UHL Reconfiguration – update

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Executive Summary

Context

A key part of the Trust Board's role is to inform strategic direction and provide appropriate challenge to plans being put forward. This ensures there is sufficient assurance associated with activities undertaken to achieve the desired future state. The UHL Reconfiguration Programme is an ambitious and complex undertaking and where the programme is moving more into delivery, it is important that the Trust Board has visibility of the progress and challenges.

This paper provides the monthly update on Reconfiguration to the Trust Board, employing the Level 1 dashboard to show an overview of the programme status and key risks, with accompanying focus on two topical workstreams each month. This month, the focus will be on 'out of hospital' beds and estates.

The purpose of the update is to ensure that the Trust Board is sighted on key issues that may impact on delivery of key milestones of the programme.

In addition, the Trust Board 'Thinking Day' in November will focus on the whole reconfiguration programme, and provide an opportunity for further discussion and input as the programme moves into delivery phase.

Questions

1. Does the report, with dashboard and risk log, provide the Board with sufficient (and appropriate) assurance of the UHL Reconfiguration Programme and its delivery timeline?
2. Is there anything else the Board would like by way of update each month or quarter?
3. For the upcoming 'Thinking Day', are there any elements of the programme that the Board would like to discuss in more detail?

Conclusion

1. The report provides a summary overview of the programme governance, updates from a number of workstreams, and the top three risks from across the programme that the Board should be sighted on. This summary follows the UHL reconfiguration programme board, which took place on 26 August 2015. Sufficient assurance should be taken from this given the governance structure underpinning the dashboard which is based on levels of reporting (described in the August Trust Board paper).
2. The approach to reporting to Trust Board (Level 1) has been agreed in principle. It is recognised that this needs to be tested through applicability and then refined as required to be fit for purpose. Feedback will be sought through the focused 'thinking day' in November

on the information presented at this level, and whether or not it provides sufficient oversight and assurance.

Input Sought

We would welcome the board's input regarding the content of the report, and any further assurance they would like to see in future reports.

For Reference

The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes /No /Not applicable]
Effective, integrated emergency care	[Yes /No /Not applicable]
Consistently meeting national access standards	[Yes /No /Not applicable]
Integrated care in partnership with others	[Yes /No /Not applicable]
Enhanced delivery in research, innovation & ed'	[Yes /No /Not applicable]
A caring, professional, engaged workforce	[Yes
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	Not applicable]

This matter relates to the following **governance** initiatives:

Organisational Risk Register	/Not applicable]
Board Assurance Framework	[Yes]

Related **Patient and Public Involvement** actions taken, or to be taken: Part of individual projects

Results of any **Equality Impact Assessment**, relating to this matter: [N/A]

Scheduled date for the **next paper** on this topic: Next Trust Board

Executive Summaries should not exceed **1 page**. [My paper does comply]

Papers should not exceed **7 pages.** [My paper does comply]

Update to the Trust Board 1 October 2015

UHL Reconfiguration Programme

1. This update paper provides a brief summary and overview of the key current programme issues, and is a reflection of the regular monthly updates provided to the Reconfiguration Programme Board. In addition, an executive level dashboard (appendix one) and programme risk log (appendix two) are provided; these reflect the integrated governance structure of the programme. It should be noted that the reconfiguration programme board last met on 30 September. Any issues identified at this meeting, not covered in this update paper, will be provided verbally by the Reconfiguration Director at the Trust Board meeting.

Governance update

2. The internal assurance process for the programme has recently been reviewed to further develop the reporting arrangements, providing assurance at different levels aimed at different audiences; Trust Board/Executive, Programme, Workstream. This integrated approach reflects the shift in focus to monitoring progress against key milestones, holding workstreams to account and ensuring the programme is on track to deliver. It also serves to provide sufficient assurance across the organisation and escalate risks in a timely manner through appropriate channels.

3. The programme risk log has been updated to ensure the risks are recorded in the right place and attributed to the right people, and accurately reflect the impact on delivery of the programme. The top programme risks are aligned with, and reflected in, the Trust's Board Assurance Framework (BAF).

