University Hospitals of Leicester NHS
NHS Trust

Full Business Case

Adult Level 3 ICU Project – Glenfield Beds Enabler

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Building Caring at its best

Document Quality Management

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Glossary of Terms

Abbreviation	Full Heading
BCT	Better Care Together
CCG	Clinical Commissioning Group
CHUGGS	Cancer, Haematology, Urology, Gastroenterology and General Surgery
CIP	Cost Improvement Programme
CMG	Clinical Management Group
CRL	Capital Resource Limit
CSI	Clinical Supporting and Imaging
DCCM	Department of Critical Care Medicine
ERCP	Endoscopic Retrograde Cholangio-pancreatography
EFL	External Financing Limit
ESB	Executive Strategy Board
ESM	Emergency and Specialist Medicine
EUS	Endoscopic Ultrasound
FBC	Full Business Case
FM	Facilities Management
GH	Glenfield Hospital
HDU	High Dependency Unit
IBD	Interest Bearing Debt
ICNARC	Intensive Care National Audit & Research Centre
ICU	Intensive Care Unit
IFPIC	Integrated Finance Performance and Investment Committee
IM&T	Information Management & Technology

Abbreviation	Full Heading
ITAPS	Critical Care, Theatre, Anaesthetic, Pain and Sleep
ITFF	Independent Trust Financing Facility
I&E	Income & Expenditure
JSNA	Joint Strategic Needs Assessment
LGH	Leicester General Hospital
LRI	Leicester Royal Infirmary
LTFM	Long-Term Financial Model
MSS	Musculoskeletal and Specialist Surgery
NSSG	Network Site Specific Groups
OSC	Overview and Scrutiny Committee
PDC	Public Dividend Capital
PCT	Primary Care Trust
PVE	Portal Vein Embolisation
RRCV	Renal, Respiratory, Cardiac and Vascular
RTT	Referral to Treatment
SMART	Specific Measurable Achievable Realistic Time-related (objectives)
SIRT	Selective Internal Radiation Therapy
SRO	Senior Responsible Officer
TACE	Transcatheter Chemo Embolisation
UHL	University Hospitals of Leicester
VAT	Value Added Tax
VFM	Value For Money
W&C	Women's & Children's
WTE	Whole Time Equivalent

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1 | Executive Summary

1.1 Introduction

This Full Business Case (FBC) is for the interim reconfiguration of the elements of the Intensive Care Unit (ICU) currently located at the Leicester General Hospital (LGH) site of the University Hospitals of Leicester NHS Trust (hereafter referred to as 'UHL' or 'the Trust'). It is presented in the context of the immediate clinical imperative to remove Adult Level 3[1] Critical Care from LGH by July 2016 and proposes to move the Trust's Hepato-Pancreato-Biliary (HPB) and Renal Transplant services to Glenfield Hospital (GH) in order to ensure that ICU Level 3 care is available to inpatients at GH. The investment will refurbish two wards at GH to house specialties moving from LGH.

The project will enable the HPB unit at GH to run as a "stand alone" service providing consultant-led care for patients presenting with emergency biliary pathology with emergency laparoscopic cholecystectomy undertaken on their index admission. It will also move Renal Transplant services from LGH to GH.

1.2 Strategic Case

1.2.1 Why is immediate change necessary?

The overarching ICU Strategy, including the recent approval of the Vascular and ICU Level 3 business cases, necessitates the refurbishment of two wards at GH to house specialties moving from LGH due to removal of ICU services from that site.

UHL's five-year plan envisages that Renal and Transplant services will move to the GH site. For this interim solution the proposal is to move all inpatient transplant activity. (An initial proposal to move Renal Transplant and acute Nephrology to GH in July 2016 was found to be unaffordable. A revised compromise was agreed that only the in-patient transplant service would move to GH with an undertaking that the services would be brought together as soon as possible with a target timeline of 2017.)

1.2.2 What benefits will it bring?

The benefits of this investment business case will include:

- HPB requires Interventional Radiology (IR) to deliver Endoscopic Retrograde Cholangio-Pancreatography (ERCP) procedures and Renal Transplant/Vascular Access patients need Level 3 care for their patients. This project will be an enabler for the transfer of these services from LGH to GH and access to IR and Level 3 support there

[1]See Appendix 1 for details of Levels of Care – definitions used throughout this document.

- UHL's HPB service will be enhanced through the creation of a specialist tertiary service separate from General Surgery
- There is a strong clinical view that it would be a significant risk to undertake Renal Transplantation without access to 24/7 Level 3 support (which is part of national service specification from specialised commissioners for Renal Transplantation). Splitting the Transplant inpatient service would make it unsustainable. Moving the service to the GH site will ensure that it remains viable
- There are commonly occurring interrelationships between renal and cardiac diseases, so the Trust cares for many patients requiring interventions for both conditions. Co-location of these departments on one site will eliminate the current need to transfer patients between the Trust's hospitals – leading to improved patient pathways, safer care and optimal clinical outcomes
- HPB surgery at GH will improve the level and capacity of clinical expertise on the site. This will be beneficial for GH inpatients who develop conditions requiring surgery. This business case will provide the full suite of surgical services in one co-located area
- Support for the Trust's longer term strategy to become smaller while expanding its provision of specialised, co-located services

1.3 Economic Case

This business case is one of a series of business cases supporting the reconfiguration of critical care services across the three hospital sites. The Trust has reviewed its overall position in respect of transferring all services related to the LGH critical to the LRI and the Glenfield Hospital. It has run a high-level economic appraisal which compares a 'Do Nothing' scenario with respect to the Critical Care facilities at the LGH with a scenario that moves Critical Care beds and associated services from the LGH and the associated moves between other hospitals.

Given the fact that Vascular services have already been approved, it examines the costs including the Vascular move and excluding the Vascular move. (Even if the Vascular moves weren't taking place, this Critical Care move would still be preferred over the 'Do Nothing' option.)

The result of this appraisal is as follows:

Table 1 Net Present Cost of Each Option Appraised

Option	NPC £'000
Do Nothing	409,795
Critical Care and Vascular moves	321,758
Critical Care Moves only	302,256

The 'Do Nothing' option is significantly more expensive than the proposed developments for critical care, including and excluding vascular services.

The option appraisal process reflected two elements of the service moves, HPB and Renal Transplant/Vascular Access. It evolved as a result of timescales and funding available. The options initially explored for each specialty are as follows.

Table 2 Options Explored – HPB Beds

Ref	Option	Description
1	New Build Wards	Construction of two new build wards on GH site
2	Wards 28 and 29	Utilisation of Cardiology and Respiratory Wards
3	Wards 26 & 27	Utilisation of Thoracic Surgery, Thoracic HDU and Heart Failure Ward
4	Wards 24 & 25	Utilisation of Endoscopy and Breast Wards
5	Ward 33a and 33	Utilisation of Cardiology Wards

Table 3 Options Explored – Renal Beds

Ref	Option	Description
A	Co-location with Vascular	Co-habitation of Renal Transplant patients on Vascular Ward
B	Conversion of Respiratory Corridor	Conversion of current office space to provide clinical space for the required beds
C	New Build	Creation of a new build 10 bedded ward

Of the HPB options only Wards 28 and 29 was a realistic option as it was the only one that did not compromise other services on the site.

For the Renal requirements conversion of Respiratory office space is the favoured solution from both a qualitative and quantitative perspective and is the recommended option within this business case.

The economic appraisal indicates a clear preference for Option 2 from both a financial and a non-financial perspective. This is illustrated in the following table.

Table 4 Summary of Cost Benefit Analysis of Options

Cost per benefit score	NPC £'000	Benefit Score	Cost per benefit Score £'000	Rank
Option 1	352,190	4.60	76,563	2
Option 2	352,229	5.65	62,341	1

Cost per benefit score	NPC £'000	Benefit Score	Cost per benefit Score £'000	Rank
Option 3	353,225	4.15	85,114	3

1.4 Commercial Case

The proposed project requires the provision of, and procurement of, the following key services:

- Reconfiguration of GH inpatient facilities to create ward spaces for HPB and Renal Transplant
- Additional workforce resources

The procurement of the team of professionals required to deliver the two areas will be sourced through two different procurement routes:

- HPB will be competitively tendered and led by the Trust Estates Team. This is procurement route is driven by the financial value of the project for HPB (£898k out-turn)
- RT will be procured via the Lot 2 contract. This procurement route is driven by the financial value of the works cost (£2,328,065.45 out-turn)

The project is constrained by the time in which it has to deliver the completed solution. The driver for the completion date is the operational pressure of workforce.

The project manager evaluated the potential routes of procurement for both capital works and services and has identified the preferred option that will ensure the project is delivered on programme.

Services

HPB: The professional team will be required to undertake the detailed design and costing of the project up front. This needs to commence as soon as practically possible. The solution for the appointment of the professional team rests with either the use of a services framework or competitive tender.

RT: The professional team will be required to undertake the key elements of costing and professional advice prior to the approval of the FBC. The procurement solution for the appointment of elements of the professional team will be through a framework agreement that provides professional services.

Works

HPB: The capital works will be procured traditionally through competition as there is sufficient time within the programme.

RT: The RT element of the building/refurbishment element will require the procurement of a contractor. The current programme pressures will not allow for the contractor to be procured for traditionally through a competitive tendering process.

1.5 Financial Case

The financial position of this business case shows an additional cost of £825,000 per annum. This is shown in the following table.

Table 5 Financial Position of the Business Case

	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000
Operating Costs				
Pharmacy		90	105	105
Dietetics		11	16	16
Ward Staffing		185	277	277
Nephrology Medics		121	182	182
General Surgery Medical rota		35	53	53
Net Impact on theatre staffing		219	204	204
Total Operating Costs		**661**	**837**	**837**
Capital Charges				
Interest	12	64	103	99
ROA	0	(69)	(134)	(129)
Depreciation	0	9	18	18
Total Capital Charges	12	5	(13)	(12)
Total Impact on I&E	**12**	**666**	**824**	**825**

Non-operating costs have been allowed for in the Trust's Long-Term Financial Model (LTFM), leaving the additional operating costs of circa £661,000 in 2016/17 and £837,000 in 2017/18 and 2018/19 outside the LTFM. If the Trust is to maintain the deficit reduction trajectory in the Financial Strategy, the operating cost revenue impact of this development is only affordable if the development is funded by the £4m per annum allowance made in the Financial Strategy for annual operating cost pressures. This approach has been supported by the Trust Board.

1.5.1 Capital Costs

The capital costs of the development total £4.3 million. The table below shows an analysis of the total costs.

Table 6 Capital Costs

	£
Departmental Costs	1,905,470
On Costs	190,547
Works cost	2,096,017
Provisional Location Adjustment	(83,840)
Sub total	2,012,177
Fees	420,297
Non Works Cost	900,000
Equipment Cost	365,815
Planning Contingency	120,730
Total For Approval Purposes	3,819,018
Optimism Bias	165,401
Sub Total	3,984,419
Inflation	329,671
Total Outturn	**4,314,091**

1.6 Management Case

The programme anticipating completion is set out below:

Table 7 Project Programme

Description	Activity/ Milestone	Start date	End date
Agree Glenfield Theatres solution	Activity	19-Oct-15	10-Nov-15
Conversion of Treatment Centre into Medical Records Space	Activity	19-Oct-15	28-Dec-15
Creation of site based implementation groups	Milestone	26-Oct-15	26-Oct-15
Fortnightly Meeting of Implementation Groups and ICU Programme Board	Activity	26-Oct-15	30-Jul-16
Re-Engage with OSC	Activity	01-Nov-15	31-Nov-15
Business Case signed off at ESB	Milestone	17-Nov-15	17-Nov-15
Business Case signed off at CMIC	Milestone	20-Nov-15	20-Nov-15
Business Case signed off at IFPIC	Milestone	26-Nov-15	26-Nov-15

Description	Activity/ Milestone	Start date	End date
Identify staff in scope for MoC	Activity	01-Dec-15	31-Dec-15
Business Case signed off at Trust Board	Milestone	03-Dec-15	03-Dec-15
Vacation of Medical Records, office space and on-call rooms at GH	Milestone	28-Dec-15	28-Dec-15
Conversion of vacated areas for Interventional Radiology	Activity	29-Dec-15	29-Jul-16
Update on PTE Capital Costs	Activity	31-Dec-15	07-Jan-16
Construction Activities	Activity	Jan 2016	Jul 2016
LIA events at CMG/Specialty Level	Activity	01-Jan-16	31-Jan-16
Draft MoC paper and undertake pre-consultation with staff side	Activity	01-Feb-16	28-Feb-16
Vacation of Respiratory corridor offices	Milestone	TBC	TBC
Conversion of Respiratory offices into Renal Transplant Ward	Activity	TBC	TBC
Wards 28 and 29 to be vacated for refurbishment	Milestone	20-Mar-16	20-Mar-16
Refurbishment of Wards 28 & 29	Activity	14-Mar-16	24-Jul-16
HPB Move into Wards 28 & 29	Milestone	29-Jul-16	29-Jul-16
Expanded Interventional Radiology space becomes operational	Milestone	29-Jul-16	29-Jul-16
Movement of Renal Transplant onto GH site	Milestone	29-Jul-16	29-Jul-16

1.7 Conclusion

This business case delivers:

- The transfer of the Trust's HPB and Renal Transplant services to GH in order to ensure that there is requisite capacity for Level 3 intensive care for their inpatients.

