University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper H

TRUST BOARD – 22 December 2014

Delivering the Five Year Strategy – Proposed Governance

DIRECTOR:	Kate Shields
AUTHOR:	Ellie Wilkes
DATE:	22 December 2014
PURPOSE:	To brief the Board on the outcome of the Department of Health Gateway Zero review recommendations and to describe the actions taken to address them. The Trust Board is asked to; • Review the Programme Brief and provide approval for the document • Agree to the proposed governance arrangements • To have 'Delivering the Five Year Strategy' as a standing item on the Trust Board
PREVIOUSLY CONSIDERED BY:	Executive Strategy Board
Objective(s) to which issue relates *	☐ 1. Safe, high quality, patient-centred healthcare ☐ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☐ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☐ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision [x] For assurance [x] For information [ ]

♦ **We treat people how we would like to be treated** ♦ **We do what we say we are going to do**
♦ **We focus on what matters most** ♦ **We are one team and we are best when we work together**
♦ **We are passionate and creative in our work**

***** tick applicable box

Delivering the Five Year Strategy – Proposed Governance

Summary

1. The attached programme brief was presented and approved at Executive Strategy Board (ESB) on 9th December 2014 as part of a paper to outline the proposed governance arrangements for overseeing delivery of the Five Year Strategy.

2. The programme brief is in direct response to the recommendations of the Gateway Zero review that was in October 2014 which rated the Trust as Amber-Red.

3. The governance structure described is proposed to be the main vehicle through which all activities pertaining to delivering the Five Year Strategy are tracked.

Background

4. A Department of Health Gateway Zero review of UHL's reconfiguration programme was carried out from 20 October 2014 to 23 October 2014 at the Leicester Royal Infirmary. The primary purpose of a Health Gateway zero review is to review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to government, departmental, NHS or organisational overall strategy.

5. The review concluded that UHL needed to appoint a Programme Director and establish an overarching governance structure in line with a recognised methodology (Prince 2/MSP) to provide assurance to the Trust Board and external bodies of ability to deliver within the timescales.

6. The plans to reduce activity and reconfigure will require significant amounts of work to realise the vision. The Better Care Ttogether (BCT) programme has a series of workstreams established to drive system change. However UHL has not as yet set up a similar governance structure to oversee the various activities (through workstreams) required to realise the five year reconfiguration strategy

Proposal

7. In response to the Gateway review a number of actions have been undertaken to provide assurance to the Trust Board and external bodies in relation to the ability to deliver the five year strategy;

    - A Programme Director appointed for 12 months to establish the governance arrangements
    - A programme brief produced – including initial governance proposals and timelines

8. The Programme Brief included in this paper articulates the overarching governance structure including workstreams and reporting.

9. To deliver the programme a Strategy Programme Management Office (PMO) is being established and will focus on supporting the workstreams to formalise, develop and implement reporting functions to monitor progress and align with the BCT PMO to ensure system wide tracking. A Programme Key Performance Indicators (KPI) dashboard will be developed as the Programme progresses to ensure activities undertaken are delivering against plan and in line with Trust Strategic benefits.

10. Following approval of the programme brief the Programme Initiation Document will commence. This requirement is also a recommendation from the Gateway review team and will be completed by the end of January 2015 for review through February by the ESB and Trust Board ahead of a follow assessment by the team.

Recommendations

11. The Trust Board is asked to:

- **Review** the programme brief and provide approval for the document
- **Agree** to the proposed governance arrangements
- **Agree** to having 'Delivering the Five Year Strategy' as a standing item on the Trust Board

University Hospitals of Leicester NHS
NHS Trust

Programme Brief for establishing the Governance arrangements for overseeing the delivery of the Five Year UHL Strategy
December 2014
Version 0.3

Purpose of document

1. This paper provides an overview of the proposed arrangements governance arrangements for the delivery of the five year strategy including the overarching governance framework, reporting instructions, programme management arrangements and key milestones.

Background

Better Care Together (BCT)

2. The BCT programme is a partnership of NHS organisations and local authorities across Leicester, Leicestershire & Rutland (LLR). It is driven by a shared recognition that major changes are needed to ensure that services are of the right quality and capable of meeting the future needs of local communities.

3. The LLR Five Year Strategy was jointly developed under the programme name of BCT. The plan sets out to reform health and social care services through a shared vision for the population of LLR, over the next five years.

4. The strategic outline case (SOC), published in October 2014, sets out the case for the BCT programme as being the preferred way forward to deliver the plans set out in the five year strategic plan. The SOC is designed to be a "wrapper" for all the future transformation business cases which will be required for the system to realise its vision.

5. The plans set out in the LLR SOC will see a significant "left-shift" of care out of acute settings, allowing UHL to concentrate on providing care to complex patients and improving the provision of sub-acute services in community hospitals, and the development of greater capacity in community teams allowing patients to live more independently in their homes.

6. The performance and effectiveness of the changes made will be measured through reduction in avoidable emergency admissions/readmissions, delayed transfers of care, residential admissions, and improved effectiveness of rehabilitation after discharge from hospital and patient/service user experience.

UHL Five Year Strategy

7. In line with the overall BCT Five Year Strategy, the Trust developed and submitted its five year plan in June 2014 which seeks to ensure that the vision of "smaller more specialised hospitals" becomes a reality and the on-going issues with emergency and urgent care are solved and that the Trust returns to financial balance. This will require UHL to go from three sites to two by 2018/19.

8. It has been calculated that UHL will need to reduce its bed base by approximately 462 beds in order to reduce the overall estate footprint.

9. There will be a number of work streams that fall into three categories: enabling works, refurbishment and strategic capital developments that will all support the reconfiguration from three to two sites;

10. It is anticipated that a number of system wide changes to current provision of care in the community plus efficiency gains in the acute setting will enable this left shift of activity and reduce the number of acute beds by 571 by 2018/19. This equates to a physical reduction of 462 beds at UHL by 2018/19. The current planning assumptions indicate that the reductions in activity will be achieved through three main workstreams:

    - **Internal UHL efficiencies** - 212 beds (Daycase/LOS): cross cutting workstreams established to support delivery

    - **Reconfiguration** - 250 beds (left shifts): Joined up approach to delivery working with LPT to identify appropriate sub-acute patients to move out

    - **Managing future demand** - reduce future need for an additional 109 beds: this is being led by primary care

Department of Health (DH) Gateway Zero review recommendations

11. A DH Gateway Zero review of UHL's reconfiguration programme was carried out from 20 October 2014 to 23 October 2014 at the Leicester Royal Infirmary. The primary purpose of a Health Gateway zero review is to review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to government, departmental, NHS or organisational overall strategy.