4. A paper was presented to the September Audit Committee providing an update on the governance of the programme and a proposal for the role of the committee in reconfiguration moving forward. It was agreed that the Audit Committee will take a role in the 'healthcheck' process of business cases, holding project boards to account to ensure feedback and actions are completed. The Audit Committee also requested an executive governance flow diagram be developed to show the reconfiguration governance through the organisation; this action is being completed by the Reconfiguration Director and Director of Corporate and Legal Affairs.

5. The Trust Board 'Thinking Day' in November will focus on the wider reconfiguration programme, covering models of care, the future operating model, capital business cases, and the estates annex. This will be an interactive session, demonstrating progress to date and upcoming activities and challenges.

Workstream updates

6. Each month several workstreams will be selected for inclusion with more detail provided on the current status, progress and any issues. Those selected will be based primarily on where there has been a lot of activity in the previous month or where an issue, or risk, might exist which could impact delivery.

7. This month two areas are briefly covered to provide an update to the Trust Board and are as follows:

'Out of hospital' shift and Plan B

8. The Out of Hospital Community Service Project is a two year collaborative programme of work between UHL and LPT which will see 250 beds worth of activity re-provided in community settings by 2016/2017. The cohort of patients that this intervention will focus on is typically the frail older person who after a stay in hospital no longer requires acute intervention but who would benefit from a short, intensive programme of re-ablement delivered either in their own home or within LLR community hospitals according to their acuity. This ambitious development is on a scale and at a pace not seen before in LLR and is the most material deliverable associated with the BCT programme to date. It is therefore not without risk.

9. **2015/2016** - The delivery plan is to expand and enhance the established Intensive Community Support service delivered by LPT (126 home beds currently) and provide an additional 130 home beds by the end of March 2016. This will reduce the length of time frail older people spend in hospital after their acute treatment and thereby reduce avoidable deconditioning and harm.

10. **The offer** - Patients will benefit from up to 4, 1 hour, face to face visits from a suitably trained individual, for an average of 10 days. The service will be tailored according to need and will be nurse or therapy led with medical support from LPT and/or the patients GP where required (as per the current service). The ICS service will risk stratify the patient cohort; Using the analogy of a virtual ward, those patients with a greater health need/higher acuity who are typically closer to the nurse station will receive higher nursing input and will have more input from medics as/when required (LPT/GP). For those who are progressing well and coming towards the end of the ICS pathway they would typically be further away from the virtual nurse station and would be helped/supported to self-care by suitably trained support workers or physical instructors (higher personal care input).

11. At the end of the 10 days the individual will revert to their normal support infrastructure (self - care, package of care etc.). Key stakeholders have been engaged in the development of this proposal from the outset so that all parties can be clear on how and when they will engage with the pathway. This has been particularly important with social care.

12. **Evidence base** – The literature shows strong patient satisfaction associated with virtual ward programmes and points to a positive impact of greater integrated care on the quality of care and health or patient satisfaction outcomes. Patients report being more satisfied with hospital at home than with inpatient care because it is possible to provide more tailored care in a more therapeutic environment.

13. **Proof of concept -** Delivery of the additional 130 beds will act as a proof of concept, at scale. It will enable us to test whether the expected benefits of the enhanced community based pathway are delivered in reality. As this is a test, a corresponding number of beds released will be mothballed in UHL until such time as evaluation is complete (we are working with Public Health to facilitate this). The long term future of any beds released will form part of the BCT Public Consultation. In the short term, as the shift in care reaches a reasonable scale, the footprint released will support the service moves required by the ICU reconfiguration.

14. **Milestones -** The business case for ICS 2015/2016 has been worked up and considered at every level of the BCT governance structure and the UHL reconfiguration programme. The case was presented to the LLR Commissioning Collaborative Board representing all 3 CCG's on the 24th September and was approved. The 2015/2016 project is now moving into the implementation phase.