1.8 Recommendation

The Trust Board is recommended to approve this business case.

2 | The Strategic Case

2.1 Structure & Content of the Document

This business case has been prepared using the agreed standards and format for business cases, as set out in Department of Health guidance and HM Treasury Green Book. The case comprises the following key components:

- **The Strategic Case** | This sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme
- **The Economic Case** | This demonstrates that the organisation has selected the choice for investment which best meets the existing and future needs of the service and optimises value for money (VFM)
- **The Commercial Case** | This outlines the content and structure of the proposed deal
- **The Financial Case** | This confirms funding arrangements and affordability and explains any impact on the balance sheet of the organisation
- **The Management Case** | This demonstrates that the scheme is achievable and can be delivered successfully to cost, time and quality

This FBC addresses the need to rapidly reconfigure elements of ward space within the GH site footprint. It will also address the staffing requirements necessary to strengthen emergency surgical provision onsite.

The FBC is presented in the context of the immediate clinical imperative to remove Adult Level 3 Critical Care from LGH by July 2016 and sets out the proposed reconfiguration of ward and non-ward space on the GH site that will allow HPB and Renal Transplant to relocate onto the GH site. At present this activity is undertaken at the LGH.

Without this proposed investment, Adult Level 3 Critical Care cannot be moved from LGH by July 2016.The only realistic alternative to this proposed investment would be for the Trust to cease provision of those activities planned to be located at GH, due to the lack of existing specialty ward space available.

Whilst the primary reason for the reconfiguration of these wards at GH is to enable Adult Critical Care Level 3 reliant activity from moving off the LGH by July 2016, the developments set out within this business case will also bring other benefits. The project will enable the HPB unit to run as a “stand alone” service providing consultant-led care for patients presenting with emergency biliary pathology with emergency laparoscopic cholecystectomy undertaken on their index admission. It will also facilitate the movement of Renal Transplant services from LGH to GH whilst ensuring that when HPB and Renal Transplant move onto the GH site that they have the support of a dedicated Emergency theatre. This will also be of benefit to vascular Surgery who will not have usage of this provision on the GH site between their movement onsite in April 2016 until July 2016.

The reconfiguration of UHL ICU services forms part of a much larger transformation programme that will deliver sustainable health and social care across Leicester, Leicestershire & Rutland (LLR). The 'Better Care Together (BCT)' programme is managed in partnership with NHS commissioners and providers, local councils and a variety of non-statutory services. To deliver the goals of the BCT Programme, the Trust has developed a five-year strategic plan underpinned by an estates strategy. These articulate that to ensure future sustainability and affordability, UHL needs to relocate acute services from LGH to LRI and GH. A sum of £327m has been identified to fund the capital reconfiguration programme at UHL.

The outcomes of the BCT programme for UHL will include:

- Providing a greater focus on specialised care, teaching and research
- Significantly smaller acute hospitals overall and fewer acute hospital beds, offering improved care and facilities
- Concentrating acute services on two sites rather than three

2.1.1 Clinical objectives

The primary clinical objective of the project is to create the ward bed space and Emergency operating capacity necessary to enable Adult Level 3 Critical Care reliant specialties to move from the LGH by July 2016.

However there are several benefits which, whilst not the primary focus of this business case, will be enabled through its implementation. These are;

- To create significant operational efficiencies including positive impact on length of stay for emergency admissions
- To help reduce the referral to treatment (RTT) backlog for laparoscopic cholecystectomies (40% of whom present as emergencies on their pathways)
- To enable the HPB unit to attract referrals for its cancer services from other regional units such as Lincoln and Coventry
- By ensuring prompt and efficient processing of emergency patients, more bed spaces will become available for elective cases leading to fewer cancellations for cancer resections
- The pooling of consultants at the LRI to one merged rota will also have beneficial impact on elective activity by reducing the frequency of on-calls. To adhere to cancer targets for treatment of bowel cancers
- Ensuring that Renal Transplant activity remains co-located with Adult Level 3 Critical Care activity (as set out within the Renal Transplant service specification)

The Trust's HPB multi-disciplinary team serves UHL and the population of Northampton, Peterborough and Kettering. The overall catchment population is around 2.5 million. The unit in Leicester is a Level 1 Primary HPB Cancer centre (as defined by the new HPB Cancer Measures[2]). Services offered include laparoscopic/open surgical

[2] Manual for Cancer Services Hepato-Pancreato-Biliary Cancer Measures Version 1, NHS England 2013

resections, ablation procedures, palliative bypasses, nuclear medicine treatment and percutaneous interventional procedures such as Transcatheter Chemo Embolisation (TACE), Selective Internal Radiation Therapy (SIRT) and Portal Vein Embolisation (PVE). In addition, UHL undertakes the majority of laparoscopic cholecystectomies (90%) and Endoscopic Retrograde Cholangio-pancreatography (ERCP) (90%) annually. It also provides an emergency HPB service for bile duct injuries and liver trauma (and the largest series of total pancreatectomy and autologous islet cell transplantation in Europe).

The work of the UHL HPB unit can be broadly divided into five main streams comprising of:

- Endoscopic work (ERCP and Endoscopic Ultrasound (EUS))
- Cancer and major resections
- Major complex biliary work
- Laparoscopic cholecystectomy and day case procedures
- National specialist services including supra-regional services, such as total pancreatectomy and autologous islet cell transplantation

The Nephrology and Renal Transplant service at UHL provides services for patients with kidney disease in Leicestershire and Rutland and the surrounding counties (Northamptonshire, Lincolnshire, Peterborough city and parts of Cambridgeshire).

Part A: The Case for Change

2.2 Introduction

The purpose of this section of the business case is to outline the strategic case for change.

2.3 Clinical Drivers for Change

The biggest risk to the delivery of a high quality ICU services offered by the Trust was identified as the lack of a suitably qualified workforce to maintain safe Level 3 ICU services at the LGH site. Lead clinicians from within Critical Care identified a number of key risks that require immediate action in addressing the long term sustainability of Critical Care across UHL. These risks were presented to a number of clinicians and managers from a range of affected specialties and formed the basis of the case for change. The risks raised were:

- A gradual movement of high dependency patients from LGH to GH and LRI sites and changes in patient flows restricts opportunities for critical care staff to maintain experience in providing care for critically ill patients. An erosion of skill base presents further risk to the most vulnerable patients in the future. This impacts on both the consultant workforce and the middle grade workforce who cannot gain suitable experiences at the LGH site
- In addition to eroding the skill base at the LGH site, efforts to recruit Consultant Intensivists have failed to attract suitably qualified clinicians in an already 'difficult to recruit' market. It is predicted this issue will be compounded when three Consultant Intensivists are due to retire in the summer of 2016. In 2014 advertisements for Consultant Intensivists at LGH were re-advertised and attracted a limited pool of applicants. Much greater levels of success are experienced for posts advertised at the LRI and GH sites
- A shortage of suitably qualified staff is replicated in the nursing workforce who can elect to work from the GH and LRI sites or alternative local hospitals offering more extensive critical care experience

If the sustainability of ICU provision across UHL is not addressed by July 2016, then the Adult Level 3 ICU service on the LGH site will cease to be provided. This course of action will lead to the cancellation of all surgery and emergency activity at the LGH site which is predicted to require level three critical care support. This reduction in activity, whilst unavoidable on the grounds of clinical quality and safety, will see a resultant loss of quality of care for Leicester patients, damaged reputation for the Trust and loss of future income.

It was agreed by the Trust Board, and in discussion with the Overview and Scrutiny Committee (OSC), that responding to the clinical concerns raised above was of paramount importance and warranted the immediate commencement of work to deliver the relocation of adult Level 3 Critical Care services from LGH.

Upon commencement of the project the Adult Level 3 ICU service was anticipated to be viable until December 2015. However, due to the complexity of the solutions required and the sheer number of stakeholders that required involvement, the project delivery date was revised to July 2016. This has only been possible due to the flexibility and co-operation of staff within ICU at UHL.

It must be noted that until July 2016, interim staffing arrangements are in place to ensure that the ICU provision at the LGH continues to be a safe and high quality service.

While set in the context of the above clinical need, the specific clinical driver for the changes proposed by this business case is:

The requirement to move adult Level 3 Critical Care services from LGH by July 2016.

The investment required is in keeping with the Trust's longer term strategic objectives. UHL's Five Year Strategy envisages that HPB and Renal Transplant services would all move to the GH site. The investment will also allow the achievement of some of the key goals set out by the HPB and Renal Transplant departments which are;

- To create significant operational efficiencies including positive impact on length of stay for emergency admissions
- To help reduce the referral to treatment (RTT) backlog for laparoscopic cholecystectomies (40% of whom present as emergencies on their pathways)
- To enable the HPB unit to attract referrals for its cancer services from other regional units such as Lincoln and Coventry
- To ensure prompt and efficient processing of emergency patients, more bed spaces will become available for elective cases leading to fewer cancellations for cancer resections.
- To facilitate the pooling of consultants at the LRI to one merged rota will also have beneficial impact on elective activity by reducing the frequency of on-calls. To adhere to cancer targets for treatment of bowel cancers
- Ensuring that Renal Transplant activity remains co-located with Adult Level 3 Critical Care activity (as set out within the Renal Transplant service specification)

Part B: The Strategic Context

2.4 Introduction

This section provides an overview of the context in which the Trust provides its services and the strategic guiding principles, directives and policies that ensure clinical quality standards are met.

The intention is to provide an overview of the Trust and its strategic objectives, to highlight current imaging services delivery and set the context for this business case. It also provides an overview of the policy drivers and technical guidance documents at national, regional and local levels.

2.5 Organisational Overview and Background

2.5.1 University Hospital Leicester NHS Trust

UHL is one of the largest teaching hospitals in the country and operates across three main sites (LRI, LGH, and GH). It is the only acute Trust serving the diverse local population of Leicester, Leicestershire and Rutland (LLR); totalling approximately 1 million residents.

The nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, cancer and renal disorders reach a further two to three million patients from the rest of the country.

2.5.2 Clinical Management

Clinical management within the Trust is provided by seven clinical management groups (CMGs), each led by clinical director who in turn reports to UHL's Chief Operating Officer Richard Mitchell. All seven CMGs will be affected by the proposed redevelopment. The groups are as follows:

- Critical Care, Theatre, Anaesthesia, Pain and Sleep (ITAPS)
- Cancer, Haematology, Urology, Gastroenterology and General Surgery (CHUGGS)
- Clinical Supporting and Imaging (CSI)
- Emergency and Specialist Medicine (ESM)
- Musculoskeletal and Specialist Surgery (MSS)
- Renal, Respiratory, Cardiac and Vascular (RRCV)
- Women's and Children's (W&C)

The CMGs comprise clinicians, nurses, allied health professionals and managers; each one has developed strategies to deliver the Trust's strategic objectives.