12. The review (appendix A) concluded that UHL needed to appoint a Programme Director and establish an overarching governance structure in line with a recognised methodology (Prince 2/MSP) to provide assurance to the Trust Board and external bodies of ability to deliver within the timescales.

13. The team also recommended that a Programme Initiation Document (PID) be produced before a follow up assessment at the end of February 2015. The purpose of the PID is to define the governance structure and delivery mechanisms of the programme including reporting and workstream functions.

14. The plans to reduce activity and reconfigure will require significant amounts of work to realise the vision. The BCT programme has a series of workstreams established to drive system change see appendix B. However UHL has not as yet set up a similar governance structure to oversee the various activities (through workstreams) required to realise the five year reconfiguration strategy

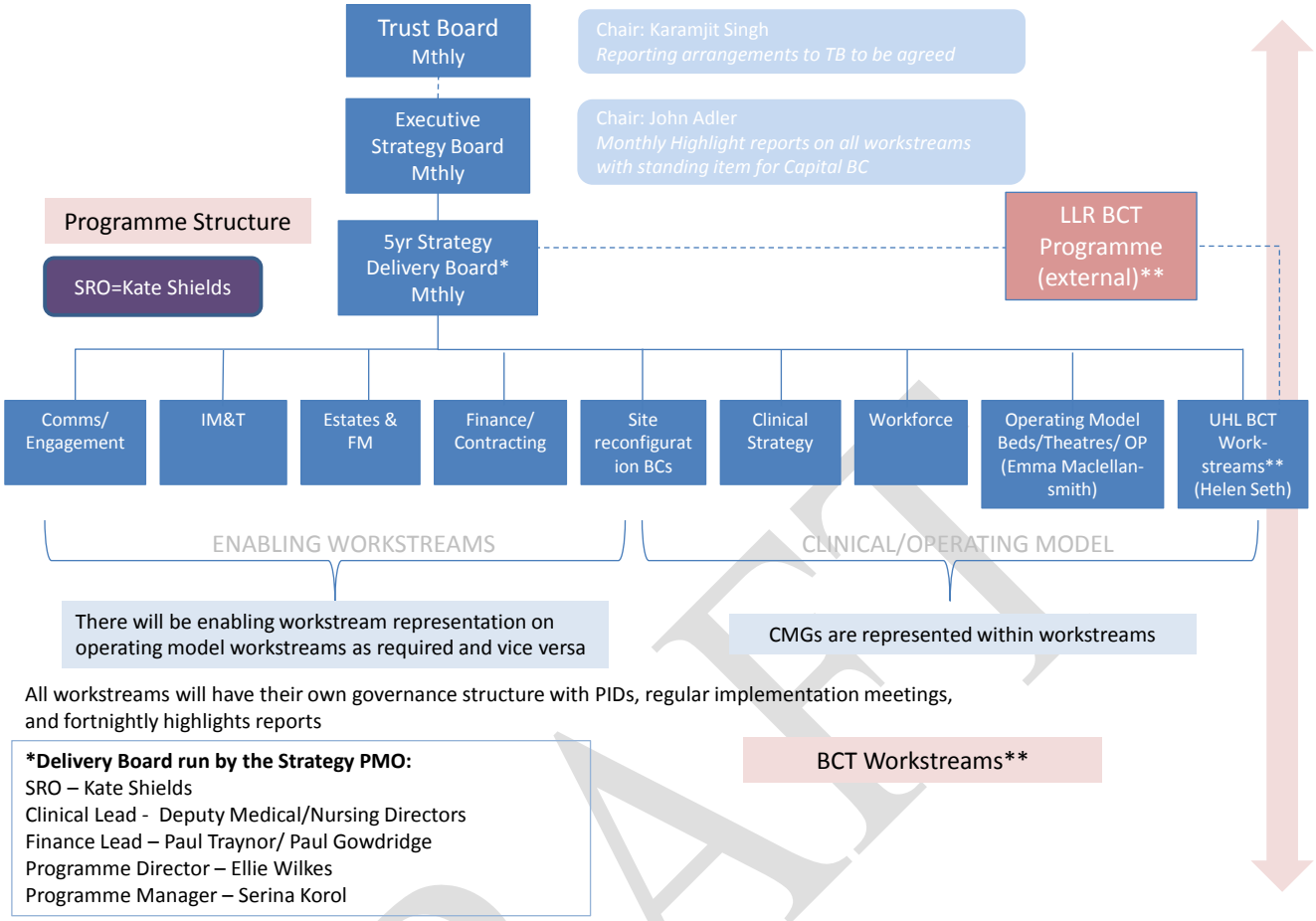
15. A DH Gateway zero review of the Better Care Together programme was held between 3rd and 6th November 2014.

Trust wide Programme Governance

16. The Programme Brief is an overview of how the governance arrangements for the delivery of the five year strategy will be implemented. Once the principles of the governance are agreed then the development of the PID will commence.

17. The proposed governance structure for the Programme is described in the organisational chart below:

Governance structure for delivering the UHL five year strategy – DRAFT V0.2



18. It is proposed that a series of workstreams are formally established and report in to the Delivery Board. These fall broadly into two categories;

- **Future Model Reconfiguration** (Operating Model including Beds, Theatres and Outpatients, Workforce and Clinical Strategy)
- **Enabling workstreams** (Finance, Estates, IM&T, Communications / Engagement, Site Reconfiguration Business Cases)

19. There will be a direct link with the BCT programme through the Strategy Programme Management Office to align reporting, support information flows and track progress in line with wider system changes. The Head of Local Partnerships and Programme Director (Strategy) will be the main points of contact for the Programme at the delivery level.

20. The Delivery Board will meet monthly; it is essential that this Board has sufficient seniority and authority to hold workstreams to account.

21. The Delivery Board will report to Executive Strategy Board on a monthly basis using a highlight reports (as mentioned in section four) and any issues/risks will be escalating with mitigating strategies for Executive awareness and resolve.

