electronic methods.
7.2	These Terms of Reference will be reviewed annually, with any change recommended to the Trust Board
8.	Administration
8.1	The Trust Secretary will ensure appropriate support is provided to the Committee.

Version:	Date Approved:	Approved by:
Version 1	04/03/2021	FoD Assurance Committee

Change Control Procedure

For

Forest of Dean Community Hospital

BLMS0480

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Document Control

Identification This Change Control Procedure is categorised as follows:

Category	Details
Project Name:	Forest of Dean Community Hospital
Project No.:	BLMS0480
Author:	Alison Halmshaw
Contributors:	Alison Halmshaw

Revision History

Each new version of the Change Control Procedure must be reviewed and recorded in the table below.

Version	Author	Reason for Issue	Issue Date
1.0	Alison Halmshaw	Initial issue	May 2021
2.0	Alison Halmshaw	Updated draft	June 2021

Document Distribution

This document has been distributed to the following Project Delivery Team members:

Name	Organisation	Role

Contents

1. Purpose	7
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4. Change Quotation / Estimate Procedure	8
5. Change Evaluation Procedure	9
6. Change Authorisation Procedure	9
7. Change Proposal Tracking and Records	10
8. Adjustment of the Stage Payment Schedule	Error! Bookmark not defined.
9. Extensions of Time	Error! Bookmark not defined.

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1. Purpose

This Change Control Procedure sets out how 'Changes' will be monitored and controlled. That is proposed, accepted or rejected, authorised and instructed. It will govern Changes to the Construction Contract throughout the Construction period – i.e. Post-Contract Changes to Project Scope, Programme and/or Cost – for:

- The addition, omission or substitution of any work specified in the Contract Documents.
- The alteration of the kind or standard of any of the materials or goods to be used;
- The removal from site of any work executed or Site Materials other and work, materials or goods which are not in accordance with the Contract.
- Standard JCT Pro Formas for all change will be used throughout the project.
- Timelines for approvals and acceptance will be followed as per the standard contract

2. Change Control Procedure

The Change Control Procedure encompasses five activities:



It addresses the following activities:

- Identification, issue and recording of Change Proposals;
- Preparation and submission of Compensation Event
- Evaluation of Compensation event, including reviewing the supporting documentation.
- Acceptance and rejection of Change Proposals;
- Tracking the status of Change Proposals; and
- Instructing 'Authorised' Changes.

3. Proposed Changes

Either the Project Manager (either of his/her own recommendation or in response to a request from the Employer or a member of the Employer's Project Delivery Team) or the Contractor may propose a Change.

3.1 Change Proposals by Employer

The Project Manager shall submit to the Contractor (copied to the Employer, the Principal Designer and the Quantity Surveyor / Cost Manager) a Change Proposal dated with the date it was sent.

Change Proposals are to be submitted, in writing, using **standard JCT Pro Formas**,

3.2 Delegated Authority

Kevin Adams Assistant Director of Estates can authorise change up to a £10,000.00 limit. Any change above this will need to be reported to and agreed by the project board.

Alongside this any change that may have an impact on fire, infection control, IT or estates / future maintenance would need to be signed off by the relevant specialist prior to instruction.

All timescales for approval must be in line with the JCT contract.

3.3 Change Proposals by Contractor

The Contractor shall submit to the Project Manager (copied to the Employer, the Principal Designer and the Cost Manager) a Change Proposal dated with the date it was sent.

Change Proposals are to be submitted, in writing, to the Project Manager using **Standard JCT Pro Formas**.

4. Change Quotation / Estimate Procedure

4.1 Employer's Change Proposals / Proposed project managers instruction

If the Employer proposes a Change by issue of a proposed project managers instruction the Contractor shall submit a Change Event as per the timescales agreed in the Contract

4.2 Contractor's Change Proposals

If the Contractor proposes a Change by the issue of a 'Contractor's Change Proposal, the contractor shall also submit a Compensation Event with the Change Proposal to the Project Manager.

4.3 Proposed changes

Proposed changes shall indicate how the Additional Cost or the Reduction in Costs is calculated by showing, separately, the amounts attributable to:

- (1) Additional Cost of resulting from the Change;
- (2) Reduction in Cost resulting from the Change;
- (3) Amount of any direct loss and/or expense directly consequential upon the Change;

- (4) Any adjustment for amount(s) previously paid in respect of any direct loss and/or expense resulting from any extension previously granted in respect of the whole, or any Section, of the Works covered by a proposed acceleration.

The change control form shall further provide a detailed breakdown showing how the Additional Cost or the Reduction in Costs is arrived at

In addition, the Change control shall give details of any effect of the Change Proposal on the Completion Date for the whole, or any Section, of the Works and provide information in support of any proposed alteration to such Dates.

4.4 Last Date for Acceptance

The last date on which the proposed change can be accepted by the Employer, and Instructed by the Project Manager, is to be stated on the change control form by the Contractor and will be in line with the Contract.

5. Change Evaluation Procedure

On receipt of a Contractor's proposed change, the Project Manager will instruct the relevant Project Delivery Team members to review and provide comment on the technical aspects of the Contractor's proposal; and instruct the Cost Manager to verify that the cost proposals are acceptable.