2.5.3 Activity and Finance

UHL provides hospital- and community-based healthcare services to patients across LLR. It also provides specialist services to patients throughout the UK. The Trust is actively engaged with key stakeholders to implement NHS policy to improve health services through a range of formal and informal partnerships. The UHL team consists of more than 10,000 staff providing healthcare primarily for the one million-plus LLR residents it serves. The nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, cancer and renal disorders reach a further two to three million patients from the rest of the country.

The Trust's main sources of income are derived from:

- Clinical Commissioning Groups;
- NHS England; and
- Education and training levies.

The Trust was formed in April 2000 and successfully met its financial targets for the first 12 years. Financial results for 2011/12 and 2012/13 show that the Trust made a surplus of £88k and £91k respectively. However 2013/14 was a challenging year both operationally and financially and the Trust reported a deficit for the first time since the organisation was formed. In 2014/15 there was a £40.6 million deficit against a plan of £40.7 million.

2.5.3.1 Financial review for the year ended 31 March 2015

UHL did not meet all of its financial and performance duties for 2014/15; it failed to break even. This was expected, however, and mitigated by a deficit reduction plan. In respect of the Trust's formal duties:

- **Balancing the books –** delivery of an income and expenditure deficit of £40.6m.
- **Managing cash** – UHL delivered both the External Financing Limit (EFL) and Capital Resource Limit (CRL).
- **Investment in buildings, equipment and technology** – the Trust invested £46.2 million in capital developments.

2.5.4 Key National Strategies

Key national strategies, programmes and policies relevant to this project are summarised in the table below.

Table 8 National Strategies, Programmes and Policies

Strategy	Aims
DH report "Comprehensive Critical Care: a Review of Adult Critical Care Services" 2000	The report recommends the establishment of adult critical care networks. (It was published in response to national concerns regarding critical care capacity, equity of access and quality of care.)
National Adult Critical Care Stakeholder Forum document, "Quality Critical Care – Beyond Comprehensive Critical Care" 2005	The document recommends that *"critical care networks be retained, strengthened and fully developed in line with local priorities and needs".*
Operational Delivery Networks (ODN) established 1st April 2013	From the 1st April 2013 adult Critical Care services across NHS England have been required to be delivered through integrated Operational Delivery Networks (ODN) with services delivered across providers in a pre-determined geographical area.
NHS England Service Specification No. D16 Adult Critical Care 2014	The Service Specification for Adult Critical Care states: "***Interdependencies with other services/providers*** *The management of critically ill patients whether commissioned by NHS England or CCGs requires the input of a number of medical and non-medical specialties, and other agencies. Ultimately the nature of core supporting services will be dependent on the patient case mix of the critical care unit but the following shall be considered as minimum interdependencies:* ***Co-located Services – to be provided on the same site and to be immediately available 24/7:*** • *Competent resident medical practitioner with* • *advanced airway skills (anaesthetist/Intensive Care Medicine)* • *General Internal Medicine* • *Endoscopy*

Strategy	Aims
	• *Radiology: CT, Ultrasound, plain x-ray* • *Echocardiography/ECG* • *General Surgery for any site with unselected medical admissions.* • *Access to Theatres* • *Transfusion Services* • *Essential haematology/biochemistry service and point of care service* • *Speciality Intensive Care Units must have their speciality specific surgical service co-located with other interdependent services e.g. Vascular surgery with interventional vascular radiology, nephrology and interventional cardiology; obstetrics with general surgery* • *Informatics support* • *Physiotherapy* • *Pharmacy* • *Medical Engineering Services* ***Interdependent Services, available 24/7*** *The response time to these specialities will depend on the case mix of the patient population and will range from available within 30mins to a maximum of 4 hours. For services not immediately available on site service level agreements need to specify response times.* • *Interventional Vascular and non-vascular Radiology* • *Neurosurgery* • *Vascular Surgery* • *General Surgery* • *Nephrology* • *Coronary Angiography* • *Cardiothoracic Surgery* • *Trauma and Orthopaedic Surgery* • *Plastic Surgery* • *Maxillo-facial Surgery* • *Ear, Nose and Throat Surgery* • *Obstetrics and Gynaecology* • *Organ Donation Services* • *Acute/Early Phase Rehabilitation Services* • *Additional laboratory diagnostic services"*

Strategy	Aims
Intensive Care Society **"Guidelines for the provision of intensive care services"** **2015**	The guidelines include the following guidance pertinent to this business case: "***Interactions with other services*** *Intensive Care Medicine presents an interesting paradox. It owns few, if any, unique therapies or interventions; it has an impressive track record of negative clinical trials; and yet … there has been an inexorable improvement in case-mix adjusted mortality rates from critical illness over the years.* *Broad inspection of the research literature suggests that most gains are to be made from interventions which facilitate earlier diagnosis and treatment, minimise the harmful effects of organ support, enhance communication, and promote a proactive system-wide approach to the care of patients at risk of critical illness. The 'art' of intensive care therefore lies more in integrating multi-professional care and complex interventions over time, across locations and between teams, than in the delivery of any single treatment.* *Consequently, intensivists must be systems experts, both in terms of physiology and of healthcare delivery. Interaction with 'other services' starts with the multi-professional teams in the Intensive Care unit: doctors, nurses, advanced Critical Care practitioners, physiotherapists, dieticians, infection control and microbiology, and pharmacists; with further input by occupational therapy, speech and language therapy, and clinical psychology. The morning and evening rounds are key opportunities to draw together information about the patients, to establish daily goals and determine main risks and communication tasks, using a standardised data collection sheet or an electronic equivalent. Given the size of the ICU team, and the impact of staff rotations and shift-working, it helps cohesion and flattens hierarchies if the morning round starts with each member introducing themselves by name and rank, including the consultants. Interaction with microbiology is best conducted with relevant laboratory data available and at a consistent time each day. The appropriateness, dose, and duration of antimicrobial therapies may be reviewed, together with the ecology of the ICU, screening practices, and patterns of resistance. Ideally a senior member of the nursing staff should also be present.* *The timing of interactions with visiting medical or surgical teams will need to accommodate their other commitments. One approach is to establish, as a routine, a brief early morning case review with a trainee member of the visiting team (to determine dischargeability for example) which may then be followed in the middle of the day by consultant-to-consultant discussion, informed by available laboratory or imaging tests. Continuity of care between teams and over time is essential. Radiological*

Strategy	Aims
	investigations should be planned in discussion with the radiologist performing the procedure. Ideally the consultant intensivist should review imaging results directly with the radiologist rather than receiving the report at a later stage, particularly if interventional radiology is a possibility."
NHS Standard Contract for Adult Kidney Transplant Services **Service Specification No A07/S/a**	The evidence base for the Standard Contract outcomes framework is derived from: • Renal Association Guidelines: Assessment of the Potential Kidney Transplant Recipient (2011) • NHSBT/British Transplantation Society (BTS) Guidelines for Consent for Solid Organ Transplantation in Adults (2011) • UK Guidelines for Living Donor Kidney Transplantation (2011) • Renal Association Guidelines: Post-operative care of the Kidney Transplant Recipient (2011) • Kidney Disease Improving Global Outcomes (KDIGO) Guideline for Care of the Kidney Transplant Recipient (2009) • British Transplantation Society Guidelines for the Prevention and Management of Cytomegalovirus Disease after Solid Organ Transplantation (2011) • European Best Practice Guidelines for Renal Transplantation (2002) • British Transplantation Society: Antibody Incompatible Transplant Guidelines (2011) • British Society for Histocompatibility and Immunogenetics (BSHI)/BTS: Guidelines for the detection and characterisation of clinically relevant antibodies in allotransplantation (2010)
Manual for Cancer Services Hepato-Pancreato-Biliary Cancer Measures **NHS England** **2013**	The Manual for Cancer Services is an integral part of Improving Outcomes: A Strategy for Cancer and aligns with the aims of the Coalition Government: to deliver health outcomes that are among the best in the world. The Manual supports the National Cancer Peer Review quality assurance programme for cancer services and enables quality improvement both in terms of clinical and patient outcomes. The Manual includes national quality measures for site specific cancer services together with cross cutting services such as chemotherapy and radiotherapy.

2.5.5 Key Regional Strategies

2.5.5.1 The Leicester Joint Strategic Needs Assessment (JSNA)

A Joint Strategic Needs Assessment (JSNA) is a statutory requirement (Health & Social Care Act 2012) placed upon the Directors of Public Health, Adult and Children's Services in all local authorities to guide the commissioning of local heath, well-being and social care services. The JSNA provides a systematic method for reviewing the short and long term health and well-being needs of a local population. This JSNA is an important starting point for strategy development and commissioning decisions.

The latest available JSNA for Leicester (2012) states that:

"People in the city die early, particularly from circulatory diseases, cancers and respiratory disease. Poor health is largely driven by deprivation and exacerbated by lifestyle factors embedded within communities. The inequalities gap in health between Leicester and England is not narrowing and the gap between the more deprived and the more affluent communities within Leicester has remained a stubborn inequality. We want to improve the health and wellbeing of the poorest fastest."

Leicester is ranked 25th worst out of 326 local authority areas in England on the national Index of Deprivation (2010). There are also areas of deprivation outside the city – notably certain wards of North West Leicestershire.

In general, the next 20 years is forecast to see an increasingly ageing population, particularly in the county areas. Of the total population growth of 32,000 to 2019, 22,000 will be in the over-65 group. This is largely a challenge in the county areas. By contrast, the key challenge in Leicester City will continue to be premature preventable death and disability.

As people grow older, there is a higher preponderance of long term illness and disability. The number of people living with long term conditions will grow as a population ages. Furthermore, many people will have multiple conditions, meaning their care needs are more complex. From a health need perspective there is a marked variation in life expectancy across LLR with the main factors contributing to mortality being cardio-vascular disease (CVD) and respiratory. Any plans for service improvement must respond to these challenges and make a significant contribution towards better outcomes.

2.5.6 Key Local Strategies

2.5.6.1 Better Care Together: A Blueprint for Health & Social Care in LLR 2014 - 2019

For LLR a Long Term System Model (the "Model") has been constructed to articulate what would happen when faced with the challenges described in the "A Call to Action" (published by NHS England). If no action were to be taken to improve the quality, outcomes and value for money of services currently provided to patients, or to develop new services, then the model predicts a financial gap over the next five years that rises to £398m by 2018/19.

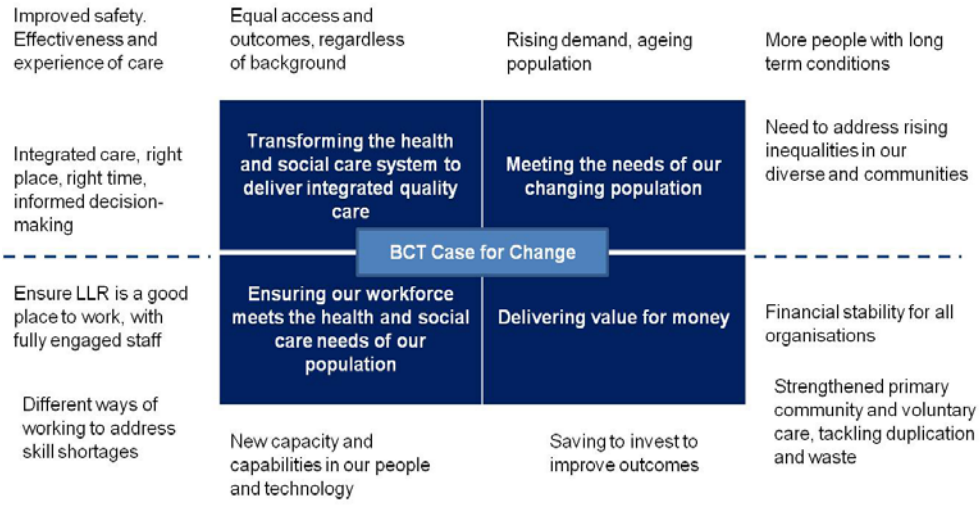
In response, the BCT programme represents the biggest ever review of health and social care across LLR. The programme represents a partnership of NHS organisations and local authorities across LLR, working together to achieve major transformation in the current and future delivery of services that are of the highest quality and are capable of meeting the future needs of local communities.