15. **Implementation** - The project is working to the following trajectory:

- October 2015 – 16 beds
- December – 24 beds
- February 2016 – 40
- March 2016 – 50 beds

16. This timeline does reflect some slippage from the original plan (delivery in Q3/Q4 rather than Q2/Q3). The two key constraints impacting on this position have been workforce and finance.

17. **Workforce** – The following additional staff numbers are required by LPT to implement the additional 130 beds in 2015/2016:

Staff Group	2015/16
Qualified Nurses	26
Physiotherapists	8
Occupational Therapists	8
Technical Instructors	16
Unqualified staff (nursing and therapy)	34
Admin	3

18. The model of care designed by the out of hospital community services project focuses on using our collective workforce differently; upskilling all workers in generic skills across nursing, therapy and social care and putting in place rotational posts for staff to work across settings of care. This will improve the quality of service provided to patients but also help the system to address workforce shortages by using the LLR workforce in a different and innovative way.

19. LPT made it clear that they would not substantively recruit until the finance and contractual issues were resolved with commissioners. To mitigate the impact of this UHL has worked very hard to support the earliest implementation by seconding staff, supporting rotational posts and looking at shared appointments. This has not been easy given our own operational challenges and the teams are to be commended on the commitment they have shown to this process. The therapy complement required has been predominantly fulfilled by the support of UHL. Nursing has been more difficult, however UHL is still exploring if there is any opportunity for further secondment in the short term that could support further additional shift in activity in November.

20. **Finance** - Agreeing the transitional funding to support the unavoidable double running associated with this development was a long and protracted process. In July LLR commissioners finally agreed £1.4m of transitional funding and in August the contractual mechanism was also agreed.

21. **Risk** – The four biggest risks associated with this important scheme are:

- Workforce
- Finance
- Impact on others
- The project fails to deliver the shift anticipated

22. Throughout the development of the case concerns have been expressed about potential knock on effect to social care and following presentation to the CCB, primary care. Our

current thinking is that any impact is more likely to be marginal rather than material. Our rationale is that if patients are coming out earlier avoiding deconditioning and they are receiving significant, intensive support they should be in a less dependent rather than more dependent condition. In reality, we will not know if this is correct until the pilot is complete and we have said that to our stakeholders. This position will be carefully monitored and evaluated.

23. Notwithstanding all of the above, there is the risk that either there may not be the number of patients identified that would be suitable for ICS or LPT are not able to recruit the staff required, or meet demand. In this context, UHL requires a contingency plan. Following the Board 'thinking day' in August a number of options are being explored that will complement the work we are undertaking in collaboration with LPT. This will provide additional flexibility and mitigate the risk to our own reconfiguration plans.

Estates

24. Through the programme board, estates colleagues established a workstream to further develop the estates strategy into a coherent set of actions. As part of this, the workstream commissioned site surveys across all three sites, the first draft of which is now completed. Work is now on-going across the Trust to confirm the 'as is' state and provide a basis for completing the reconfiguration mapping across the estate. This will inform the remaining capital business cases, so a plan of how we will get to where we need to be can be developed. This includes identification of clinical and non-clinical space for potential repatriation.

25. Other priorities over the coming month include validating the survey with CMGs to ensure all services (clinical/non-clinical/corporate) are captured, and for LGH specifically, all interdependencies between services are known. This will be supported by an estates reconfiguration planning workshop on 30 September which will bring together a number of workstreams to work up some of the key actions required. This will take the existing estates strategy and move it to a granular level, to ensure the programme of work moving forward clearly shows how we move from three to two sites.

26. By November, the workstream will be able to confirm the services that are on the LGH and be able to model the residual position once major business cases and the future operating model assumptions have been overlaid. This will ensure all services (that need to be) are captured in the reconfiguration programme and inform the modelling/planning work. It will also provide options for the LGH in the future, and will enable an infrastructure review of what we currently have and what is needed in the future.

27. An updated gantt chart of all estates phases, actions and timelines will be produced following 30 September workshop, and presented to the Trust Board thinking day in November.