22. Appointed workstream leads will be expected to attend the Delivery Board on a monthly basis and to send an agreed deputy in their absence. This will ensure that the Programme Board, Executive Strategy Board, and ultimately Trust Board, will have oversight of the entire Programme in order to monitor and track progress against plan

Membership of the Delivery Board

23. It is proposed that the Delivery Board will be co-chaired by Kate Shields, Director of Strategy and SRO, and Andrew Furlong, Deputy Medical Director. The meeting will be supported by the Programme Director.

24. Named leads (or deputies) for all workstreams (future operating model – to include clinical/CMG representation) must be present at every meeting.

High level programme plan

25. There are a number of key milestones within the first 3-6 months (see appendix d for the plan).

- Establish the UHL Strategy PMO (by end December 2014)
- Complete the '5 year strategy' PID (by end January 2015)
- Workstreams established and project charters complete (by end December 2014)
- First 5 year strategy Programme Board (January 2015)
- Workstream Project Initiation Documents/plans complete (end February 2015)
- Gateway review assessment (end February 2015)

26. A more detailed Programme plan will be developed to map out the initial stages of the programme (3-6 months) and then to incorporate the key milestones across two years. When workstream project plans are agreed then aggregated milestones will be incorporated to a 'master' programme plan. All plans will be correlated against the BCT programme key milestones.

Programme Management Office (PMO)

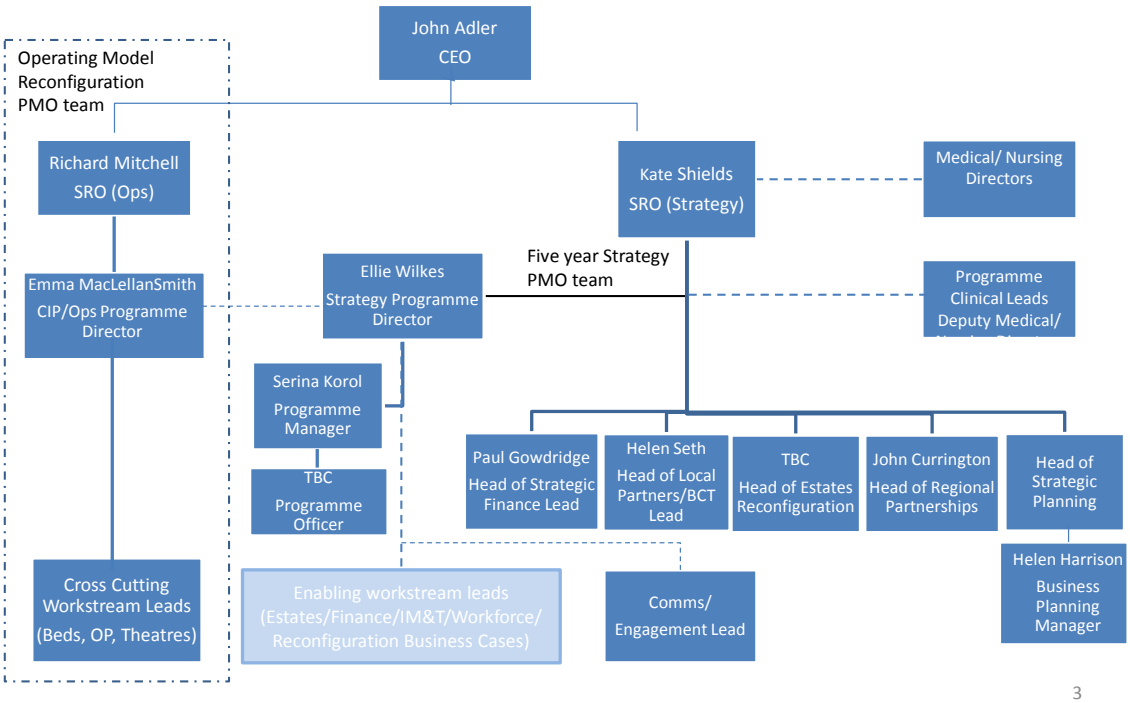
27. A PMO will be established to support the establishment of the governance structure and monitor progress. The PMO will be responsible for running the Trust wide Programme Governance for delivery of the 5 year strategy and will be accountable to the Trust Board through the Executive Strategy Board.

28. The PMO will be led by Kate Shields (Director of Strategy) as SRO with full time support from a Programme Director and Programme Manager. A number of other posts will need to be filled to support the running of the Programme on a full or part time basis. A suggested structure is illustrated in the organisational chart below.

29. The PMO will run in line with the principles of MSP and Prince2 methodology and its structure will be tested through the initiation document and Gateway Review follow up.

30. It is proposed that the PMO be set up as described in the organisational chart below.

Overarching PMO for delivering the 5 year strategy – DRAFT v0.3



Roles and Responsibilities

31. The key roles and responsibilities within the PMO are shown below. Subject Matter Expertise (SME) will be sourced as and when required. Best practice guidance is followed in establishing and managing the programme. The Office of Government Commerce recommends identifying certain key project roles at the outset.

- The **Investment Decision Maker** takes the investment decision for use of resources. This is the Trust Board
- The **Senior Responsible Owner** defines the scope of the programme and is the individual who is personally accountable for its success
- The **Programme Director** is responsible for day to day management and decisions on behalf of the Senior Responsible Owner to ensure that the programme's objectives are delivered
- The **Programme Manager** has a full time commitment to the programme managing and coordinating the integrated Programme Team on a day to day basis

32. There will be several layers to the PMO to support the establishment of the programme and ongoing monitoring, tracking and risk management. There will also be a direct link between the UHL PMO and the BCT PMO for monitoring and reporting. The PMO management structure is described in appendix C.

Workstreams

33. The governance chart described earlier includes a number of expected workstreams which will be in place to deliver different parts of the overall 5 year strategy. It may be that additional ones are identified through the design phase as part of developing the PID.

34. All workstreams will have to go through an approval process for initiation. This will involve completing a project charter and project initiation document. Key responsibilities will include:

- Enabling the 5 year strategy at a specialty, CMG and Trust level
- Working with other workstreams to ensure one interdependent and cohesive strategy at specialty, CMG and Trust level
- Ensure the workstream delivers its component of the 5 year strategy on a clinical, operational, corporate and financial basis

35. Workstreams will be held to account for delivery and will be expected to complete all required documentation plus attend the Delivery Board on a monthly basis. Each workstream will have a named Director to ensure accountability is maintained.