The programme is underpinned by a clear case for change with the aim of focusing on a significant increase in community based prevention and care and delivering only the most complex care from an acute hospital setting. As a consequence of the shift to community settings the Trust intends to consolidate acute services onto a smaller footprint and to grow its specialised, teaching and research portfolio, only providing in hospital the acute care that cannot be provided in the community. In doing this the Trust expects to significantly increase the efficiency, quality and, ultimately, the sustainability of key services; shrink the size of the required estate; significantly rebalance bed capacity between acute and community settings; provide alternative solutions to traditional in-patient care and thus reduce total costs. The impact of this on UHL could include:

- Delivering better care to fewer patients
- Making more of our specialist expertise available to primary and social care; and delivering more of our non-specialist services to the community
- Play a much bigger role in preventing illness and supporting patients before they reach a point of crisis
- A greater focus on specialised care, teaching and research
- Redevelopment of the Emergency Department at the LRI
- Significantly smaller acute hospitals overall
- Fewer acute hospital beds
- Concentrating acute services on two sites rather than three
- Reshaping services on the LGH site including community beds and the Diabetes Centre of Excellence
- Financially sustainable

The BCT case for change is summarised in the diagram below.

Figure 1 Better Care Together Case for Change



2.5.6.2 UHL's 'Caring at its Best' strategy

In the next five years, UHL will become a Trust that is internationally renowned for placing quality, safety and innovation at the centre of service provision.

The Trust will build on its strengths in specialised services, research and teaching, offer faster access to high quality care, develop its staff and improve patient experience.

UHL recognises the significant challenges it faces alongside others in the LLR health and social care system, including:

- The long-term financial pressures facing all public sector organisations
- Rigorous regulation of healthcare providers within a competitive landscape
- Changes in the wider health and political landscape
- Focus on choice
- Greater patient and community involvement
- The inherent inefficiency of the Trust's current physical configuration
- Fiscal drag of ageing estate reflecting incremental development over decades

The UHL team consists of more than 10,000 staff providing healthcare primarily for the one million-plus LLR residents it serves. The nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, cancer and renal disorders reach a further two to three million patients from the rest of the country.

UHL works with partners at the University of Leicester and De Montfort University providing world-class teaching to nurture and develop the next generation of doctors, nurses and other healthcare professionals, many of whom go on to spend their working lives with the Trust.

The Trust focuses on being at the forefront of many research programmes and new surgical procedures, in areas such as diabetes, genetics, cancer and cardio-respiratory

diseases. UHL is now the home of three National Institute of Health Research (NIHR) Biomedical Research Units and during the year carried out over 800 clinical trials, bringing further benefits to thousands of patients.

The heart centre at GH continues to lead the way in developing new and innovative research and techniques, such as TAVI (Trans-Catheter Aortic Valve Insertion) and the use of the suture-less valves in heart surgery.

UHL also has one of the best vascular services nationally, with more patients surviving longer after following an aneurysm repair (to fix a life threatening bulge in a blood vessel).

The Trust has some of the lowest rates of hospital-acquired infections, such as C. Difficile and MRSA, in the country; the hospital standardised mortality rates are very good, demonstrating a high clinical quality; with the provision of food has also been rated as 'excellent' by an independent panel.

UHL's purpose is to provide 'Caring at its Best' and staff have helped to create a set of values, which are:

Figure 2 Caring at its Best

UHL patients are at the heart of all that is done at the Trust. 'Caring at its Best' is not just about the treatments and services provided but about giving patients the best possible experience.

Each element of the objectives and supporting strategy are performance-managed through the Trust Board scorecard, regularly reported to Board through the Integrated Performance Report (IPR).

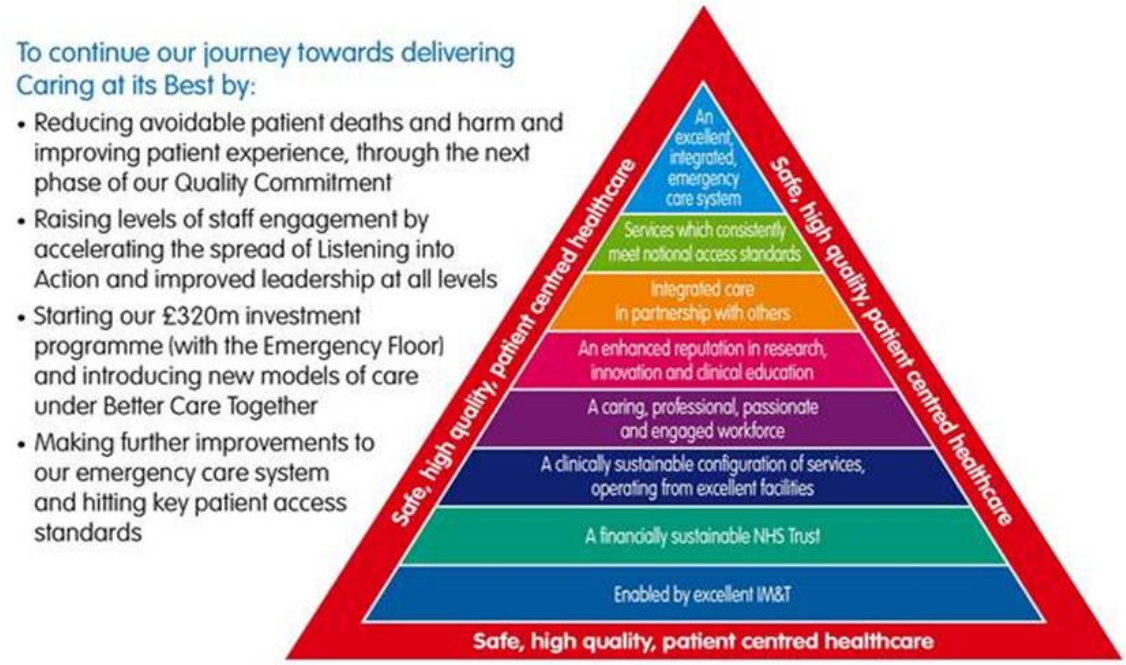
2.5.7 The Trust's Strategic Objectives

The strategic objectives of the Trust are to provide:

- Safe, high-quality, patient-centred healthcare
- An effective and integrated emergency care system
- Services which consistently meet national access standards

- Integrated care in partnership with others (local and specialised)
- Enhanced delivery in research, innovation and clinical education
- A caring, professional and engaged workforce
- A clinically sustainable configuration of services, operating from excellent facilities
- A financially sustainable NHS organisation
- Enabled by excellent IM&T

Figure 3 UHL's Strategic Objectives



2.5.8 UHL Five Year Integrated Business Plan 2014 – 2019

The Trust's Five Year Integrated Business Plan 2014-2019 was developed through four key phases: evidence gathering; analysis, synthesis; and planning. In developing the strategy, the Trust has identified that it operates predominantly in two core markets:

- Local services for LLR where it is the major provider of local secondary care services
- The wider Midlands and East regional economy where the Trust is a key provider of specialised adult and children's services
- In order to deliver financially sustainable, high quality services in the future, UHL's hospitals will need to become smaller and more specialised whilst supporting delivery of care in the community

2.5.9 The Trust's Five Year Estate Strategy (June 2014)

The Trust's current Estate Strategy identifies the need for flexibility, to move property from being a constraint to being an enabler for change.

The Trust has undertaken an exercise to review the strategic future of its estate, with a view to creating a development control plan that looks twenty years ahead, recognising that "The quality and fitness for purpose of the NHS Estate and the services that maintain it are integral to delivering high quality, safe and efficient care"3. Of course the estate is also an area of significant spend: the budget for Estates and FM Services across the Trust in 2013/14 was £31m.

UHL has also developed a 'Hospitals Estate Transformation Plan', which is based on a strategy that consolidates the estate, develops new facilities, disposes of surplus land and buildings and encourages third party partnerships that will raise income for the Trust. This plan will be a cornerstone of service reconfiguration and improved utilisation of the Trust's estate. This must be balanced by organisational and public expectations about the provision of highly specialised services alongside local access to primary and secondary care, in the context of high levels of public support for the associated hospitals. It is in this context that any opportunities for significant and far-reaching estate transformation will be determined.

The Hospitals Estate Transformation Plan will:

- Underpin the strategic direction of the Trust through the transformation of the physical estate
- Support the clinical strategy to improve patient pathways and to improve the quality of care
- Support the Strategic Outline Case for reconfiguration across the sites
- Show a clear implementation programme over five years for transformation with tangible benefits
- Improve the patient and staff built environment, investing in improved facilities and infrastructure; greatly aiding recruitment and retention
- Identify capital developments that will unlock the embedded value of Trust assets
- Support the Trust's capability to deliver clinical transformation and achieve QIPP efficiency savings

Efficient estate solutions will improve frontline service provision as well as achieving improved utilisation of the estate. This will be achieved by delivering a high-quality clinical and working environment for patients and staff – resulting in better levels of recruitment and retention, productivity, flexibility and patient and staff satisfaction.

The Transformation Plan will also support cross-CMG strategies that maximise optimisation of the estate resources across UHL. It will set out detailed strategies for the Trust's three main hospital sites. The Estates Strategy will be updated during 2015/16.

[3]Treasury Value for Money Update, 2009

2.5.10 Stakeholder Engagement

Owing to the urgent clinical need to expedite the reconfiguration of UHL's Level 3 care, in the early part of 2014 the Trust's Overview and Scrutiny Committee was informed of the clinical need. It supported the Trust's intention to proceed with the programme at pace and without the need for public consultation.

The over-arching ICU project has seen a wide variety of engagement from across the Trust and also further reaching:

Over-arching ICU programme:

- Involvement of key service leads from all affected areas through planning
- Representation of HealthWatch patient representative on ICU Board
- Communication with OSC at key points within the project
- Site based communication events

Staff currently working at the LGH site within HPB and Renal Transplant, as well as those utilising theatres, will be affected by this change due to the change in location of their services or a short term change in timing of operating lists. This will be managed through a robust and transparent change management process to ensure that high quality services can continue to be provided and that disruption to staff is minimised.

In order to ensure that an optimal working environment is achieved the following specialties were consulted during the design process and have signed off the design:

- Infection Prevention Team
- Clinical Teams (Consultants, Matrons)
- Fire Officer

The undertaking of such a wide ranging set of engagement activities has been crucial in ensuring that clinical staff have been heavily involved in planning, crucial in such a complex project. The input of patient representatives has also ensured that decisions taken have remained centred around the best interest of patients.

2.5.11 The Trust's Clinical Strategy

UHL is focused on delivering high-quality, patient-centred services in the most appropriate setting with excellent clinical outcomes. There is a process of continual quality improvement for clinical outcomes, morbidity and mortality rates and other clinical indicators to ensure that the Trust remain the provider of choice for patients.

The strategy reflects the changes in population demographics, placing the patient at the centre of service planning and design, ensuring that holistic, patient-centred care remains at the heart of everything we do. For example, services will be tailored to meet

the challenges of a rising elderly population; ensuring integrated care is provided across primary, community and social care.

The Trust will work with partners to develop the infrastructure and networks to offer expertise across the health community to ensure that care for the older person is as seamless as possible, in the following ways:

- Developing a more flexible and integrated workforce
  - The model of clinical practice will be to provide consultant-delivered (rather than consultant-led) patient care;
  - The Trust will seek and exploit opportunities for service integration across health and social care by removing the historical barriers to change;
  - Training and education will play an integral part in ensuring staff have the right skills now and for the future. Training opportunities to support self-care in long-term condition management and carers will be explored;
  - UHL will create a sustainable workforce for the delivery of responsive multi-disciplinary clinical services seven days a week that meets the needs of patients and clinicians;
  - UHL will ensure that appropriate staffing is recruited and retained to achieve the identified standards.