Risks

28. The top three UHL reconfiguration programme risks to delivery this month are:

Risk: Delivery of 250 beds worth of activity from UHL to LPT
Mitigation: The first 130 bed activity shift is planned for 2015/16. The contract variation between organisations has now been agreed (but has impacted timescales), and the enhanced Intensive Community Support service (phase one) is now in a position to start in October. To ensure the new service is embedded as efficiently as possible, UHL will scale up its internal process to identify appropriate patients who can use the service and have a detailed mobilisation plan in place.

Risk: **Unmitigated growth in activity from failure of demand management initiatives to reduce acute admissions impacting original bed model assumptions**
Mitigation: The original assumption was that growth would be mitigated by system wide demand management strategies. This is not being evidenced in practice and therefore the Trust will be developing their own strategies to manage this demand (through new models of care) and using the recent Vanguard designation to drive this.

Risk: Risk of non-delivery of out of hospital beds could jeopardise ability to provide additional bed base at Glenfield for ICU level three and impacted specialities.
Mitigation: The Executive team are cited on the risk of moving 52 beds of activity from Glenfield site by March 2016 to enable refurbishment works to be completed in line with the July 2016 deadline. This will be delivered through a combination of Out of Hospital shift, internal efficiencies and revisions to the model of care being undertaken on the site. In addition, a Plan B is being considered (outreach type model) which could provide additional capacity within the system.

29. The risk log is reviewed and updated each month.

Recommendation

30. We would welcome the board's input regarding the content of the report, and any further assurance they would like to see in future reports.

Workstream progress report - October 2015

	This month	Last month	Comments
Overall programme progress	**Amber**	**Amber**	Programme this month focused on refining dashboards to demonstrate progress with delivery of all workstreams, and updating programme governance structure. Programme raged amber due to ongoing risk associated with out of hospital delivery and ICU relocation.