Both the Project Delivery Team members and the Cost Manager are to submit their conclusions and recommendations to the Project Manager

The Project Manager collates and summaries the conclusions and recommendations.

6. Change Authorisation Procedure

A 'Change Authorisation' is initiated by the Project Manager providing:

- (1) Summary of the Change Proposal;
- (2) Summary of the effects of the Change Proposal on the Contract – in terms of both cost and programme;
- (3) Comments on the Contractor's Change Quotation / Estimate;
- (4) Recommendation as to whether the Employer should accept or reject the Contractor's Change Quotation / Estimate;
- (5) Highlight the 'Last Date for Acceptance of Quotation / Estimate' by the Employer.

When completed, the Project Manager forwards the 'Change Authorisation' request, together with all necessary supporting documents, to the Employer or acceptance or rejection.

The Employer will review the 'Change Authorisation' request and indicate their decisions by completing the appropriate part of the 'Change Authorisation' request and returning it to the Project Manager

For '**Accepted**' Change Proposals, the Project Manager will draft and issue an Instruction to the Contractor in accordance with the Contract Conditions, and will update the Change Control Register.

For '**Rejected**' Change Proposals, the Project Manager will inform the Contractor, in writing, and will update the Change Control Register.

7. Change Proposal Tracking and Records

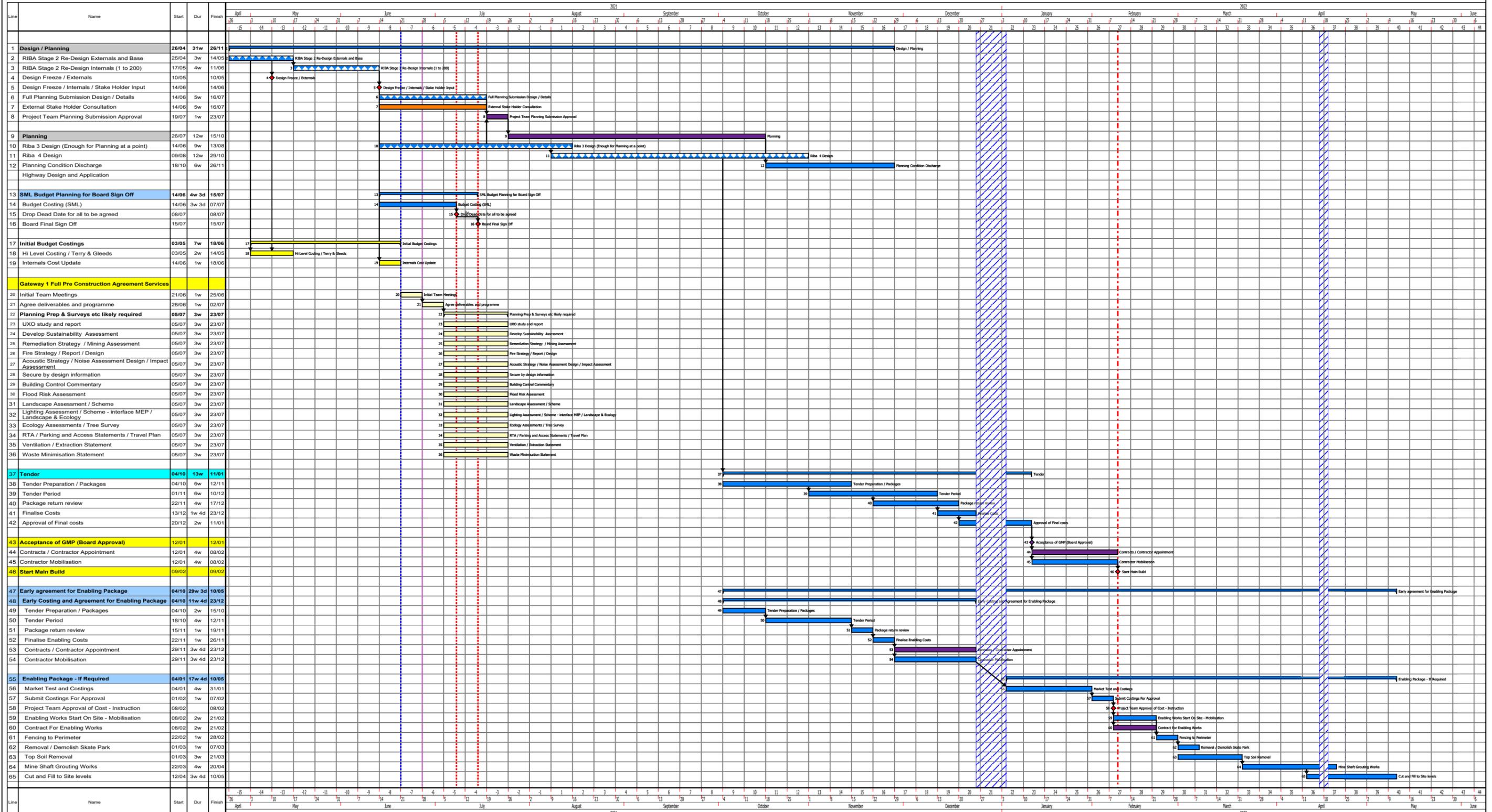
The Project Manager will maintain a Change Control Register

The Change Control Register is a live Project Document and will be maintained by the Project Manager throughout the Construction Stage to Practical Completion.