- Consolidating and making better use of finite resources
  - People are living longer, and the NHS' ability to treat and help to manage conditions that were previously life-threatening continues to improve. Alongside this, the NHS faces a potential funding gap of around £30 billion by 2020/21 meaning that the NHS will need to radically transform the way it has traditionally provided care to new and innovative models necessitating a significant shift in activity and resource from the hospital sector to the community;
  - UHL will meet this funding gap by working collaboratively with its LLR Health and Social Care partners to re-design patient care pathways to ensure that they continue to provide high quality care, outcomes and patient experience whilst delivering value for money;
  - The Trust has an on-going operating deficit in part related to the current configuration of its clinical services which do not optimise clinical adjacencies and patient pathways;
  - In order to deliver financially sustainable, high quality services in the future, UHL's hospitals will need to become smaller and more specialised whilst supporting delivery of care in the community;
  - As a consequence UHL has developed a clinical and estates strategy that optimises where and on which site its services are located as care pathways are changed to meet the financial challenge. The methodology about future location of services is clinically driven, evidence based, inclusive, open and transparent, and involve patients and the public in a meaningful way however will necessitate tough

decisions for the health community if it is to meet the 'value for money' test;

- The Trust is proactively responding to the national drive towards fewer regional centres of excellence for specialised services by ensuring its services deliver innovative, high quality patient care through robust research and development programmes that enable patients to benefit from leading edge developments in the care of specific conditions;
- The Trust will specifically seek to ensure it remains as a national centre of excellence for its work in Cardiac, Respiratory, Vascular, Renal, Cancer and Diabetes and significantly strengthen its portfolio of other key services to ensure they are sustainable in the future.

2.5.12 The Trust's ICU Strategy

The over-arching strategy for delivering ICU care at UHL supports both the national and local imperatives identified above.

There is a recognised move towards using critical care beds at an earlier stage in a patient's treatment. On an international level the UK already has a low number of ICU beds compared to its population, and even within the UK UHL is notable as a Trust with a low provision of ICU beds per capita.

The Trust's five-year strategy for delivering critical care services is the creation of two super critical care units by 2019 at the LRI and GH. These will care for Level 2, 3 and 4 patients staffed and delivered to the national core standards to ensure that the local population and referrals for tertiary care have the highest quality care in the most appropriate environment. This will be supported by a robust tier of Level 1 care beds within specialties throughout the organisation which will, in turn, be supported by critical care outreach services delivering 24/7 service.

The first year of the strategy is underway, precipitated by the need to re-locate adult Level 3 ICU beds at the LGH due to on-going staffing issues. This has driven the need to provide an interim solution for an expansion of the adult Level 3 ICU beds at the LRI and the GH, pending implementation of the longer-term solutions to address the identified gap in capacity over the next ten years.

The imperative is to deliver the change as rapidly as possible; the realistic timescale sees delivery by July 2016.

2.6 Current Activity and Demand

UHL provides hospital- and community-based healthcare services to patients across LLR. It also provides specialist services to patients throughout the UK. The Trust is actively engaged with key stakeholders to implement NHS policy to improve health services through a range of formal and informal partnerships. The UHL team consists of more than 10,000 staff providing healthcare primarily for the one million-plus LLR residents it serves. The nationally and internationally-renowned specialist treatment

and services in cardio-respiratory diseases, cancer and renal disorders reach a further two to three million patients from the rest of the country.

2.6.1 Demand and Capacity Modelling

2.6.1.1 HPB services

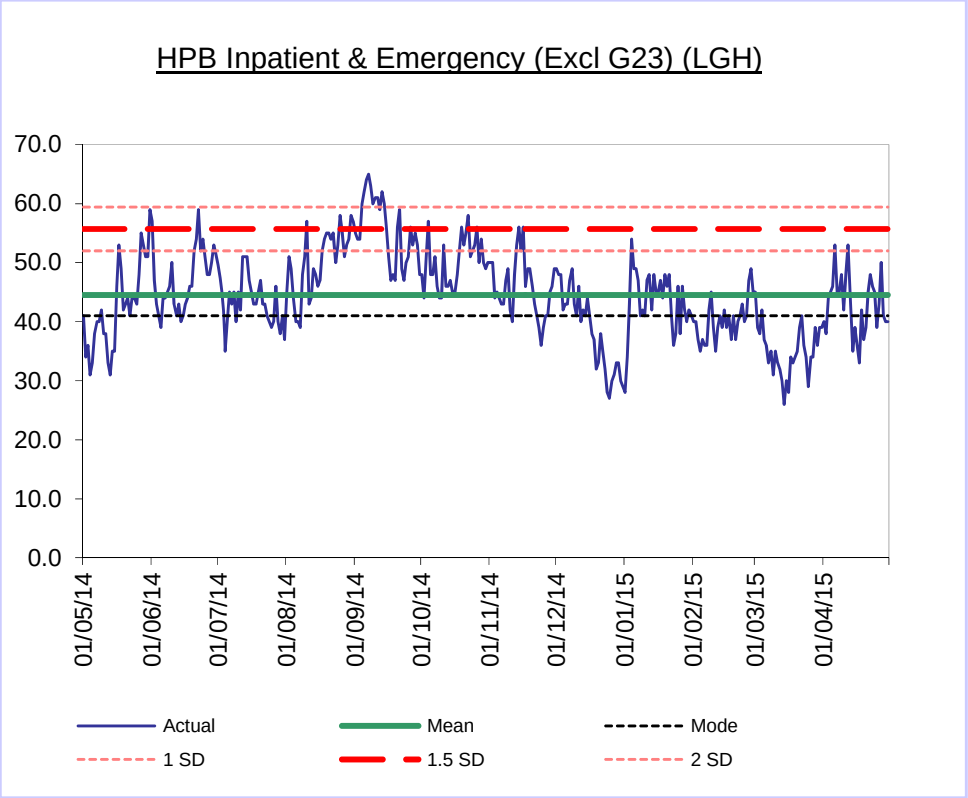
The work of the unit can be broadly divided into five main streams comprising of:

- Endoscopic Work (ERCP & EUS)
- Cancer & Major Resections
- Major Complex Biliary Work
- Laparoscopic Cholecystectomy & Day Case Procedures
- National specialist services including supra-regional services such as total pancreatectomy and autologous islet cell transplantation

Detailed work has been undertaken using Trust activity data for 2014/15, in order to determine the number of beds that HPB will require at the GH.

This analysis was undertaken by looking at the number of patients in HPB beds at LGH every day for a year. This approach was used to ensure that enough capacity was provided to meet peaks in activity as opposed to planning on an overall number of bed days. The below analysis sets out the beds required by HPB based upon standard deviation analysis and indicated that 56 beds would be required to meet the majority of peaks in demand.

Figure 4 HPB Inpatient & Emergency Activity - LGH



Min	26
Max	65
Mean	45
Median	44
Mode	41
1 SD from Mean	52.0
1.5 SD from Mean	**55.7**
2 SD from Mean	59.4
85% LOS Method	52.4

Please refer to Appendix 2 (HPB Operational Policy) which sets out a detailed analysis of current activity types.

2.6.1.2 Nephrology and Renal Transplant

Renal Transplant undertook a bespoke local audit to ensure that staff were sighted on the types of patients that would be required to move to GH by July 2016 and the following statement from the service demonstrates their requirements;

There will need to be enough inpatient services still based at LGH to provide a critical mass to justify support from support services (e.g. radiology, critical care, hospital at night and generic resident medical support). There is agreement that the transplant bed base would be reduced from 14 to 10. The service also requires access to two day

case beds and day case theatres on the LGH site. This is based on the fact that currently there is an overflow of Nephrology patients to Transplant beds and this will be constrained by splitting the service.

There were 39 nephrology/transplant patients treated in the main LGH ITU/HDU in the 9 months to the end of 2014, i.e. around 1 per week.

2.6.1.3 Theatres

The movement of HPB and Renal Transplant onto the GH site (alongside Vascular Surgery which will have moved in April 2016) will require a fully operational dedicated Emergency Theatre to be in place by July 2016.

Along with the ten weekly elective Vascular lists, six weekly Renal Surgery lists and ten weekly elective HPB elective lists that will transfer by July 2016 the site was due to experience a significant capacity gap.

The agreement to release Theatre 6 by transferring day case General Surgical work to the LGH left the capacity gap at 14 weekly sessions between July 2016 (when all services will have moved onsite) until December 2016 (when the Hybrid theatre opens to provide additional capacity).

All specialties that are currently operating/will be operating on the GH site were approached to see whether there was an operational solution to solving this problem that avoided the need to commit to an expensive and time pressured capital build.

The following plans have been put forward by each specialty.

- HPB:- will move one session to the evening and two sessions to the weekend;
- Renal Transplant:- will leave two routine vascular access lists at LGH and will move two lists to the weekend;
- Thoracic Surgery:- will move two lists to the weekend;
- Cardiac Surgery:- will move two lists to the weekend;
- Vascular Surgery:- will leave one list at LRI as a daycase list;
- Breast Surgery:- will lengthen two lists to enable the release of two in week lists.

Further work will be required to ensure that operational impact on all areas of the GH site are understood and are prepared to support this change in working practice.

2.7 UHL Quality Commitments

The Trust is committed to improving the quality and safety of care for all the patients it serves. The quality commitment articulates three key aims:

- To provide effective care – to improve patient outcomes

  “To deliver evidence based care/best practice and effective pathways and to improve clinician and patient reported outcomes.”

- To improve safety – to reduce harm

  "To reduce avoidable death and injury, to improve patient safety culture and leadership and to reduce the risk of error and adverse incidents."

- Care and Compassion – to improve the patient experience

  "To listen and learn from patient feedback and to improve patient experience of care."

2.8 Investment Objectives, Key Deliverables and Benefits Criteria

In the context of the above and the Trust's corporate objectives, the 'SMART' investment objectives for this project are detailed below as part of the wider Benefits Realisation Plan.

- To move Adult Level 3 Critical Care activity off the Leicester General Hospital site, still providing the ability to stabilise and transfer where this is required
- To increase capacity for Level 3 care at both the LRI and GH. Modelling has built in the ability to provide enough physical bed spaces for known growth at GH and also ICU driven cancellations and still provides some physical capacity to allow for further future growth
- To improve the clinical adjacencies of ICUs and dependent specialties to optimise clinical safety and reduce clinical risk
- To develop a centre of excellence, enhancing the Trust's reputation for training, service delivery and treatment through the provision of a more streamlined ICU service
- To create a design that is fit for purpose
- To deliver the development in time for the increased clinical demand over winter
- To deliver the development with minimal disruption to the current provision of service to current ICU areas
- To allow the creation of a standalone specialist HPB service
- To ensure that Renal Transplant are co-located on a site with Adult Level 3 Critical Care (as per service specifications)
- To ensure that disruption through the transitional theatres period (July 2016-December 2016) is minimised

3 | The Economic Case

3.1 Introduction

This case describes the options for delivering bed capacity for HPB and Renal Transplant on the GH sites in terms of their relative benefits and costs. It highlights the preferred option after each shortlisted option has been appraised on a financial and non-financial basis.

3.2 Overall Economic Position for Critical Care

This business case is one of a series of business cases supporting the reconfiguration of critical care services across the three hospital sites. The Trust has reviewed its overall position in respect of transferring all services related to the LGH critical to the LRI and the Glenfield Hospital. It has run a high-level economic appraisal which compares a 'Do Nothing' scenario with respect to the Critical Care facilities at the LGH with a scenario that moves Critical Care beds and associated services from the LGH and the associated moves between other hospitals.

Given the fact that Vascular services have already been approved, it examines the costs including the Vascular move and excluding the Vascular move. (Even if the Vascular moves weren't taking place, this Critical Care move would still be preferred over the 'Do Nothing' option.)

The result of this appraisal is as follows:

Table 9 Net Present Cost of Each Option Appraised

Option	NPC £'000
Do Nothing	409,795
Critical Care and Vascular moves	321,758
Critical Care Moves only	302,256

The 'Do Nothing' option is significantly more expensive than the proposed developments for critical care, including and excluding vascular services.

The option appraisal process reflected two elements of the service moves, HPB and Renal Transplant/Vascular Access. It evolved as a result of timescales and funding available. The options initially explored for each specialty are as follows.