36. Through the Head of Local Partnerships there will be a reporting link with the wider BCT workstreams. This role will oversee delivery of UHL's element of the BCT workstreams and provide information to other workstreams through the Delivery Board.

Reporting and Template

37. The PMO will be responsible for ensuring that all aspects of the programme are reported on, both internally to ESB and ultimately the Trust Board and externally to the BCT programme.

38. All workstreams will be expected to complete a number of templates to properly establish the project in line with best practice. These include a project charter, project initiation document and project plan. All documentation will be signed off at the Programme Board. In addition workstreams will be expected to complete a fortnightly highlight report. Guidance will be produced to support workstreams fulfil the requirements of the PMO.

Programme Scope and Deliverables

39. Included within the scope of the Programme is the oversight of the future model reconfiguration workstreams, site reconfiguration and enabling workstreams

40. Outside of the scope of the Programme is managing the deliverables of the BCT programme and development/delivery of CMG CIP schemes

41. Key deliverables of the PMO: PID, established PMO with robust governance structures, comprehensive workstream plans, overarching programme plan, risk management process.

Decisions required;

42. The Executive Strategy Board is asked to:

- Agree the overarching governance proposal within this Programme Brief
- Agree the workstreams and sponsors/implementation leads
- Give approval to proceed with development of Programme Initiation Document

Appendix A – Gateway Zero review

See separate PDF document

Appendix B- BCT programme workstreams

Sets out plans for eight clinical workstreams and within four different care settings Social Care, Primary Care, Community and Acute Care

Planned care	Mental health	Maternity and neonates	Children and young people
• Implementation of PRISM system to improve referral quality • 40% left shift of acute activity into community • 10% of outpatient activity attendances will be decommissioned • 50% of out of county OP/DC repatriated to LLR (excluding City CCG). • Reviewing pathways for 18 specialties • Introduce non-face to face where appropriate • Full compliance with BADS • UHL OP and daycase elective care hub	• Strengthen prevention and self-help services to improve resilience • Implement Crisis House, step down beds, discharge team and changes to inpatient pathway to reduce out of county placements • Increased access to alternative services, for example through IAPT; • Reduce alternative health placements by 40%, • Providing more step-down support post-discharge, for example step down beds and crisis house facilities.	• Development of single obstetric unit at UHL • Maximise the uptake of midwifery led care options by promoting home births and midwife-led provision – the key system intervention is redesigning how community based midwife led services are delivered to ensure that there is a sustainable model for community based midwife care • Continue with the multi-agency programme to improve perinatal outcomes in Leicester. • Develop an integrated maternal mental health pathway	• Merger of Children's ED and CAU to become a single Ambulatory care unit and deliver Children's acute care provision from a single site • Increasing the provision of counselling and emotional health and wellbeing services to reduce the number of children escalating to tier 3 CAMHS • Reduce out of area placements • Redesigning the hepatitis B pathway to shift 100% of activity from to primary care • Develop options to deliver integrated provision

Learning disabilities	Urgent care	Long term conditions	Frail older people
• Review team to benchmark and analyse the cost and content of high cost packages of care • Reconfiguration of short break services for LD patients / service users • Implementation of an Outreach Team that will work between the community and the Agnes Unit for challenging individuals LLR approach to enable carers to be involved in service development and planning • Flexible LLR wide provision of short term intensive crisis support • Pooled personal budgets and personal health budgets	• New emergency floor at LRI to ensure there is sufficient space to support the flow of "majors" and to offer dignified care and create a positive working environment. • Improving system navigation by boosting NHS111, out of hours medical cover and local single point of access • Increasing the availability of ambulatory care options • Boosting the urgent out of hospital options for at risk patients; • A "Choose Well" public campaign to help people to make the right urgent care choices.	• Based around principles of "Education", "Prediction", "Care planning", "Ambulatory pathways", "Innovation", "Services available when required", and "Choices and plans at the end of life" • Specific interventions include: integrated COPD team cover primary, community and acute care avoiding hospital admissions, including ambulatory care wherever possible. • Exercise medicine to improving levels of activity, giving people access to integrated reablement services • Workplace wellness proof of concept in UHL	• Primarily based on existing BCF plans • Age well and Stay well: Introduce Unified Prevention Offer • Risk stratification, Early diagnosis and referral, and the increase in the number of quality care plans • Care Navigators, Local Area co-ordinators and the development of integrated pathways for Dementia. • Clinical Response team, the Falls service, Integrated Crisis response • Assistive technology. • Good discharge planning and post discharge support

Appendix C - **PMO Management Structure**

There will be several layers to the PMO to support the establishment of the programme and ongoing monitoring, tracking and risk management:

Programme Management Office Team:
Programme Director, Programme Manager, Programme Officer, Head of Strategic Finance, Head of Local Partnerships, Business Planning Manager

- To set up and run the Programme Management Office
- To prepare the Programme Board including reporting
- To establish and oversee benefits tracker
- To be the main contact point for the BCT programme (information/reporting)
- To provide reports on progress to BCT programme (in an agreed format/depth of content)

Programme Core Management:
Programme Director (Strategy), Head of Strategic Finance, Programme Director (Ops/BCT), Head of Local Partnerships (Strategy/BCT), Head of Informatics, Director of Capital Reconfiguration, Assistant Director of Workforce, Head of Communications

- To meet fortnightly and oversee the running of the Programme including contributing to the ongoing development of the structure and materials
- To address any issues/ monitor progress and ensure activities aligned with BCT
- Ensure the link with internal business planning and IBP refreshes.