	Workstream	Executive Lead	Workstream Lead	Objectives	On track (RAG)	Complete (%)	Comments
1	Clinical Strategy (Models of Care)	Andrew Furlong	Gino DiStefano	To ensure all specialties have models of care for the future which are efficient, modern and achieve the 2 acute site reconfiguration with optimal patient care	amber	10%	A number of first workshops held with most specialities to generate ideas and help shrink acute footprint. This has not generated desired outputs to the granular level required therefore there will be a re-focus with high impact specialties (hence why workstream now amber). Approach discussed and supported at Sept ESB.
2a	Future Operating Model - Beds (internal)	Richard Mitchell	Simon Barton	To deliver bed reductions through internal efficiencies and achieve a 212 total reduction by 18/19 with a footprint capacity requirement by specialty	Green	65%	Sustained progress with agreed bed closures and reductions in LOS. CMGs developing winter bed plans and bed reduction plans. Next steps include review modelled/non-modelled Beds interventions from Future Operating Model / Models of Care workshops and support work-up of prioritised interventions
2b	Future Operating Model- Beds (out of hospital)	Kate Shields	Helen Seth	To increase community provision to enable out of hospital care and reduce acute activity by 250 beds worth	Amber	50%	Contractual mechanism agreed with work underway on implementation. Issue remains with workforce and number of secondments; recruitment underway by LPT following late drop in staff numbers; this is being picked up with chief nurse. 10 beds due to go live in October.
2c	Future Operating Model - Theatres	Richard Mitchell	Simon Barton	To articulate the future footprint for theatres in a 2 acute site model including efficiency gains and left shift	Amber	40%	Unbudgeted WLI usage remains low compared to same time last year; work ongoing with remaining specialties who are main drivers of unfunded usage; Support to ITAPS in MOC sessions to determine how they can work differently to provide theatres and impact on other CMGs.
2d	Future Operating Model- Outpatients	Richard Mitchell	Simon Barton	To articulate the future capacity requirements for outpatients in a 2 acute site model including efficiency gains and left shift	Green	50%	Continue using work on maximum productivity opportunities to identify next cohort of specialties to undertake cross-cutting CIP process and backlog modelling tool; Review modelled/non-modelled OP interventions from FOM/MOC workshops and support work-up of prioritised interventions.
2e	Future Operating Model- Diagnostics	Kate Shields	Suzanne Khalid	To articulate the future capacity requirements for diagnostics in a 2 acute site model including efficiency gains and left shift	Amber		Workstream only recently formed, and producing a charter and PID to inform scope and objectives.
2f	Future Operating model- Workforce	Louise Tibbert	Louise Gallagher	To design the workforce model for a reconfigured organisation bringing in new roles and modern ways of working, achieving an overall headcount reduction	Amber	25%	CIP: Ongoing work to review medical job plans and ward budgets and roster variances; premium pay workstream scoped for implementation. Reconfiguration: UHL HR director exploring establishing an overarching workforce confirm and challenge, and dedicated delivery board for overall BCT workforce strategy.FOM aspect of workforce to be developed.
3	ICU Level 3	Kate Shields	Chris Green	Safe transfer of level three critical care service, and dependent specialties, from LGH to GH and LRI sites.	Amber	65%	Interim solution approved at September TB. All specialty locations confirmed with estates working up preferred solutions. Remaining confirm and challenge actions ongoing to confirm staffing. Staff engagement events in November. Business cases due for approval at December board.
4	Reconfiguration business cases	Kate Shields	Nicky Topham	To deliver a £320m capital programme through a series of strategic business cases to reconfigure the estate	Green	30%	Vascular FBCs, including hybrid theatre, approved at Trust Board; project team focusing now on operationalisation of plans on the service. Agreement on interim EMCHC solution; ongoing discussion with service and stakeholders on midwifery led offer as part of BCT consultation.
5	Estates	Darryn Kerr	Richard Kinnersley	To deliver a £320m capital programme through a programme of work around infrastructure, capital projects, property and maintenance	Amber	20%	Initial site surveys complete; focus over next month is validation of results. Estates workshop being held 30/9 to review all aspects of reconfiguration, latest position, and identifying the gaps. Programme plan to be produced for November Board.
6	IM&T	John Clarke	Elizabeth Simons	To enact the IM&T strategy and have a modern and fit for purpose infrastructure which supports the 2 acute site model and community provision strategy	Amber	65%	Commencement of EPR early works (at risk); plan for EDRM full deployment across Trust by end October.
7	Finance/ Contracting	Paul Traynor	Paul Gowdridge	To achieve financial sustainability by 18/19 and support reconfiguration of services through effective contracting	n/a	n/a	Risk regarding access to capital (national trend). ITFF submitted for 15/16 and regular meetings held to manage risk.
8	Communication & Engagement	Mark Wightman	Rhiannon Pepper	Ensure staff, stakeholders, and public are aware of UHL reconfiguration and are able to contribute and feed into discussions.	Green	n/a	Drafting of pre-consultation business case for women's project; staff engagement events scheduled for November for ICU reconfiguration; stand at APM highlighting Road Map to change; ongoing support to projects.
9	Better Care Together	Kate Shields	Helen Seth	Realising the UHL elements of BCT within the organisation through new ways of working/pathways and activity reductions	Amber	35%	Completed lock-in sessions for pre-consultation business case for TDA review in October. Activity impacts on UHL still not confirmed which presents a delay to UHL to ascertain the acute footprint. Approvals process for business cases agreed with UHL/Alliance with dermatology business case going through first.