***** End of Change Control Procedure *****

Forest Of Dean Community Hospital

GHCS NHS FT
Steam Mills Road, Cinderford



Revision: Rev 17.06.2021
Revision Date: 17/06/2021
Comment: Latest Update 1st Pass

Prog No
Drawn By
A Hind
Drawn Date
17/06/2021

Program Status
Review Programme

Please click on +/- sign above to expand/contract view of the 3 project phases of Preparation/Mobilisation/Initial Delivery
 To expand /contract the action areas in Column A please click on +/- signs to the left of Column A

	PREPARATION PHASE												MOBILISATION PHASE						INITIAL DELIVERY PHASE																	
	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24					
	-23 mth	-22 mth	-21 mth	-20 mth	-19 mth	-18 mth	-17 mth	-16 mth	-15 mth	-14 mth	-13 mth	-12 mth	-11 mths	-10 mths	-9mths	-8mths	-7mths	-6 mths	-5 mths	-4mths	-3mths	-2mths	-1mth	0 mth	+ 1 mth	+ 2 mth	+3 mth	+ 4 mth	+ 5 mth	+ 6 mth	+ 7 mth					
Governance	[Gantt bars for Governance tasks]																																			
Relocation and removals	[Gantt bars for Relocation and removals tasks]																																			
Operational planning	[Gantt bars for Operational planning tasks]																																			
Mobilisation	[Gantt bars for Mobilisation tasks]																																			
Inpatients	[Gantt bars for Inpatients tasks]																																			
Outpatients	[Gantt bars for Outpatients tasks]																																			
Endoscopy Suite	[Gantt bars for Endoscopy Suite tasks]																																			
Urgent Care	[Gantt bars for Urgent Care tasks]																																			
Imaging	[Gantt bars for Imaging tasks]																																			

IT
 Complete audit of all IT equipment and moves required
 Agreement of printer sharing arrangements
 Link with development of SOPs
 Plan for and arrange data links/ agree double running period
 Set up and test all new systems - including telephony
 On site support on day of move and for the following week

PREPARATION PHASE														MOBILISATION PHASE						INITIAL DELIVERY PHASE										
Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
-23 mth	-22 mth	-21 mth	-20 mth	-19 mth	-18 mth	-17 mth	-16 mth	-15 mth	-14 mth	-13 mth	-12 mth	-11 mths	-10 mths	-9mths	-8mths	-7mths	-6 mths	-5 mths	-4mths	-3mths	-2mths	-1mth	0 mth	+1 mth	+2 mth	+3 mth	+4 mth	+5 mth	+6 mth	+7 mth



Risk Register - Speller Metcalfe - Forest of Dean Community Hospital - Project Risk Register Rev 4 18/06/21