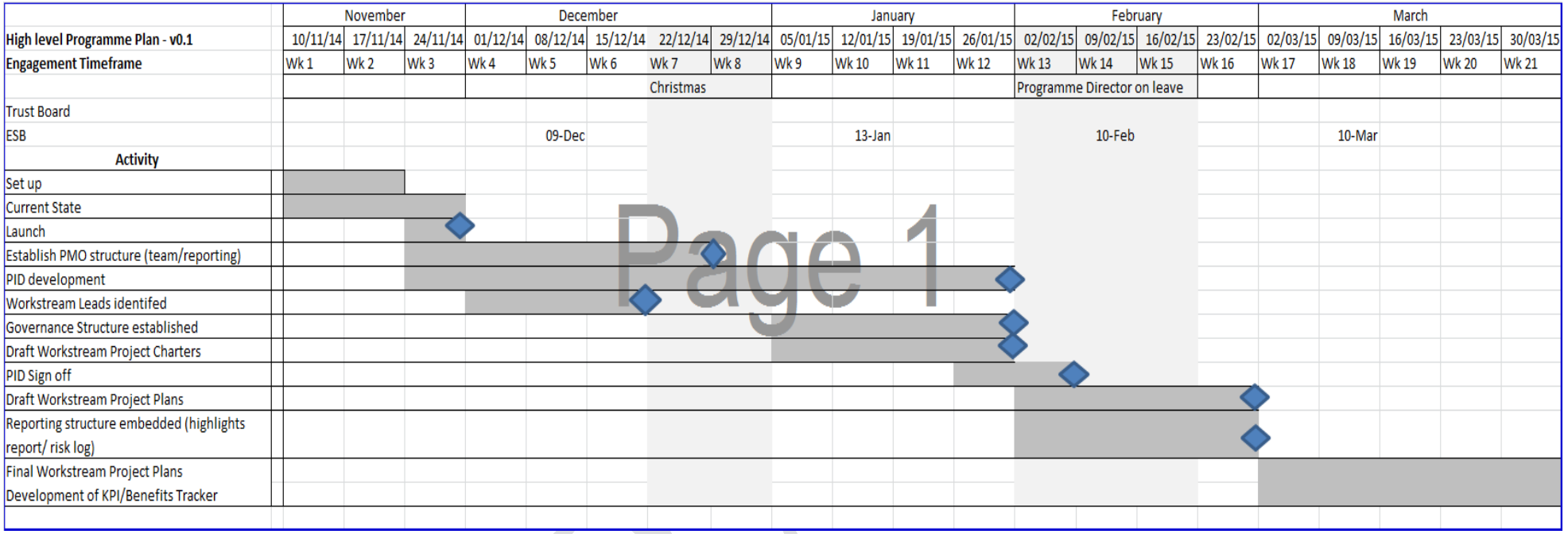
Programme Board:
As above and including the SRO, Clinical Lead, Director of Finance, Workstream leads and ad hoc representatives as required

- To meet monthly to report on progress against delivery using highlights reports (completed fortnightly) and raise any issues/risks with mitigating strategies
- To track milestones and deliverables through updated project plans (feeding into an overarching programme one) and through a dashboard (to be developed)

Implementation workstreams
Membership will vary according to the specific workstream but will need to include as a minimum; a Director sponsor, clinical lead, senior management lead, nursing lead, representation from CMGs/workforce/finance/IM&T/estates and other corporate functions as required.

- To meet fortnightly/monthly to design project, agree deliverables and milestones
- To complete project initiation documentation and update the project plan and risks/issues log on a regularly basis
- To attend the programme Board and submit completed and timely reports as outlined by the PMO.

Appendix D – High Level Programme Plan



Health Gateway Review 0: Strategic assessment (Early)
Programme Title: University Hospitals of Leicester Reconfiguration
Health Gateway ID: DH 806

Department of Health

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Version 3.0 (Issued) July 2013

Health Gateway Review
Review 0: Strategic assessment

Version number: Final

Date of issue to SRO: 23 October 2014

SRO: Kate Shields (Director of Strategy)

Organisation: University Hospitals of Leicester NHS Trust

Health Gateway Review dates: 20/10/2014 – 23/10/2014

Health Gateway Review Team Leader:
Stuart Douglas

Health Gateway Review Team Members:
Gerald Clemence
Debbie Glenn

Health Gateway Review 0: Strategic assessment (Early)
Programme Title: University Hospitals of Leicester Reconfiguration
Health Gateway ID: DH 806

Background

The University Hospitals of Leicester NHS Trust (UHL) was formed in 2000 from the merger of the city's acute hospital Trusts located at:

- Leicester Royal Infirmary
- Leicester General
- Glenfield Hospital

The Trust provides acute health services to the population of Leicester, Leicestershire and Rutland (LLR).

In recent years, the Trust had worked with a private sector partner (via a Private Finance Initiative) to develop proposals to modernise its facilities, however the programme was abandoned in 2008, as they were unaffordable.

After a long pause, UHL has now commenced working on a 5 year plan and a associated Reconfiguration Programme (RP) which is intended to bring about the long awaited modernisation of services and facilities.

The UHLRP forms part of a wider programme 'Better Care Together' (BCT) which is being progressed as a partnership between local health, council and associated agencies to plan a whole LLR economy reconfiguration of health and social care services into a modern, viable and efficient configuration.

The aims of the programme:
The key objectives of the UHL Reconfiguration programme are to:

- Move from 3 to 2 Acute Hospital sites with enhanced community based services
- Create a single co-located children's service
- Create a larger single site maternity unit
- Create a new day case hub for elective care
- Create a new emergency floor (subject to the separate DH796 Health gateway)
- In overall terms, to remove 462 beds from the acute service profile.

The UHL Reconfiguration programme comprises 16 investment projects and is expected to cost circa £322m.

Health Gateway Review 0: Strategic assessment (Early)

Programme Title: University Hospitals of Leicester Reconfiguration

Health Gateway ID: DH 806

The driving force for the programme:
The reconfiguration responds to the following drivers:

- Services being provided by the right organisations (leading in many cases to a migration of activity to a community setting)
- Provision of safe and sustainable services in clinical and financial terms
- The need to modernise the estate to a compliant and efficient standard which aligns with the models of care
- The need to respond to changes in demand for care (maternity, children's services, day case activity etc.)

The procurement/delivery status:
Of the 16 projects identified within this programme, 2 have advanced to the point of completing the Outline Business Case and of having a procurement strategy.

- The Emergency Floor Project (circa £48m investment) is progressing on the basis of a partnering arrangement with Interserve, who have been appointed following a full OJEU selection process to work with the Trust to complete the design, package tendering and construction process.
- The Vascular Services Project (circa £12.5million investment) is using the same procurement approach

The RT was advised that no decision has been made on procurement of the remaining 14 projects as they are at an early stage of development.

Current position regarding Health Gateway Reviews:
This is the first Health Gateway Review for the UHLRP. A Health Gateway Review was completed for the Emergency Floor project in June 2014.