Table 10 Options Explored – HPB Beds

Ref	Option	Description
1	New Build Wards	Construction of two new build wards on GH site
2	Wards 28 and 29	Utilisation of Cardiology and Respiratory Wards
3	Wards 26 & 27	Utilisation of Thoracic Surgery, Thoracic HDU and Heart Failure Ward
4	Wards 24 & 25	Utilisation of Endoscopy and Breast Wards
5	Ward 33a and 33	Utilisation of Cardiology Wards

Table 11 Options Explored – Renal Beds

Ref	Option	Description
A	Co-location with Vascular	Co-habitation of Renal Transplant patients on Vascular Ward
B	Conversion of Respiratory Corridor	Conversion of current office space to provide clinical space for the required beds
C	New Build	Creation of a new build 10 bedded ward

Table 12 Detailed Renal Transplant Scoring

Ref	Benefit Criteria	Weighting	Option A - Share with Vascular	Option B - Respiratory Corridor	Option C - New build ward
1	**Clinical Quality and Configuration**	**5%**	**8**	**8**	**8**
A	Enables an acute configuration of services that maximises clinical affinities and critical adjacencies minimises clinical risk		3	3	3
B	Is in line with the trust vision – 2 acute and 1 ambulatory sites		5	5	5
2	**Efficiency & Effectiveness**	**5%**	**4**	**5**	**5**
A	Will provide capacity Renal transplant activity moving from LGH		4	5	5
3	**Staffing**	**20%**	**3**	**3**	**3**

A	Ease of staffing cover		3	3	3
4	**Quality of the Patient Environment**	**10%**	**10**	**14**	**14**
A	Improves the quality of the patient environment; privacy & dignity; single sex areas; single rooms		3	5	5
B	Enhances the overall patient experience		3	4	4
C	Safe from an infection control perspective		3	5	5
5	**Achievability**	**50%**	**3**	**4**	**1**
A	Likely timescale and cost of conversion works/interdependencies		3	4	1
6	**Accessibility**	**10%**	**9**	**10**	**10**
A	Operational access to area		3	4	4
B	Clinical adjacencies		3	3	3
C	Overall patient journey		3	3	3
Totals			**37**	**44**	**41**
Weighted Totals			**4.6**	**5.65**	**4.15**
Rank			**2**	**1**	**3**

Ward space for HPB – of the available options, Wards 28 and 29 are the favoured option as it is the only one that would not compromise other services on site.

Ward space for Renal Transplant – The conversion of Respiratory office space is the favoured solution from both a qualitative and quantitative perspective.

3.3 Benefits appraisal process

Each of the above options has been subjected to an option appraisal process based on pre-determined non-financial benefit criteria. The benefit criteria applied within this assessment were as follows:

Table 13 Benefits Criteria

Objectives		Measurement (the degree to which an option is likely to result in…)
A	To provide a solution that maximises clinical quality and safety whilst remaining consistent with future configuration	An acute configuration of services that maximises clinical affinities and critical adjacencies minimises clinical risk
B	To provide an efficient and effective solution for the expansion of IR at GHGH	Extra imaging capacity to enable Level 2 and Level 3 activity moving from other sites
C	To allow staffing pressures to be minimised in delivering the solution	Ease of effective staffing cover
D	To ensure that the quality of the patient environment and experience remains a priority	Enhanced patient experience, safety in terms of infection control and prevention and improvement in the quality of the patient environment; privacy & dignity; single sex areas; single rooms
E	To deliver a solution that is achievable and delivers the required capacity within the timescale of July 2016	Achievement of timescale of conversion works/interdependencies
F	To deliver a solution that ensures accessibility to patients	Clinical adjacencies and an acceptable overall patient journey

The project team met to determine the relative importance of each of these categories. The results of the weighting exercise are as follows.

Table 14 Weighting of Criteria

Criterion		Weighting	Points Available	Maximum Weighted Points
A	Clinical Quality and Configuration	5%	10	0.5
B	Efficiency & Effectiveness	5%	5	0.3
C	Staffing	20%	5	1.0
D	Quality of the Patient Environment	10%	15	1.5
E	Achievability	50%	5	2.5
F	Accessibility	10%	15	1.5

As it was agreed that clinical safety and quality would necessarily be central to the project's aim, the greatest weightings were attributed to those factors that maximised achievability of a suitable option in line by the absolute deadline of July 2016.

Each of these key categories contained a number of sub-elements to ensure robust decision making.

Participants then scored the options against each of the criteria, applying the measurement criteria listed in the table above. Each option was scored as detailed in section 3.5.

3.4 Options development

A number of options exist for the delivery of the proposed reconfiguration. Options were first generated through a detailed analysis of the GHGH site, these options were then assessed with Imaging and Estates staff to ensure that a full qualitative benefits appraisal was undertaken. A key constraint in reviewing these options was ensuring continuity between this appraisal and the longer term site reconfiguration, both in terms of capital cost and strategic location.

The options initially explored for each specialty are as follows.

Table 15 Options Explored: HPB Beds

Ref	Option	Description
1	New Build Wards	Construction of two new build wards on GH site
2	Wards 28 and 29	Utilisation of Cardiology and Respiratory Wards
3	Wards 26 & 27	Utilisation of Thoracic Surgery, Thoracic HDU and Heart Failure Ward
4	Wards 24 & 25	Utilisation of Endoscopy and Breast Wards
5	Ward 33a and 33	Utilisation of Cardiology Wards

Table 16 Options Explored – Renal Beds

Ref	Option	Description
A	Co-location with Vascular	Co-habitation of Renal Transplant patients on Vascular Ward
B	Conversion of Respiratory Corridor	Conversion of current office space to provide clinical space for the required beds
C	New Build	Creation of a new build 10 bedded ward

Ward space for HPB – of the available options, Wards 28 and 29 are the favoured option as it is the only one that would not compromise other services on site.

Ward space for Renal Transplant – The conversion of Respiratory office space is the favoured solution from both a qualitative and quantitative perspective.

3.4.1 Long List to Short List

HPB's relocation to the LGH by July 2016 requires the provision of 44 acute beds across two separate, but co-located, wards on the GH site to accommodate Emergency and Complex Elective HPB patients.

In the interest of undertaking a complete and thorough options assessment the costs of a new build solution was initially assessed to determine whether this could offer a viable solution compared to the refurbishment of existing estate.

The estates team provided the cost to deliver these wards as a new build solution. The project board determined at this stage that the cost to provide this ward space would not deliver acceptable value for money. In line with the Trust's strategic Estates vision to reduce the overall estate footprint and utilise retained estate where possible, it was agreed that the delivery of the HPB beds should be achieved through the refurbishment of two existing GH wards.

3.4.2 Short-listed Options

The requirement for these beds to be co-located on the GH site limited the options available for discussion to the four ward configurations described below. The Renal, Respiratory, Cardiac and Vascular CMG were asked to review the wards in order to educate the selection of wards suitable for refurbishment and their assessment is reflected below.

- **Wards 28 and 29**

  These wards would be suitable.

- **Wards 26 & 27**

  Contains Thoracic HDU and heart failure ward recently refurbished for this specific purpose, using these wards would not be preferable for this reason due to the wasted conversion costs and the additional costs or changing the space back to ward space.

- **Wards 24 & 25**

  Endoscopy and Breast, Neither service are currently anticipated to move site so the wards would not be available.

- **Ward 33a and 33**

  These wards are adjacent to Catheter labs, an adjacency that will remain key for the Cardiology beds.

As a result of this review, the only combination of wards that is determined would not have a resultant negative impact on remaining specialties is Wards 28 and 29.

Three options were generated to enable the relocation of Renal Transplant beds from the LGH by July 2016. These are set out below.

- **A – Colocation with Vascular Surgery**
  The only existing clinical space that offered a possible solution was to utilise spare capacity on the newly created Vascular Surgery ward which, in the longer term, will be filled with a growth in activity.

  When Infection Prevention were engaged to assess the risks of co-habiting patients together their opinion was that 'any interim arrangement for renal patients should provide accommodation which is solely for their use and not shared with other patient groups' due to the risk of cross contamination.

- **B – Conversion of Respiratory Corridor**
  The Estates team reviewed the Glenfield site to determine whether any existing space could be utilised for the re-location of the 10 required Renal Transplant beds. It became apparent that the physical footprint required could only be provided in a space currently occupied by Respiratory Medicine office space.

- **C – New Build 10 bedded ward**
  The option to construct a new build ward space was explored as, due to the relatively modest size of the Renal Transplant requirement, this was not judged to be as prohibitively expensive as the provision of two full HPB wards.

  A qualitative options appraisal was undertaken to determine the best solution for the Renal Transplant beds.

3.5 Benefit scoring by potential location

Table 17 Options Scores – Renal Transplant at GH

Criteria/ Scores		A	B	C
A	Clinical Quality and Configuration	8	8	8
B	Efficiency & Effectiveness	4	5	5
C	Staffing	3	3	3
D	Quality of the Patient Environment	10	14	14
E	Achievability	3	4	1
F	Accessibility	9	10	10
OVERALL SCORES		**37**	**44**	**41**
RANK		**3**	**2**	**1**

These scores were then weighted as follows.

Table 18 Options Scores – Weighted

Criteria/Weighted Scores		A	B	C
A	Clinical Quality and Configuration	0.4	0.4	0.4
B	Efficiency & Effectiveness	0.2	0.3	0.3
C	Staffing	0.6	0.6	0.6
D	Quality of the Patient Environment	1.0	1.4	1.4
E	Achievability	1.5	2.0	0.5
F	Accessibility	0.9	1.0	1.0
OVERALL WEIGHTED SCORES		**3.60**	**5.65**	**4.15**
RANK		**2**	**1**	**3**

3.6 Subsequent enabling requirements

The ability to release the Respiratory corridor at the GH relies upon re-housing the inhabitants of 29 offices. Delivery of this space will firstly rely upon the application of the Trust's space utilisation policy by the RRCV CMG who currently occupies the offices.

Part of this exercise will involve identification of staff that have an absolute need to remain in the current Glenfield building as opposed to another location on the site. The Trust's space utilisation team will then work to re-house any additional office space.

3.7 Qualitative analysis conclusion

As per the undertaking of the qualitative benefits analysis, the preferred options to proceed to economic appraisal were:

1. **HPB Beds:** Refurbishment of Wards 28 & 29
2. **Renal Transplant:** The favoured option from the qualitative appraisal process was the conversion of Respiratory Offices: this will be assessed alongside the creation of the beds with a new build solution for completeness

3.8 Financial & economic appraisal

The options were then subjected to a financial appraisal. The options were considered over a period of 30 years. The financial appraisal reflects the following:

- Capital costs excluding VAT for each option on each site including equipment
- Lifecycle costs
- Revenue workforce costs for each site

3.8.1 Capital Costs

Capital costs for each option are shown below.

Table 19 Capital Costs

	Option A £	Option B £	Option C £
Departmental Costs	1,800,642	1,905,470	2,804,227
On Costs	1,072,870	190,547	393,838
Works cost	2,873,512	2,096,017	3,198,065
Provisional Location Adjustment	(79,228)	(83,840)	(127,923)
Sub total	2,794,284	2,012,177	3,070,142
Fees	499,478	420,297	687,663
Non Works Cost	0	900,000	0
Equipment Cost	401,699	365,815	544,324
Planning Contingency	114,089	120,730	184,209
Total For Approval Purposes	3,809,549	3,819,018	4,486,337
Optimism Bias	156,301	165,401	252,365
Sub Total	3,965,851	3,984,419	4,738,702
Inflation	311,535	329,671	503,006
Total Outturn	4,277,386	4,314,091	5,241,709

3.8.2 Lifecycle Costs

Lifecycle costs are derived from the capital costs reflecting replacement of individual elements of the capital scheme.

3.8.3 Revenue Costs

The assessed baseline of HPB and Renal expenditure across the Trust has been used in developing the revenue costs. This is broken down as follows:

Table 20 Summary of Baseline Costs

	£'000
Renal Transplant Costs	5,318
HPB Costs	12,184
Total HPB and Renal Transplant Baseline Costs	**17,502**

3.8.3.1 Changes in revenue costs

The following changes in costs have been assessed as being necessary to deliver the scheme. These costs are the same for each option. The additional costs are non-recurrent and will not continue past April 2019.