GREY BOX = CLOSED RISK
WHITE BOX = LIVE RISK

Very Low	Low	Medium	High	Very High
VL	L	M	H	VH
2	4	6	8	10

Risk Identification						Risk Analysis					Risk Management Plan								
UIN	Date Raised	Risk Category	Cause of Risk / Risk Description	Provisional/ Risk Cost?	Contractor D&B Contingency	Risk Proximity	Likelihood	Impact	Risk Matrix	Total Risk Score	Risk Status	Risk Response	Action Taken	Actions Planned	Risk Owner	Action Owner	Date By	Last Updated	Comments
1	06-Jan-21	EOR-Finance	Project exceeds Client Budget			Within the Project	VH	VH	VHVH	16000	RED	Reduce	Initial update of cost plan has indicated that the scheme is substantially over the Trust's budget allowance (circa £6m over).	Refer to overarching risk register owned by the NHS where this risk is recognised. Continual evolution and update of the project cost plan to increase granularity of cost plan crucial. Given the impact of project abnormal position & size of the building on the site needs to be revisited before RIBA Stage 2 process can be progressed, otherwise project viability is under threat.	NHS Trust	ALL	Ongoing	18-Jun-21	We have not included a separate cost in the risk register as cost is reflected in the overall scheme cost plan & contingencies.
2	06-Jan-21	EOR-Third Party	Failure to agree access & egress solution with Highways			Within the Pre-Construct on Stage	L	VH	LVH	4000	ORANGE	Avoid	Design scoping document created and submitted to Highways on 29th January 2021.	Feedback anticipated from Highways 15th February 2021 earliest.	NHS Trust	CTP	Planning Determination	18-Jun-21	18/06/21 - Cotswold Transport Planning have now undertaken comprehensive transport monitoring and detailed design for access & egress off Steamills Road with a staggered junction opposite Valley Road. This has now been submitted to Highways for review and feedback is awaited. Risk likelihood has been downgraded.
3	06-Jan-21	CON-Time/Cost	Cost and feasibility of solution to deal with mine workings (Foundations & Ground Improvement)	£50,000.00		Within the Construct on Stage	M	H	MH	4000	ORANGE	Reduce	Cost information has been sort from specialists. Further design information will progress to inform the solution by mid February.	Progression of ground investigation and interpretation - engagement of specialist supply chain.	NHS Trust	Barnsley Marshall	Practical Completion	18-Jun-21	18/06/21 - Mine probing investigation works have now been undertaken to inform budget for the works and the cost plan has been adjusted accordingly. Whilst the likelihood of works additional to the scope identified has significantly reduced a risk still remains. Risk allowance reduced.
4	06-Jan-21	EOR-Third Party	Foul & Storm drainage strategy add excessive costs to the project	£-		Within the Construct on Stage	VL	M	VLM	100	AMBER	Avoid	Additional drainage information has been requested from Severn Trent, including land to south of Steam Mills Road.	Progress drainage design in line with feedback and records. Further site investigations / CCTV of drainage to inform.	NHS Trust	Barnsley Marshall	Practical Completion	18-Jun-21	18/06/21 - Drainage design and liaison as now progressed with Severn Trent to the extent that the pumping station and foul drainage attenuation has been removed. This risk is significantly reduced.
5	06-Jan-21	CON-Time/Cost	Supply Chain Insolvency		£100,000.00	Within the Project	M	VH	MVH	8000	RED	Avoid		Credit checks of any supply chain member prior to placement of order. Management accounts to be requested for large orders.	Speller Metcalfe	Speller Metcalfe	Practical Completion	18-Jun-21	This risk sum sits with Speller Metcalfe, not the client project contingency
6	06-Jan-21	EOR-Time/Cost	Unforeseen ground conditions / contamination	£50,000.00		Within the Project	M	VH	MVH	8000	RED	Reduce	Initial ground investigations.	Receive final G.I. report - further ground investigations / mine probing to be commissioned working in conjunction with MJ Drilling (specialist subcontractor). ARUP to comment on WAC / contamination in initial design report	NHS Trust	Barnsley Marshall	Practical Completion	18-Jun-21	18/06/21 - This risk remains as is - further WAC testing to be carried out to derisk.
7	06-Jan-21	EOR-Brief	Achieving programme to achieve Full Business Case Sign Off (July)			Imminent	L	H	LH	2000	ORANGE	Accept			NHS Trust	All	15-Jul-21	18-Jun-21	18/06/21 FBC date was pushed back to allow further time for site abnormal investigations and redesign.
8	06-Jan-21	EOR-Brief	Full Business Case not approved			Within the Pre-Construct on Stage	L	VH	LVH	4000	ORANGE	Reduce	Detailed design programme created to denote all necessary deliverables and activities for FBC. Draft FBC structure understood.		NHS Trust	All	15-Jul-21	18-Jun-21	18/06/21 It is very unlikely that as a team we will be presenting a business case that we do not think is feasible.
9	06-Jan-21	EOR-Finance	Cost risk of access road			Within the Project	M	H	MH	4000	ORANGE	Closed	Liaison with Highways	Act on feedback from Highways.	NHS Trust	CTP	01-May-21	18-Jun-21	18/06/21 This is now encompassed withing risk ID6 - so this risk is closed
13	06-Jan-21	CON-Time/Cost	Insufficient Supply Chain or Material Resource to service project		£60,000.00	Imminent	M	VH	MVH	8000	RED	Avoid		Research & contingency planning by Speller Metcalfe on specified materials and products - notes to be made on procurement schedules to ensure focus and derisked.	Speller Metcalfe	Speller Metcalfe	Practical Completion	18-Jun-21	18/06/21 - Given current market conditions with supply of materials & subcontractor resource cause by Coronavirus, the risk as been upgraded
14	06-Jan-21	CON-Finacial	Impact of Coronavirus & BREXIT on supply chain (inflation risk)	£160,000.00		Within the Pre-Construct on Stage	H	VH	HVH	12000	RED	Reduce		Detailed cost planning and market testing - place order ASAP to fix prices.	NHS Trust	Speller Metcalfe	Practical Completion	18-Jun-21	18/06/21 - Given current market conditions with supply of materials & subcontractor resource cause by Coronavirus, the risk as been upgraded, as there has been significant inflation across the material supply chain in the past few weeks.
15	06-Jan-21	EOR-Third Party	Nett Biodiversity gain required for Planning				M	H	MH	4000	ORANGE	Reduce	Initial cognisance of requirements	Detailed landscape design	NHS Trust	Astley Partnerships	Practical Completion	18-Jun-21	18/06/21 - Currently a sensible allowance for planting has been made in the cost plan. Detail of landscape design now been worked on by Astley Partnerships
16	06-Jan-21	EOR-Third Party	Existing site services increase cost or delay programme				M	H	MH	4000	ORANGE	Reduce	Initial site records and investigations	Design on basis of information received. Further site investigations planned.	NHS Trust	Barnsley Marshall	Practical Completion	18-Jun-21	18/06/21 - Further site investigations works have failed to identify any water main.
17	06-Jan-21	EOR-Third Party	Dormouse EPS licensing requirements delay project. Bat Mitigation also to be considered.			Within the Project	L	H	LH	2000	ORANGE	Reduce	Initial liaison with Ecologist and scope prepared.	Fee bid and programme detail to be firmed up.	NHS Trust	Focus Ecology	01-Dec-22	18-Jun-21	18/06/21 - Formal license application can only be done once planning is achieved. This is accounted for in current programme and design approach with Focus Ecology leading technical approach.
11	06-Jan-21	EOR-Third Party	Agreement for land use not agreed with Forestry Commission			Within the Project	L	H	LH	2000	ORANGE	Avoid	Good initial liaison undertaken - positive relationship	Ongoing liaison and dialogue on design	NHS Trust	Gleeds	01-Sep-21	18-Jun-21	18/06/21 - Ongoing liaison with the Forestry Commission, impact on their land has reduced with current design - no longer going to have access on 'triangle'.
12	06-Jan-21	EOR-Other	Insurances & compliant Fire Strategy			Within the Project	L	H	LH	2000	ORANGE	Reduce	Initial meeting held with NHS Trust Fire Officer	Ongoing liaison and dialogue on design	NHS Trust	Gleeds	01-Nov-21	18-Jun-21	18/06/21 - Costs for compliance should be incorporated in cost plan