Purposes and conduct of the Health Gateway Review

Purposes of the Health Gateway Review
The primary purposes of a Health Gateway Review 0: Strategic assessment, are to review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to government, departmental, NHS or organisational overall strategy.

Appendix A gives the full purposes statement for a Health Gateway Review 0.

Conduct of the Health Gateway Review
This Health Gateway Review was carried out from 20 October 2014 to 23 October 2014 at the Leicester Royal Infirmary. The team members are listed on the front cover.

The people interviewed are listed in Appendix B.

The Review Team would like to thank the UHL Reconfiguration Programme Team for their support and openness, which contributed to the Review Team's understanding of the programme and the outcome of this review.

Delivery Confidence Assessment

The health economy in Leicester, Leicestershire and Rutland is currently running at a substantial deficit.

After a long period of inactivity, local health and social care organisations have been brought together to plan and implement a programme of change 'Better Care Together' (BCT); which will see services and facilities modernised and brought into an affordable configuration.

The Review Team was pleased to note that this economy wide programme is being led and supported by the NHS Trust Development Authority and NHS England and that it is widely and actively supported by local health and social care organisations.

UHL's Reconfiguration Programme represents a major component of BCT, and is aimed at providing a modern and viable configuration for the Trust's future operations. It currently comprises 16 projects, involves an investment of £322million, and needs to be complete within 5 years to meet the NHS Trust Development Authority's strict deadline for achieving a break even position.

The RT found that whilst this vital programme is being taken forward by an experienced and committed SRO with some management support, it is far from being properly resourced. Immediate steps must be taken appoint a Programme Director and a supporting Programme Office facility. This should enable the Programme to be properly defined, and to have clear management and governance arrangements as the basis for progression in conjunction with the BCT Programme.

In the same vein, a Resource Plan should also be developed to identify the nature and scope of additional skills / support required across the Programme to ensure that they can be procured to meet the needs of each of the constituent projects.

The RT noted that the Reconfiguration Programme is progressing within very tight parameters, which create significant risks to delivery, including:

- The scope of change is material, including moving from 3 acute sites to 2 and making significant reductions in acute inpatient capacity
- The timescale for delivery is very ambitious
- The capital investment profile is large and likely to come under close external scrutiny (which could delay progress)
- Capital investment allocations are at the lower end of the benchmark scale for development
- There are significant interdependencies between organisations for planning and delivery of major changes (such as bed reductions)

- A formal Public Consultation will be required to inform the final change profile and is likely to mean that the bulk of proposals will not be put forward until post-election.

The RT concludes that progressing a mission critical programme with this type of risk profile and without the required resources, means that the successful delivery must be in doubt. On this basis, the rating to be applied is **AMBER RED**.

However, with the leadership and support being provided by the NTDA, NHS England and local partners, Delivery Confidence could increase if appropriate Programme leadership and resources are secured promptly. The RT hopes that the Trust will not miss this unique opportunity to step up to the plate.

Colour	Criteria Description
G	Successful delivery of the project/programme appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery significantly
A	Successful delivery appears likely. However attention will be needed to ensure risks do not materialise into major issues threatening delivery
A	Successful delivery appears feasible but issues require management attention. The issues appear resolvable at this stage of the programme/project if addressed promptly.
AR	Successful delivery of the project/programme is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed.
R	Successful delivery of the project/programme appears to be unachievable. There are major issues on project/programme definition, schedule, budget, required quality or benefits delivery, which at this stage do not appear to be manageable or resolvable. The project/ programme may need re-baselining and/or overall viability re-assessed

A summary of recommendations can be found in Appendix C.

The RT was pleased to note as an example of good practice, that the NHSTDA and NHS England had facilitated development of a wrap-around Strategic Outline Case to demonstrate the case for investment in a system wide change to achieve a transformation of a challenged local health economy to deliver an affordable and sustainable configuration.

Findings and Recommendations

1: Policy and business context

University Hospitals Leicester NHS Trust (the Trust) is one of the largest teaching hospitals in the country. As the only acute Trust in the area it provides district general hospital services to the diverse population of Leicester, Leicestershire and Rutland (LLR) as well as specialist services to the wider population of the Midlands and East.

For a number of years it has been clear that major reconfiguration of services across LLR is required, with poor performance in a range of key performance indicators. Between 2000 – 2007 the Trust planned significant reconfiguration through a major PFI[1] procurement and reconfiguration plan called 'Pathway'. However in 2007, when the total costs were estimated in excess of £900m, the UHL Board halted the procurement and momentum for change was lost. Whilst a small level of service development has taken place more recently, UHL continues to face significant financial and operational pressures missing several key targets and posting a £40m deficit in 2013/14.

The Better Care Together (BCT) Programme was established 2-3 years ago to enable health and social care organisations to jointly deliver system wide change. Previous public consultations have described the challenges facing the system and resulted in general awareness and acceptance of the need for change. However this has not been followed up with specific proposals or an agreed system wide change plan.

Due to the lack of major service reconfiguration over the last 10 – 15 years and the annual growth in demand the LLR system continues to struggle. It has been designated as one of the 'challenged' health systems in the country. This, along with advent of the Better Care Fund has resulted in a renewed focus on joint working. The BCT Programme has been refreshed and a 5 year joint plan has recently been agreed. External consultants are supporting development of a Strategic Outline Case (SOC) with an investment value understood to be in the region of £600m. This covers a system wide transformation across eight joint clinical work streams as well as the Trusts own £322m RP. The NTDA and NHS England expect to receive the BCT SOC shortly.

The £322m UHLRP forms part of its June 2014 Integrated Business Plan (IBP) and Long Term Financial Model (LTFM), and is designed to deliver clinical and financial sustainability within 5 years. It sets out a major change programme which concentrates acute services onto two sites instead of three. One site will, in the main, co-locate emergency services, and the other planned and specialist surgery. The third site will then be designated for community health and non-acute services.

[1] Private Finance Initiative

The programme will also involve significant changes to care pathways and service models.

Operational pressures have meant that work has already begun on redesigning emergency services (the Emergency Floor project). In addition it has recently become apparent that level 3 Intensive Treatment Unit (ITU) cannot be sustained across all three acute sites beyond December 2015; creating another major operational pressure and catalyst for change.