UHL Reconfiguration Programme Board - October

Risk log

Top 10 risks across all workstreams

Risk ID	Workstream	Risk description	Likelihood (1-5)	Impact (1-5)	Risk severity (RAG)- current month	Risk severity (RAG)- previous month	Raised by	Risk mitigation	RAG post mitigation	Risk Owner	Last updated	Alignment to BAF
1	Overall programme	Capital funding not guaranteed for the estimated £330m, and will affect 3 to 2 site strategy if not secured. National capital availability at risk and impact not yet known.	3	5	15	15	PT	NTDA fully cited on capital programme and in support. Regular meetings with NTDA. ITFF application submitted for emergency floor. OBC and FBCs continue to be implemented as per original plans.	12	Paul Traynor	30-Jul-15	
2	Overall programme	Transitional funding required to deliver programme (PMO/business case support/FOM) needs to be committed now and is not yet secured.	4	5	20	20	EW	Resource requirements identified and process for internal management (ahead of external approval) agreed with central tracking in place. Monthly updates to programme board on costs committed.	12	Paul Gowdridge	30-Jul-15	
3	Overall programme	Consultation timelines significantly impact on business case timelines, and ability to achieve 19/20 target for moving off the General.	4	4	16	16	RP	Discussions with BCT programme lead on consultation timelines and process, and seeking legal advice on options moving forward. Continue to progress business cases as per plan.	12	Mark Wightman	30-Jul-15	
4	Overall programme	Operational delivery/pressures may be negatively impacted by requirements of reconfiguration ie, operational resource/input	3	5	15		RM	Each FOM workstream has a dashboard where operational risks will be identified. Operational representation on the programme board and business case meeting to ensure strategy and operations better align and issues addressed early.	12	Simon Barton	24-Sep-15	
5	Internal beds	There is a risk that some bed closures may not be achievable as there are no clear plans for 109 beds worth of demand management where the BCT SOC assumed this would occur.	4	5	20	25	EMS	Continued monitoring of actual vs. planned activity and clear escalation route through UHL reconfiguration programme board, LLR Service Bed Reconfiguration board and IFPIC. Risk remains a concern whilst partner plans remain absent and to be formally escalated to LLR Bed Service Reconfiguration group - need to explore what can be done through vanguard, MOC and BCT. Pushing for a LLR dashboard to be developed to manage system wide position.	20	Kate Shields	24-Sep-15	
6	Out of hospital beds	Workforce- Overall staffing numbers required may not be available in the short term to reach the target occupancy level	4	5	20	20	HS	Joint workforce plan agreed with LPT for the out of hospital community service. A similar approach will need to be considered project by project	12	Helen Seth	30-Jul-15	
7	Level three ICU	Current revenue and capital implications may not be affordable and therefore have significant impact on other business cases as this is a must do.	3	4	16	0	CG	Continued confirm and challenges, led by medical director and team, of revenue and estate assumptions and impact moving forward. Final revenue and capital estimates to go to IFPIC for review/sign off.	12	Kate Shields	24-Sep-15	
8	Level three ICU	Risk of delivery of out of hospital beds could jeopardise ability to provide additional bed base at Glenfield, which is required to relocate HPB.	4	5	20	0	CG	The Executive team are cited on the risk of moving 52 beds of activity from Glenfield site by March 2016 to enable refurbishment works to be completed in line with the July 2016 deadline. This will be delivered through a combination of Out of Hospital shift, internal efficiencies and revisions to the model of care being undertaken on the site.	12	Kate Shields	30-Jul-15	
9	Workforce reconfiguration	Initial workforce plans proposed within reconfiguration business cases are generating revenue cost pressures, not previously anticipated.	4	5	20	0	Finance/Workforce	Robust arrangements for confirm and challenge and clarity about planning 'rules'. All workforce issues for business cases will lbe picked up in the regular monthly meeting (newly created).	12	Relevant project board	01-Aug-15	
10	Capital reconfiguration business case: Emergency floor	EPR will not be available ahead of ED build which impacts on required space estimated within business case, and therfore has cost implications.	4	4	16	0	John Clarke	Monitoring plan with NTDA. Ensure timely responses to TDA and DH. Develop plan B to support ED paperless environment.	9	JC	01-Aug-15	

Risk Matrix

Impact	Likelihood				
5 Very High	5	10	15	20	25
4 High	4	8	12	16	20
3 Medium	3	6	9	12	15
2 Low	2	4	6	8	10
1 Negligible	1	2	3	4	5
	1 Rare	2 Unlikely	3 Possible	4 Probable	5 Almost Certain