Risk Register - Speller Metcalfe - Forest of Dean Community Hospital - Project Risk Register Rev 4 18/06/21

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Very Low	Low	Medium	High	Very High
VL	L	M	H	VH
2	4	6	8	10

Risk Identification						Risk Analysis					Risk Management Plan								
UIN	Date Raised	Risk Category	Cause of Risk / Risk Description	Provisional/ Risk Cost?	Contractor D&B Contingency	Risk Proximity	Likelihood	Impact	Risk Matrix	Total Risk Score	Risk Status	Risk Response	Action Taken	Actions Planned	Risk Owner	Action Owner	Date By	Last Updated	Comments
17	06-Jan-21	EOR-Management	Failure to achieve Planning Permission			Within the Pre-Construct on Stage	VL	VH	VLVH	2000	ORANGE	Avoid	Pre-app advice formally sought and report received.	Act upon feedback formally received in pre-app report.	NHS Trust	Avison Young	Planning Permission	18-Jun-21	18/06/21 - Ongoing liaison with the Planners through newly appointed Planning Consultant, Avison Young
18	06-Jan-21	EOR-Other	Unforeseen Ecological Risks (invasive species)	£-		Within the Project	VL	H	VLH	1000	ORANGE	Avoid	Site constraints drawing does indicate invasive species - received 05/02/21/.	Further investigations required to inform costings for treatment	NHS Trust	Focus Ecology	Construction Commencement	18-Jun-21	18/06/21 Focus have carried out a survey of the site which has not identified anything of concern. Cost risk downgraded
19	05-Feb-21	EOR-Third Party	Delayed construction of skate park delays ability to commence / planning permission	£100,000.00		Within the Pre-Construct on Stage	L	H	LH	2000	ORANGE	Avoid	Initial liaison with Planners and town council - budget contribution to skate park	Ensure that Cinderford Council are aware of potential impact on the project. Communicate to Cinderford Town council to commence to pre-app ASAP to de-risk. Ideally their planning application needs to be determined prior.	NHS Trust	Gleeds	Planning Permission	18-Jun-21	Costs associated with delay to start (additional inflation & personnel)
19	06-Jan-21	EOR-Third Party	Agreement for access road works not obtained with Bayliss Family			Within the Project	VL	H	VLH	1000	ORANGE	Avoid	Initial meeting with Bayliss family undertaken by Kevin Adams & Adrian Speller. Follow up MS Teams meeting held to explain scheme design.	Ongoing liaison and dialogue on design	NHS Trust	Speller Metcalfe	Construction Commencement	18-Jun-21	Current design means no improvements intended but good communication is still essential to ensure the Baylisses remain onboard in support of the project.
20	06-Jan-21	DDR	COVID impacts on ability of team to progress design & construction (Lockdown)			Within the Project	VL	H	VLH	1000	ORANGE	Reduce		Ongoing good standards of communication and contingency planning for loss of key project personnel required.	NHS Trust	ALL	Project Completion	18-Jun-21	Remains a risk
21	06-Jan-21	EOR-Brief	Failure to meet Trust / HTM specification requirements (project does not meet brief)			Within the Project	VL	H	VLH	1000	ORANGE	Avoid		Potential derogation of HTM if necessary a control measure.	NHS Trust	One Creative	Project Completion	18-Jun-21	18-06-21 Clear Derogation schedule to defined with cost plan
23	06-Jan-21	EOR-Brief	Ensuring flexibility / adaptability of design for future expansion & service provisions			Beyond the Project	M	M	MM	400	AMBER	Reduce	SIPS focused on as enabling flexibility of substructure for future alterations.	Continue to focus on flexibility in design progression.	NHS Trust	One Creative	Project Completion	18-Jun-21	18-06-21 Superstructure Options Still being considered
24	06-Jan-21	ECR	Late Client changes impact on programme and cost			Within the Project	M	M	MM	400	AMBER	Reduce	Good design consultation has been undertaken with clinical stakeholders.	Ongoing detailed consultation with clinical stakeholders on room data sheets and layouts to reduce potential for late changes during project.	NHS Trust	One Creative	Project Completion	18-Jun-21	18-06-21 Allowance withing project contingency - One have now carried out several further co-ordination meetings with clinical stakeholders to set 1:200s
25	06-Jan-21	EOR-Other	Aboriginal Constraints			Within the Construct on Stage	M	M	MM	400	AMBER	Reduce	Initial aboriginal surveys	Further detailed aboriginal survey in context of proposed design	NHS Trust	Focus Ecology	Project Completion	18-Jun-21	Already an allowance in the cost plan for treeworks.