Table 21 Additional Revenue Costs

	16/17 £'000	17/18 £'000
Pharmacy	90[4]	105
Dietetics	11	16
Ward Staffing	185	277
Nephrology Medics	121	182
General Surgery Medical rota	35	53
Net Impact on theatre staffing	219	204
Total Direct Costs	**661**	**837**

3.8.4 Results of economic appraisal

The results of the economic appraisal are as follows.

Table 22 Economic Appraisal Summary

	NPC £'000	Rank
Option 1	352,190	1
Option 2	352,229	2
Option 3	353,225	3

The financial appraisal indicates that the preferred option is Option 2.

3.9 Cost-benefit analysis

The financial and non-financial scores were combined on a cost per benefit point basis. The results of this are as follows.

Table 23 Cost-benefit Analysis

Option	NPC £'000	Benefit Score	Cost per benefit Score £'000	Rank
Option 1	352,190	4.60	76,563	2
Option 2	352,229	5.65	62,341	1
Option 3	353,225	4.15	85,114	3

[4] Includes £20,000 non recurrent non pay costs to enhance Fridge capacity and IT infrastructure.

3.10 Preferred option

Cost-benefit analysis shows that by combining the financial and non-financial scores, the preferred options are as follows.

- **Ward space for HPB** – of the available options, Wards 28 and 29 are the favoured option as it is the only one that would not compromise other services on site
- **Ward space for Renal Transplant** – The conversion of Respiratory office space is the favoured solution from both a qualitative and quantitative perspective and is the recommended option within this business case.

4 | The Commercial Case

4.1 Introduction

This section of the FBC outlines the proposed procurement strategy in relation to the preferred option outlined in the Economic Case.

4.2 Procurement Strategy

The proposed project requires the provision of, and procurement of, the following key services:

- Reconfiguration of GH inpatient facilities to create ward spaces for HPB and Renal Transplant;
- Additional workforce resources.

The procurement of the team of professionals required to deliver the two areas will be sourced through two different procurement routes:

- HPB will be competitively tendered and led by the Trust Estates Team. This is procurement route is driven by the financial value of the project for HPB (£898k out-turn).
- RT will be procured via the Lot 2 contract. This procurement route is driven by the financial value of the works cost (£2,328,065.45 out-turn)

The project is constrained by the time in which it has to deliver the completed solution. The driver for the completion date is the operational pressure of workforce.

The project manager evaluated the potential routes of procurement for both capital works and services and has identified the preferred option that will ensure the project is delivered on programme.

4.2.1 Services

HPB: The professional team will be required to undertake the detailed design and costing of the project up front. This needs to commence as soon as practically possible. The solution for the appointment of the professional team rests with either the use of a services framework or competitive tender.

RT: The professional team will be required to undertake the key elements of costing and professional advice prior to the approval of the FBC. The procurement solution for the appointment of elements of the professional team will be through a framework agreement that provides professional services.

4.2.2 Works

HPB: The capital works will be procured traditionally through competition as there is sufficient time within the programme.

RT: The RT element of the building/refurbishment element will require the procurement of a contractor. The current programme pressures will not allow for the contractor to be procured for traditionally through a competitive tendering process.

4.3 Key Factors Affecting Outcomes

4.3.1 Planning Permission

As this interim scheme for improvements to the existing facilities at GH will be contained within the existing building envelope, planning permission will not be required.

4.3.2 Building Research Establishment Environmental Assessment Method (BREEAM)

The design solution has been developed to meet BREEAM Healthcare “Very Good” standard, meeting the highest achievable standard for a part refurbishment project.

4.4 Risk

All projects are subject to risk and uncertainty. Successful project management should ensure that major foreseeable risks are identified, their effects considered and actions taken to remove, or mitigate the risks concerned.

Risks will be classified as:

- Client – these will be the responsibility of the Project Board to manage and monitor
- Contractor – a project specific risk register will be set up for the Project. These will be the responsibility of the Contractor to monitor and will form part of the GMP

The qualification of the costs of identified risks will enable the calculation of a realistic client contingency.

A pro-active risk management regime will be employed throughout the project. It is essential on any project that the risk management process involves all key members of the project team.

The following risks have been identified for this project.

Table 24 Identified Risks

Risk description	Likelihood (1-5)	Impact (1-5)	RAG	Risk mitigation	RAG post mitigation	Risk Owner
Tight nature of timescale means that any delays risk the project exceeding the deadline of July 2016. This will have a negative reputational impact on the Trust	4	5	**20 Red**	Risks to timely delivery are escalated through ICU board and safe operational resolutions found as rapidly as possible	**Amber**	CA/JJ
Ability to staff vacancies and recruit/retain staff where split site coverage is required may make delivery of services more difficult	3	5	**15 Red**	There will be a need to go out to recruit to vacancies rapidly. This will be addressed through Workforce determining a critical path for recruitment and progressing high risk areas first	**Amber**	ICU Board / Specialties concerned
Required staffing is costed at substantive rate. If there is an inability to recruit to vacancies then premium pay spend may be incurred above the originally agreed budget	3	5	**15 Red**	Early engagement of workforce team to build a clear workforce recruitment plan will be required to identify and target likely risk areas rapidly	**Amber**	ICU Board / Specialties concerned
Any additional increases in revenue costs, as a result of issues as yet undetected, may make the project unaffordable	3	5	**15 Red**	Rigorous application of the Trust Change control process will be required for any future alterations	**Amber**	ICU Board
In the absence of a formal agreement the Trust will need to establish how the capital programme will be managed in	3	5	**15 Red**	This is managed through the capital monitoring & delivery group and ongoing discussions	**Amber**	ICU Board

Risk description	Likelihood (1-5)	Impact (1-5)	RAG	Risk mitigation	RAG post mitigation	Risk Owner
order to keep the works to programme and achieve the tight delivery framework.				with the TDA. Failing this internal capital will be required to be re-prioritised to fund the ICU project		
Deskilling/Loss of ICU nursing staff at LGH	3	4	**12 Amber**	Ensure that all staff can indicate where they would like to work in the future. Rotational posts across all three sites	**Amber**	CA/JJ
Failure to transfer critically ill patient in a timely manner	2	5	**10 Amber**	Clear modelling to identify capacity needed. Work with EMAS to ensure comprehensive support. Initial support at level 3 for patients needing ICU support until transport is arranged.	**Amber**	CA/JJ
Further delay in ICU reconfiguration process meaning that the project is subsumed into BCT consultation	2	5	**10 Amber**	Any remaining issues to be escalated for decision by the trust as soon as practically possible. Clear communication required with HealthWatch throughout	**Amber**	ICU Board
HDU staffing levels for the 6 months must be at a level to allow flow and acceptance of patients	3	3	**9 Amber**	PW to investigate and review DTOC from ICU	**Amber**	ICU Board

Risk description	Likelihood (1-5)	Impact (1-5)	RAG	Risk mitigation	RAG post mitigation	Risk Owner
Workforce for ICU must possess sufficient skill and experience to treat patients on each site, including safe cover of a full range of specialist conditions and eventualities that may occur	3	3	9 Amber	ICU workforce planning and past experience suggests that workforce is ready and able to support a range of services, this will be explored through the "operational policy" for ICU	Green	Clinical models Group / ICU
It has been assumed that conversion of existing Trust-owned space for capital works will see any increase in residual asset value offset by a corresponding impairment. If this is not the case then capital charges will be higher than assumed within this business case	2	4	8 Green	Early involvement of valuers will be required to ensure that UHL's case for impairment is understood and that any subsequent risk can be identified early in the process.	Amber	ICU Board

4.5 Proposed Contract Lengths

A period of mobilisation will be required following approval of the business case.

4.6 Financial Reporting Standard 5 Accountancy Treatment

Any assets underpinning delivery of the service will be reflected on the Trust's balance sheet.

5 | The Financial Case

5.1 Introduction

The Financial Case examines the affordability of the preferred options and sets out the financial implications for the Trust in terms of capital expenditure and cash flow, income and expenditure account and borrowing.

The purpose of this section is to set out the forecast financial implications of the preferred options as set out in the Economic Case and the proposed deal (as described in the Commercial Case).

5.2 Capital Costs

Total costs are summarised in the following table.

Table 25 Summary of Capital Costs

	£
Departmental Costs	1,905,470
On Costs	190,547
Works cost	2,096,017
Provisional Location Adjustment	(83,840)
Sub total	2,012,177
Fees	420,297
Non Works Cost	900,000
Equipment Cost	365,815
Planning Contingency	120,730
Total For Approval Purposes	3,819,018
Optimism Bias	165,401
Sub Total	3,984,419
Inflation	329,671
Total Outturn	**4,314,091**

5.2.1 Financing

The Trust has assumed the scheme will be funded through Interim Capital Support Loan (ICSL) in line with Department of Health guidance. (This assumption would not be the Trust's preferred option but guidance dictates that ICSL must be considered as the primary funding source in a business case.) The Trust requires funding in 2015/16 and 2016/17.

5.3 Income and Expenditure

5.3.1 Summary

The projected impact on the Trust's income and expenditure (I&E) position is summarised in the table below.

Table 26 Income and Expenditure Changes

	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000
Operating Costs				
Pharmacy		90	105	105
Dietetics		11	16	16
Ward Staffing		185	277	277
Nephrology Medics		121	182	182
General Surgery Medical rota		35	53	53
Net Impact on theatre staffing		219	204	204
Total Operating Costs		**661**	**837**	**837**
Capital Charges				
Interest	12	64	103	99
ROA	0	(69)	(134)	(129)
Depreciation	0	9	18	18
Total Capital Charges	12	5	(13)	(12)
Total Impact on I&E	**12**	**666**	**824**	**825**

5.3.2 Methodology

The additional costs have been based on the proposed service reconfigurations reflecting restructure services and rotas. The workforce costs have all been through confirm and challenge process and they have been identified as legitimate increases in costs as a result of the reconfiguration. All these costs are deemed to be transitional costs incurred until the Trust consolidates on to two sites. The costs reflect nurse staffing at mid-point with appropriate on costs and enhancements. Middle grades have been assumed to have an average cost of £70,000 per annum.

A key assumption is that the Trust is able to recruit staff. If there is any difficulty in recruiting and there is a requirement for recruiting at premium rates. Then there would be an additional cost pressure. Currently the full year effect of the business case in workforce terms is £837,000 per annum; a 50% premium cost in relation to failure to recruit would be as much as £419,000 per annum.

5.3.3 Workforce

The capital investment will allow for the transfer of HPB and renal to the Glenfield site. As a result of this, additional costs will be incurred whilst the Trust is still running some acute services from three sites. The changes in workforce are described below.

5.3.4 Pharmacy

Pharmacy dispensary costs will increase as a result of the need to maintain dispensary opening hours at LGH whilst transferring workload to the other two sites. The staff associated with the beds relocating from LGH will need to move to LRI or GH to support the increased workload on these two sites, leading to a shortfall in the staff remaining to support the LGH dispensary. As the LGH dispensary already operates on minimal staffing i.e. a single pharmacist at any one time, the same number of staff will be required to support the LGH dispensary even though the workload has dropped. The workload in the dispensaries at GH and LRI is already such that they cannot absorb the additional workload without staff transferring.

The Pharmacy department has sought to minimise cost implications and has reviewed and proposed changes in its ways of working as a result. The additional workforce required is as follows:

- 1.0 WTE band 5 technician;
- 0.5 WTE band 7 pharmacist;
- 1.0 WTE band 8a pharmacist (0.5 WTE renal and 0.5 WTE dispensary);
- £20k (non-recurrent) non-pay costs.

There are no recruitment challenges envisaged for the pharmacy posts.

5.3.4 Dietietics

There is a requirement for additional dietetic support as a result of the changes on configuration of clinical services:

- 0.1 WTE band 6 dietician is linked to general surgery moves as an LGH the dietician will now cover emergency and elective inpatient surgery at the LRI and outpatients including pre assessment clinics at the LGH;
- 0.1 WTE band 7 dietician is linked to HPB. The HPB dietician will now cover emergency and elective inpatient surgery at the GH and outpatients including pre assessment clinics at the LGH;
- 0.1 WTE band 7 dietician and 0.1 WTE band 6 dietician is linked to renal services. Currently renal dieticians work across the LGH and Loughborough Hospital site. A three site model is proposed. A transplant dietician will be needed at the Glenfield several times a week to help manage unstable inpatients.