As a result of these and other recent developments a sense of momentum is building across the system, with widespread agreement of the need for change sooner rather than later. Aspects of the BCT plans will require formal public consultation, the detail of which is being worked through by the communications and engagement enabling work stream.

The UHLRP involves complex, large scale change and requires robust programme governance. The current, early stage, governance arrangements need strengthening. Whilst the IBP provides a short overview of the aims and initial investment there is no Programme Brief that captures the overall picture including:

- Objectives and background: the main vision and purpose, key drivers and deliverables, timescales and success criteria
- Scope: list of individual projects making up this change programme
- Benefits: identification and quantification of key benefits
- Timeline, critical path and key dependencies (internal and external)
- Key assumptions and constraints
- Finance: for individual projects and the overall programme
- Risks and issues: the main risks/issues identified and management processes
- Stakeholders: a stakeholder map and approach to communications & engagement
- Governance: roles and responsibilities of decision making bodies and key players

Recommendation 1: Prepare a Programme Brief to define scope, required benefits / outcomes and delivery arrangements.

2: Business case and stakeholders

Business Case

The RT was advised that NTDA and NHS England have facilitated the BCT Programme's development of a wrap-around SOC in support of investment proposals to achieve system wide change, and this includes the full scope of the UHLRP.

This provides a very helpful means of providing the wider context to changes to be delivered by local health and social care partners and it is understood that with this in

place, NTDA has authorised UHL to proceed with Outline Business Cases (OBC) for the specific projects within the UHLRP.

Whilst this provides an agreed way forward, it is important that the UHLRP recognises that 2 of its 16 projects still exceed the £50million threshold for seeking Department of Health and HM Treasury approval. Accordingly, activities will need to be re-planned to absorb the additional approvals period (or to negotiate additional time for delivery with NHSTDA).

Discussions indicated that the current programme is capital investment led, whereas there is a recognition that the focus needs to be changed to make the process clinically led, and for estate proposals to be built on the clinical service transformation. The RT endorses this policy.

Stakeholders

The RT was advised during interviews that a Stakeholder Management Plan and Communications Strategy is being developed for the BCT programme and that it is intended for this to cover the needs of the UHLRP.

During discussions it was recognised that some UHLRP components, such as the Multi Storey car park project, will not necessarily be covered by the BCT document. Accordingly, the UHL needs to develop its own supplementary plans for embracing the full breadth of UHLRP proposals.

The RT was able to confirm during interviews that the East Midlands Ambulance Service NHS Trust (EMAS) is involved in planning the BCT and UHLRP programmes. It should be noted however that the recent BCT Blueprint document does not include EMAS in the list of local partners. This omission should be addressed in future publications to do justice to the far reaching involvement and buy in to the programmes.

Public Engagement and Consultation

By way of background, the RT noted that various engagement and consultation exercises have previously taken place and as a result there is a general recognition of the need for reconfiguration. This has clearly generated a good foundation for the work which is now being progressed.

The RT was provided with details of the Better Care Together 5 Year Plan, which was published in June 2014 as the basis for engaging with the public on the BCT Programme proposals.

The RT was advised that a joint working group has been set up to plan future engagement and the formal consultation process(es) to follow.

In discussions it was made clear that the impact of the General Election in May 2015 is likely to mean that the bulk of proposals will not be put forward until post-election.

This generates a degree of uncertainty in planning a number of projects, but in particular, plans to gain approval to transfer level 3 ITU services from the Leicester General Hospital to the Glenfield and Leicester Royal sites.

The RT was advised that discussions with Health Overview and Scrutiny partners indicated an understanding of the proposals and recognition that exercises in previous years may enable some matters to be allowed to progress without further examination.

In light of the potential delays and consequences (in particular clinical) which could be generated through challenges to the process, and the need to move quickly, the RT recommends that legal advice should be sought to inform selection of the changes to be submitted and the strategy for progression of the Consultation process.

Recommendation 2: Seek legal advice to assist in evaluating the scope of the proposed consultation and strategy for implementation.

3: Management of intended outcomes

The UHLRP is currently being progressed by the SRO with very limited resources, and provided in part through an external consultancy. Whilst it is known that some work is being done to identify resource for the programme office function, this is only recent and comes at a late stage.

Given the nature and scope of changes proposed through the Programme, and its importance to the future sustainability of the organisation, UHL should take immediate steps to adequately support the management of the programme. This should include:

1) appointing a permanent dedicated Programme Director preferably with a strong background of NHS programme delivery
2) appointing Programme Office staff, with the capacity to support the Programme with:

    a) programme documents (e.g. brief, benefits, definition document)
    b) project management documents (e.g. brief, initiation document)
    c) programme and project reporting
    d) programme and project planning
    e) risk coordination, tracking and reporting
    f) benefits planning, tracking and reporting

These appointments should support the Trust's wider strategy of building up its own skill base and achieving a transfer of knowledge from external consultants, to create longer term delivery capability.

Recommendation 3: Appoint a dedicated Programme Director, together with supporting Programme Office support.

With the Trust mobilising to take forward a broad range of service and estate development proposals, it is vital that the Programme Director should oversee development of a resource plan for areas of support, for both internal and external staff / service providers, to support the delivery of required outcomes. This would include external professional advisors such as healthcare and workforce planning, design team, legal advice and planning advice.

This will also involve significant input from Trust staff and it will be essential that these staff are given sufficient time, away from their usual duties, to contribute to the development of the project plans. This will involve a range of staff including HR, communications, general managers, finance and clinicians. It will be particularly important to recognise that clinicians will have an important role in the service design phases of the projects and may require support to ensure patient activity is not compromised.

Recommendation 4: The Programme Director should lead process of developing a resource plan including a strategy for recruitment / procurement.

As part of developing the Programme Plan, it is important that all the interfaces and dependencies with other programmes and projects are mapped and any implications fully understood: Although it is known that many of the changes and efficiencies can be achieved by the Trust without any external assistance. There are a number where the Trust cannot deliver the required outcomes without actions being undertaken by other organisations, such as emergency admission avoidance.

It will also be important for the Trust to be clear about the priority and phasing of the 16 UHLRP projects. It is understood that the Emergency Floor and Vascular projects are well advanced and that OBCs have been completed for each and are with the NTDA for approval. Recent events, such as the level 3 ITU beds and the proposed change to Children's services, will have an impact on the phasing of the remaining projects. These will need to be discussed internally and with BCT partners, to agree the dependencies and to finalise the phasing.