26	05-Feb-21	EOR-Third Party	Need for Section 106 contributions through planning requirements	£50,000.00		Beyond the Project	M	M	MM	400	AMBER	Avoid	Pre-app advice formally sought and report received.	Further liaison with planners to understand likelihood of contributions	NHS Trust	Avison Young	Planning Permission	18-Jun-21	18-06-21 Still remains
26	06-Jan-21	DDR	COVID impacts on ability to engage with NHS Stakeholders			Within the Project	VL	M	VLM	100	AMBER	Accept		Early progression of room data sheets to allow ample time for input of clinical stakeholders.	NHS Trust	MJ Medical	Project Completion	18-Jun-21	18-06-21 Virtual meetings working successfully, risk downgraded
27	06-Jan-21	EOR-Third Party	Community Engagement - failure to keep Cinderford & wider FOD communities onside with the scheme			Beyond the Project	L	M	LM	200	AMBER	Reduce	Stakeholder Mapping and plan undertaken	Ongoing management of stakeholder communications through project stakeholder management committee	NHS Trust	NHS Trust	Project Completion	18-Jun-21	18-06-21 Stakeholder Engagement plan in place
28	06-Jan-21	CON-Time/Cost	Considerate Construction for Neighbours - risk of planning enforcement / complaints			Within the Construct on Stage	L	M	LM	200	AMBER	Reduce		Letter drop and stakeholder consultation during design phase. Communications plan to be deployed during construction phase.	Speller Metcalfe	Speller Metcalfe	Project Completion	18-Jun-21	
29	06-Jan-21	EOR-Time/Cost	Extent of Skate park structure adds cost to demolitions	£10,000.00		Within the Construct on Stage	L	M	LM	200	AMBER	Reduce		Trial hole in skate park to firm up understanding of construction	NHS Trust	Speller Metcalfe	01-Feb-22	18-Jun-21	Sensible allowance has been made withing the current cost plan for demolition.
30	06-Jan-21	EOR-Brief	Not Achieving BREEAM Excellent			Within the Project	L	M	LM	200	AMBER	Avoid	Early BREEAM meetings and design activities instigated	Ongoing management of BREEAM deliverables with design activities then construction phase	Speller Metcalfe	Speller Metcalfe	12 months Defects	18-Jun-21	Costs for BREEAM are within cost plan allowance.
31	06-Jan-21	EOR-Brief	Failure to achieve BIM Level 2			Within the Project	L	M	LM	200	AMBER	Avoid	Initial discussions held on BIM	Create Detailed BIM Execution Plan	Speller Metcalfe	Speller Metcalfe	12 months Defects	18-Jun-21	
32	06-Jan-21	EOR-Management	Failure to engage and plan for facilities management			Beyond the Project	L	M	LM	200	AMBER	Avoid	Initial consultation meetings held with NHS FM Team	Continue liaison meetings. Formalise Soft Landings Delivery Plan.	NHS Trust	Speller Metcalfe	12 months Defects	18-Jun-21	
33	06-Jan-21	EOR-Other	Wild Boar ecological control			Beyond the Project	L	M	LM	200	AMBER	Reduce	Initial Ecological appraisal	Ecologist advise and suitable landscape design	NHS Trust	Focus Ecology	12 months Defects	18-Jun-21	
34	06-Jan-21	CON-Time/Cost	Site Security risks during Construction Phase			Within the Construct on Stage	L	M	LM	200	AMBER	Reduce		Sensible allowance for security guards and site fencing in SML prelims	Speller Metcalfe	Speller Metcalfe	Practical Completion	18-Jun-21	Will be included in prelims - currently a sensible allowance within the cost plan.
35	06-Jan-21	EOR-Other	Changes to Legislation, Building Regs or HTMs			Within the Project	L	M	LM	200	AMBER	Accept		Fix stage 2 documentation to a point. Keep abreast of any likely changes across all disciplines.	NHS Trust	All	Practical Completion	18-Jun-21	Designing to known building regulations - not thought to be a risk of change during the design period.
36	06-Jan-21	CON-Time/Cost	Pollution / run off to watercourses			Beyond the Project	L	M	LM	200	AMBER	Avoid		Ensure design mitigates pollution possibility	NHS Trust	Barnsley Marshall	Practical Completion	18-Jun-21	
45	06-Jan-21	EOR-Third Party	Improvements required to the Culvert	£50,000.00		Within the Construct on Stage	L	M	LM	200	AMBER	Avoid	Initial site records and investigations	Feedback from Severn Trent to be acted on when received. Further CCTV survey of culvert.	NHS Trust	Barnsley Marshall	01-May-21	18-Jun-21	18-06-21 No real proactive options available to derisk reliant on Severn Trent
37	06-Jan-21	EOR-Time/Cost	Project delivery exceeds programme requirements			Beyond the Project	VL	M	VLM	100	AMBER	Reduce	Detailed design programme undertaken - construction phase programme in progression	Replicated on overarching Trust risks. Detailed programme planning around project critical path. Regular updates to Client and stakeholders.	NHS Trust	Speller Metcalfe	Occupation	18-Jun-21	

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Risk Identification						Risk Analysis					Risk Management Plan									
UIN	Date Raised	Risk Category	Cause of Risk / Risk Description	Provisional/ Risk Cost?	Contractor D&B Contingency	Risk Proximity	Likelihood	Impact	Risk Matrix	Total Risk Score	Risk Status	Risk Response	Action Taken	Actions Planned	Risk Owner	Action Owner	Date By	Last Updated	Comments	
38	06-Jan-21	DDR	Failure / Poor Feedback from Design Quality Indicator review			Within the Pre-Construction Stage	VL	M	VLM	100	AMBER	Avoid	DQI meeting undertaken - good feedback received verbally	Formalise DQI feedback in record document. Ongoing liaison	NHS Trust	Gleeds	Planning Permission	18-Jun-21	18-06-21 DQI process needs revisiting with new design	
39	06-Jan-21	EOR-Time/Cost	Failure to sign off planning conditions			Within the Project	VL	M	VLM	100	AMBER	Avoid	Initial pre app consultation	Avison Young to run planning conditions tracker to manage discharge once conditions received. Submit information with planning pack to avoid information being conditioned (e.g. CEMP)	NHS Trust	Avison Young	Practical Completion	18-Jun-21		
40	06-Jan-21	EOR-Finance	Collateral Warranties insufficient for Trust needs or not agreed			Beyond the Project	VL	M	VLM	100	AMBER	Avoid		Draft collateral warranties for comment as soon as practicable	NHS Trust	Gleeds	Practical Completion	18-Jun-21		
41	06-Jan-21	EOR-Time/Cost	Procurement of X-Ray and other specialist equipment delayed			Within the Project	VL	M	VLM	100	AMBER	Reduce		Early enquiries for procurement	NHS Trust	NHS Trust	Construction Commencement	18-Jun-21		
42	06-Jan-21	EOR-Time/Cost	Legacy equipment not integrated properly with scheme			Beyond the Project	L	L	LL	20	GREEN	Reduce		Schedule of legacy equipment to be produced then cross referenced with MJ Medical Room Data Sheets	NHS Trust	NHS Trust	RIBA Stage 4 design	18-Jun-21	Risk of expenditure on additional new equipment. Sensible budget for new equipment is currently allowed for in the cost plan, so no additionally contingency is allowed for here.	
43	06-Jan-21	EOR-Third Party	Right of access for fence maintenance problematic			Beyond the Project	L	L	LL	20	GREEN	Avoid	Initial stakeholder consultation meeting with residents held in January 21.	Ongoing liaison and dialogue on design	NHS Trust	One Creative	RIBA Stage 4 design	18-Jun-21		
44	06-Jan-21	EOR-Third Party	Local Utilities Capacity	£30,000.00		Within the Project	VL	VL	VLVL	2	GREEN	Reduce	Utilities have been approached - no current issues known	Quotes to be refreshed based on agreed design to derisk.	NHS Trust	ARUP MEP	01-May-21	18-Jun-21	Potential for additional off or onsite works to enhance utilities and infrastructure so that they can cope with the additional capacity. A sensible allowance base on previous quotes has been allowed for in the cost plan.	
Total Risk Amount				£500,000.00	£160,000.00															

Summary of all Benefits

Strategic Investment Objective	Benefits realised through the design and satisfactory completion of the building	Benefits facilitated by the building design but requiring specific action to realise	Benefits as perceived by staff and patients using the building	Benefits included in the Economic Model
<i>To facilitate the delivery of sustainable models of care</i>	Improved ability to cover staff shortages which are currently covered by staff travelling between the wards on the two sites.	The ability to operate multidisciplinary clinics bringing together a range of different skills and activities thus improving clinical effectiveness and efficiency and enabling patients to avoid multiple visits through a one-stop approach.	Patient and user satisfaction relating to the bringing together of services in one place	Avoided travel to Cheltenham for endoscopy with cost and time benefits for patients and carers
		A new endoscopy service meaning patients can avoid travel to Cheltenham for endoscopy with cost and time benefits for patients and carers		Reduction of hours pa when MIU is closed to new patients
		Community initiated use of rooms for health creating activity		
	Greater resilience in staffing radiography to enable potential operation 7 days a week	Training and professional development activity arising from joint working and use of the centre's facilities Anticipated service commencement by Gloucestershire Hospitals NHS FT June/July 2023		