Both of the above measures will assist with developing the Programme Plan, project timelines and the critical path.

4: Risk management

The RT was advised that at this early stage in UHL RP lifecycle, no formal risk management arrangements are in place at Programme level. However risk registers do exist for current projects (eg Emergency Floor).

Given the importance of this Programme in delivering clinical and financial sustainability for the Trust, the large capital investment involved, tight timescales, emerging operational risks (e.g. Level 3 ITU), and the key internal and external dependencies (BCT Programme) it is critical that a well-resourced and robust risk management approach is developed.

The RT would anticipate the following features of a successful arrangement:

- A robust, systematic method of identifying and managing the risks and issues. This needs to align with the Trust's risk management strategy, and feed into other linked Programmes (BCT).
- The UHLRP Programme Office to lead and coordinate the risk management process at project and programme level (including maintaining and updating risk and issue logs).
- An escalation process which ensures risks are raised at the right levels of the organisation for attention.
- Appropriate skills and resources to manage this process (eg risk manager)

Recommendation 5: Develop and implement robust risk management arrangements, including appropriate arrangements for escalation and linkage to other Programmes.

The RT noted the prevailing risk profile for the programme includes:

- The scope of change is material, including moving from 3 acute sites to 2 and making significant reductions in acute inpatient capacity
- The timescale for delivery is recognised as being very ambitious
- The capital investment profile is large and likely to come under close external scrutiny (which could delay progress)
- Capital investment allocations are recognised as being at the lower end of the benchmark scale for development
- There are significant interdependencies between organisations for planning and delivery of major changes (such as bed reductions)
- A formal Public Consultation will be required to inform the final change profile and it is likely that the process will not be able to complete for the majority of proposed changes until after the 2015 General Election

5: Readiness for the next phase: Delivery of outcomes

Interviews indicated that that the Reconfiguration Programme has gained momentum over the past few months after a period of inaction. The RT heard from a range of

key external stakeholders that they supported the UHL change programme and that this should now be delivered at the earliest opportunity. These changes, linked with the other initiatives being undertaken as part of the overarching BCT Programme, would deliver a sustainable future for the Trust and the local health and social care economy.

Interviews indicated that relationships between the health and social care partners in the BCT Programme were improving. It is important that this continues, not only at senior staff levels but also between those staff who will be delivering the changes across the health economy. This is an issue that will require careful management by all the organisations involved and will be assisted by the BCT Programme having clear objectives and agreed delivery plans.

The UHLRP includes substantial transformation of clinical services. The RT noted that the Emergency Floor project included a process of securing independent assurance in relation to its planned service transformation. The RT commends this approach and would recommend that this be extended to apply to all projects, ensuring that a process is in place to appraise the impacts on all affected services.

An Assurance of Action Plan should be completed within 4 months of this review.

The next Health Gateway 0 Review is expected within 12 months of this review.

APPENDIX A

Purposes of Health Gateway Project Review 0: Strategic assessment

- Review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to the overall strategy of the organisation and its senior management.
- Ensure that the programme is supported by key stakeholders.
- Confirm that the programme's potential to succeed has been considered in the wider context of the organisation's delivery plans and change programmes, and any interdependencies with other programmes or projects in the organisation's portfolio and, where relevant, those of other organisations.
- Review the arrangements for leading, managing and monitoring the programme as a whole and the links to individual parts of it (e.g. to any existing projects in the programme's portfolio).
- Review the arrangements for identifying and managing the main programme risks (and the individual project risks), including external risks such as changing business priorities.
- Check that provision for financial and other resources has been made for the programme (initially identified at programme initiation and committed later) and that plans for the work to be done through to the next stage are realistic, properly resourced with sufficient people of appropriate experience, and authorised.
- After the initial review, check progress against plans and the expected achievement of outcomes.
- Check that there is engagement with the market as appropriate on the feasibility of achieving the required outcome.
- Where relevant, check that the programme takes account of joining up with other programmes, internal and external.

APPENDIX B

Interviewees (University Hospital of Leicester NHS Trust unless otherwise stated)

Name	Role
1. Kate Shields	Director of Strategy and Programme SRO
2. Richard Kinnersley	Major Capital Projects Technical Director
3. John Jameson	Consultant Surgeon (Surgical Clinical Director)
4. Jeff Worrall	Portfolio Director (NHSTDA)
5. Mick Connell	Director of adults and Communities (Social Services), Leicestershire County Council
6. Dr Peter Miller	Chief Executive of Leicestershire Partnership NHS Trust
7. Paul Gowdridge	Head of Strategy Finance
8. Richard Mitchell	Chief Operating Officer
9. Ian Turnbull	Deputy Director of Strategy & Planning (East Midlands Ambulance Service)
10. Richard Power	Consultant Orthopaedic Surgeon
11. John Adler	Chief Executive
12. Christopher Allsager	Consultant Anaesthetist
13. Toby Sanders	Managing Director (West Leicester Clinical Commissioning Group)
14. Mick Cawley	Director of Finance (Better Care Together)
15. Sue Locke	Acting Managing Director (Leicester City Clinical Commissioning Group)
16. Mark Wightman	Director of Communications
17. Ellie Wilkes	Health Care Advisory Section, Ernst & Young
18. Emma MacLellan-Smith	Health Care Advisory Section, Ernst & Young

APPENDIX C

Summary of recommendations

The suggested timing for implementation of recommendations is as follows:-

Do Now – **To increase the likelihood of a successful outcome it is of the greatest importance that the programme/project should take action immediately.**

Do By – To increase the likelihood of a successful outcome the programme/project should take action by the date defined.

Ref. No.	**Recommendation**	**Timing**
1.	Prepare a Programme Brief to define scope, required benefits / outcomes and delivery arrangements.	Do now
2.	Seek legal advice to assist in evaluating the scope of the proposed consultation and strategy for implementation.	Do now
3.	Appoint a dedicated Programme Director, together with a supporting Programme Office support.	Do now
4.	The Programme Director should lead process of developing a resource plan including a strategy for recruitment / procurement.	Do by Dec 14
5.	Develop and implement robust risk management arrangements, including appropriate arrangements for escalation and linkage to other Programmes.	Do by Jan 15