Strategic Investment Objective	Benefits realised through the design and satisfactory completion of the building	Benefits facilitated by the building design but requiring specific action to realise	Benefits as perceived by staff and patients using the building	Benefits included in the Economic Model
<p><i>To facilitate an inpatient service that integrates nursing and therapies maximising the rehabilitation potential of patients and making a fuller contribution to the flow and discharge of inpatients in the One Gloucestershire system</i></p>	<p>Improved ability to cover ward staff shortages which are currently covered by staff travelling between the wards on the two sites.</p>	<p>A reduced total nursing staff cost by 2025-6 (See Management Case)</p>		<p>Days saved in getting patients ready for discharge. Due to complexity of patients, the average Length of Stay will not reduce but the integrated nursing and therapy model available 7 days a week, means the time required to get patients ready for discharge will be less than it would have been if the therapy service was not in place.</p>
	<p>Single rooms provide greater compliance with Infection Prevention and Control standards and reduce risk of transmission of infectious disease. Single rooms improve bed availability regardless of patient sex and infection status</p>			<p>Reduction of bed days lost due to infection</p>
				<p>Efficiency gain in switching staff resources from nursing to therapies (non-cash releasing benefit)</p>

Strategic Investment Objective	Benefits realised through the design and satisfactory completion of the building	Benefits facilitated by the building design but requiring specific action to realise	Benefits as perceived by staff and patients using the building	Benefits included in the Economic Model
<i>To facilitate a reliable and consistent Urgent Care service for the Forest of Dean as part of the One Gloucestershire integrated urgent care system.</i>		Consistent service 365 days per year with no/minimal closures due to staffing and skill issues	Patient satisfaction	
		Evidence of joint working with Rapid Response to avoid admission and avoid escalation to Gloucester ED		
		Evidence of collaborative work with OOH primary care and impact with a positive impact on both services		
<i>To provide a building that meets all foreseeable modern standards, meets the needs of users, is economic to operate and maintain and which will be flexible for current and future requirements.</i>	Avoidance of the need to fund the backlog maintenance for the existing sites	Improved building performance KPIs including room utilisation	Patient satisfaction with relation to privacy and dignity, dementia etc	
	Full DDA compliance		Staff satisfaction relating to working environment, clinical space and adjacencies etc	

Strategic Investment Objective	Benefits realised through the design and satisfactory completion of the building	Benefits facilitated by the building design but requiring specific action to realise	Benefits as perceived by staff and patients using the building	Benefits included in the Economic Model
	Building to current standards (subject to agreed derogations)			
<i>To contribute significantly towards the environment and local sustainability by supporting the journey towards Net-zero carbon emissions.</i>	(See benefit included in the economic model)	Demonstration of a high level of Corporate Social Responsibility.		Optimised energy efficiency (demonstrated through both reduced costs and reduced carbon emissions).
	Contributing to the Trust's reduced organisational impact on the Climate Health Emergency.	Opportunity for social cohesion, self-management of health and local community projects with physical and mental health benefits.		

Appendix 5.9 Planned changes to staff structures

Role	Current Total - 2 sites	Proposed Total - One Hospital	Difference H/(L)
Band 2 Porters	2.4	1.0	1.4
Band 2 Catering	3.9	2.2	1.7
Band 2 Cleaning	9.6	5.5	4.0
Band 2 Team Leader	1.3	0.7	0.7
Band 3 Facilities Supervisor	2.0	1.0	1.0
Total WTE	19.2	10.4	8.8

Service	Urgent Care (inc. Triage) 8-8; 7 days a week			Inpatients					Outpatients			Endoscopy		
Band	Current WTE	Proposed WTE	Difference H/(L)	Current WTE (contracted)	Current WTE (contracted) pro-rata to 24 beds	Proposed WTE	Difference H/(L) vs FoD (contracted)	Difference H/(L) vs pro-rata 24 beds	Current WTE (contracted)	Proposed WTE	Difference H/(L)	Current WTE	Proposed WTE	Difference H/(L)
2	0.2	2.2	2.1	34.0	17.4	16.3	(17.8)	(1.1)	1.5	1.5	-	-	2.0	2.00
3	4.5	2.7	(1.7)	8.3	4.3	2.8	(5.5)	(1.5)	-	-	-	-	-	0.0
4	-	-	0.0	0.2	0.1	-	(0.2)	(0.1)	-	-	-	-	-	0.0
5	4.8	2.8	(2.0)	18.4	9.4	8.2	(10.3)	(1.2)	2.0	2.0	-	-	5.0	5.0
6	4.1	1.4	(2.7)	10.9	5.5	9.4	(1.5)	3.8	1.0	1.0	-	-	1.5	1.5
7	3.8	5.6	1.8	2.4	1.2	1.0	(1.4)	(0.2)	1.0	1.0	-	-	1.0	1.0
8a	-	-	0.0	0.3	0.2	1.0	0.7	0.8	-	-	-	-	-	-
Total WTE	17.3	14.8	(2.6)	74.6	38.1	38.6	(36.0)	0.5	5.5	5.5	-	-	9.5	9.5
<i>of which</i>														
Nursing	17.2	12.6	(4.6)	62.6	32.0	28.54	(34.1)	(3.4)	5.5	5.5	-	-	9.5	9.5
Therapy	-	-	0.0	8.4	4.3	7.20	(1.2)	2.9	-	-	-	-	-	-
Other	-	-	0.0	1.0	0.5	1.70	0.7	1.2	-	-	-	-	-	-
Non-Clinical	0.2	2.2	2.1	2.5	1.3	1.16	(1.4)	(0.1)	-	-	-	-	-	-
Total WTE	17.3	14.8	(2.6)	74.6	38.1	38.6	(36.0)	0.5	5.5	5.5	-	-	9.5	9.5