There are no recruitment challenges envisaged for the dietetics posts.

5.3.5 Ward Staffing

The proposed ward configuration at each of the three sites to accommodate the proposed service changes reflects inefficiency due to the size of wards. Although the number of beds does not increase the proposed physical arrangement of the beds requires an additional ward. As a result of this, there are additional ward manager costs and particularly ward nursing costs at night, where minimum levels of staffing are required. The increase is staffing is shown in the table below.

Table 27 Ward Staffing Changes

	As Was	General S Proposed	Change	MSS	Gynae	Net Impact	Cost Per WTE	Glenfield Proportion	LRI proportion	Total Additional Cost
	WTE	WTE	WTE	WTE	WTE	WTE	£'000	£'000	£'000	£'000
Band 7	5.00	6.00	1.00			1.00	44	44		44
Band 6	13.41	14.00	0.59			0.59	41	24		24
Band 5	85.87	96.39	10.52	(4.52)	(1.90)	4.10	34	10	130	139
Band 4	0.00	2.00	2.00			2.00	28	56		56
Band 2	65.41	79.03	13.62	(2.71)	(1.27)	9.64	23	146	71	218
Band 1 Housekeeper	11.42	10.00	(1.42)			(1.42)	18	(26)		(26)
Ward Clerk	7.40	8.40	1.00			1.00	22	22		22
Total	**188.51**	**215.82**	**27.31**	**(7.23)**	**(3.17)**	**16.91**		**277**	**201**	478

The additional cost associated with the GH case relates to the proportion of LGH beds related to GH as a proportion of the additional £478,000 cost pressure. The ward configuration allows HPB patients to managed on two 20 bedded wards reflecting an inefficiency due to the less than optimal number of beds on each ward. There is no change in staffing for Renal Transplant which is moving to GH.

5.3.6 Nephrology Medics

An allowance has been made to cover the additional costs of covering renal transplant at the Glenfield Hospital, this reflects a merged CT rota with Cardiac, Thoracic, Vascular and Transplant providing one F2/CT 24/7 cover plus an F1 rota providing 24/7 cover.

The junior renal rota at the LGH site currently covers both transplant and nephrology and is delivered on the basis of a combined FY1/CT 1:11 rota. Splitting the rota across two sites at LGH and GH creates inefficiencies. The preferred and most cost effective option for providing resident Transplant out of hours cover at the GH site is to operate merged FY2/CT rota with Transplant, Cardiac, Thoracic and Vascular. In addition this will provide a separate FY1 rota which will provide improved cover and a better training experience for FY1's. This has an additional advantage in that it will provide an FY2/CT

rota which meets Royal College guidance with 10 doctors and a separate FY1 rota with 8 doctors providing cover to Vascular, Transplant and Thoracics.

- The impact of this is to increase banding payments:
- An additional 10% for two FY2s in transplant, 2 CTs in vascular and 7 FY1s
- An additional 50% banding for a thoracic post.

Removing FY2's from the LGH site will reduce cover for Urology and Nephrology by one doctor each and these need to be replaced to create viable rotas at LGH. The cost pressure of this is:

- 1 x CT Urology with 50% banding
- 1 X CT Nephrology with 50% banding

5.3.7 General Surgery/ HPB Middle Grades

An inefficiency of 1.0 WTE Middle Grade is assumed as a joint rota is created to cover three sites covering General Surgery and HPB. The current requirement is 20 Middle Grade Drs (excluding two vascular middle grades who will move to an independent rota) to 22 middle grade doctors. 1.0 WTE is required at the LRI site and is allowed for in the LRI Beds business case.

5.3.8 Theatres Staff

The additional cost of theatres staffing is driven by the requirement for an emergency on call service at the Glenfield Site. This is offset by some savings from the LGH site in respect of day time emergency theatre sessions and the saving of staff in respect of elective vascular theatre sessions at the LRI. A proportion of the additional cost has been assumed in the Vascular services business case. The net additional cost is broken down as follows.

Table 28 Changes in Theatres Costs

	WTE	Cost £'000	Critical Care Proportion £'000	Vascular Proportion £'000
Additional Cost of Emergency Glenfield Theatres with On call	17.40	585	351	234
Saving on Emergency theatre sessions at the LGH	(4.92)	(147)	(147)	
Net Additional Theatres Cost	**12.48**	**438**	**204**	**234**

Theatres nursing already have in place a robust system for monitoring and proactively recruiting to vacancies. For the financial year leading to the Business Case, the table below illustrates the plans for closing theatres vacancies from 93 to 66.

Figure 5 WTEs Vacancy Bridge Summary

WTES VACANCY BRIDGE SUMMARY
Theatres Nursing Vacancy Reduction Plan

		Nursing Vacancy WTE
	Feb-15 nursing vacancy WTEs	**93.0**
Recruitment	International	-24.0
	Rolling Advert	-42.0
	Clearing House - Nurses	-20.0
	Clearing House - ODPs	-22.0
	Job swaps / open days	-18.0
	Leavers	60.0
	Total movements identified	**-66.0**
	Projected Mar-16 nursing vacancy WTEs	**27.0**

Currently theatres have high agency usage and in order redress this cost pressure, a band 7 local bank has been introduced which will lower the cost of WTEs to cover vacancies.

In addition to this, services will be using weekend lists until the Hybrid theatre is operational in December 2016. There is an additional cost of this as a result of weekend working. This has been estimated to be £83,000 for the five-month period between August and December 2016.

5.3.9 Capital Related Revenue Costs

The other major cost element is the capital costs. The capital itself has been assumed to be funded through Interim Capital Support Loan (ICSL). The revenue consequences represent the interest on the loan provided and depreciation. However as the majority of the capital cost is based on a refurbished asset, it is unlikely to materially add to value, meaning that depreciation is low. Maintenance costs for ventilators are assumed to be allowed for in current budgets as the additional amount of equipment in the Trust does not increase.

The table below shows the basis of the capital charges calculation.

Table 29 Capital Charge Impact of the Scheme (ICSL)

Critical Care Capital Charges	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000
Opening Balance		956	4,276	4,098
Drawdown	956	3,358		
Loan Repayments		(38)	(178)	(178)
Closing loan	**956**	**4,276**	**4,098**	**3,920**
Interest on loan (1 July 2015 rate 2.46%)	12	64	103	99
ROA	0	(69)	(134)	(129)
Depreciation		9	18	18
Total Capital Charges and interest	**12**	**5**	**(13)**	**(12)**

The Trust has modelled the use of Public Dividend Capital (PDC) to fund the development rather than IBD. The Position using PDC is as follows:

Table 30 Capital Charge Impact of Scheme (PDC)

ICU Capital Charges PDC	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000
Return on Asset	17	23	12	12
Depreciation		9	18	18
Total Capital Charges (PDC)	17	32	30	30

This analysis assumes an impairment of £3.948 million relating to the refurbishment element of the development as it does not add to the value of the buildings.

Although the Trust would need to earn a higher rate of return if the scheme were funded through PDC, the Trust would also need to pay back the loan required to fund the scheme. It is assumed that £178,000 per annum loan repayment would be made from late 2016/17. Therefore the impact on I&E is compounded by an even more significant impact on the Trust's cash flow of £178,000 per annum. With everything else being equal, this would reduce the amount of operational capital available to the Trust by this amount.

5.4 Impact on Trust Income, Cash Flow & Balance Sheet

The Table below sets out the impact on the Trust's balance sheet.

Table 31 Impact on the Trust's Balance Sheet

	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000
Opening Balance		956	357	339
Capital Expenditure	956	3,358		
Impairment		(3,948)		
Depreciation		(9)	(18)	(18)
Closing Balance	956	357	339	321

5.5 Affordability

The scheme identifies increases in recurrent revenue costs aside from capital charges and interest payments on the loan funding. All the workforce costs identified are viewed to be non-recurrent and will not be incurred after the Trust consolidates its acute services on to two sites.

The Trust Financial Strategy, approved by the Trust Board on 4th June 2015, assumes that the operating cost impact of site reconfiguration will be zero and the non-operating costs impact will be as per the capital programme.

Therefore, if the Trust is to maintain the deficit reduction trajectory in the Financial Strategy the operating cost revenue impact of this development is only affordable if either:

- CIP targets are increased to offset these costs;
- Transitional income is secured to offset these costs;
- The development is funded by the £4m per annum allowance made in the Financial Strategy for annual operating cost pressures.

5.5.1 Long Term Financial Model (LTFM)

The current five year LTFM which reflects the detail of the Financial Strategy approved by the Trust Board on the 4th June 2015 is constructed in a way which aggregates this development as part of the general site rationalisation service development. The assumptions regarding this service development include the premise that the operating costs impact of the developments will be zero.

As shown above, the case identifies additional operating costs of circa £661k in 2016/17 and £837k in 2017/18 and 2018/19. The revenue costs will need to be managed as described above and potentially reduced as a result of further investigation.

5.5.2 Capital Affordability

The scheme is included in the reconfiguration programme's capital cost allowance. Due to the urgency of the scheme the funding of this will be reviewed in terms of budget allocations for critical care and beds at the LRI and Glenfield. This review will take place in November 2015.

6 | The Management Case

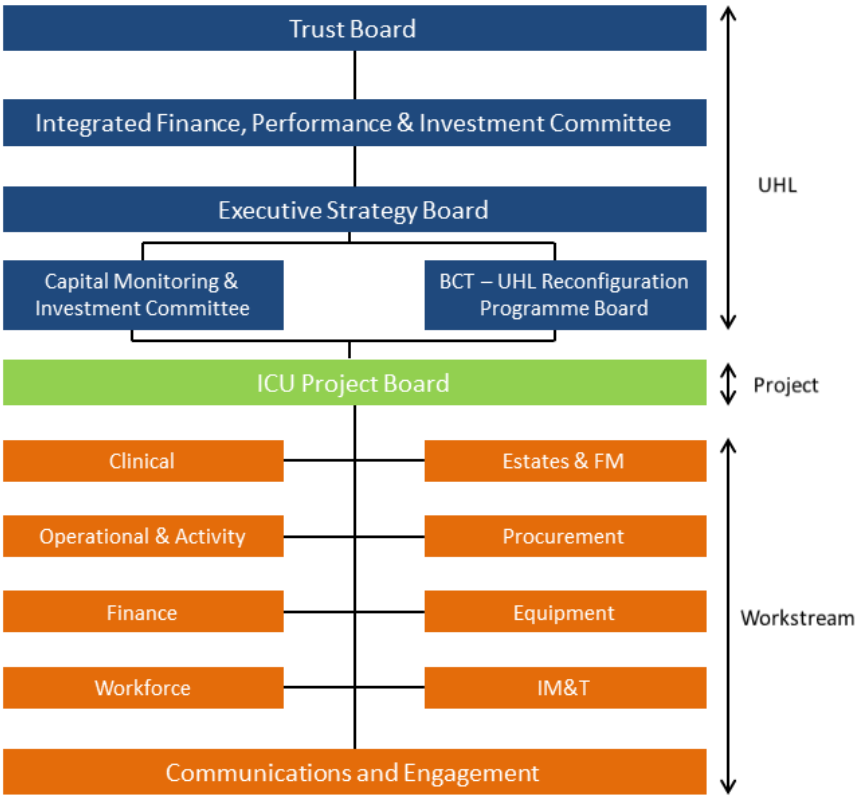
6.1 Introduction

The Management Case provides a summary of the arrangements which have been put into place for the successful delivery of the GH Beds and Theatre scheme; the associated other service relocations required as a result of decanting moves; service operation changes; and to secure the benefits sought through the investment. The project will be managed using PRINCE2 compliant methodology and project management tools such as Gantt charting and critical path analysis. Project direction and management will be determined by the Project Board.

6.2 Project Governance Arrangements

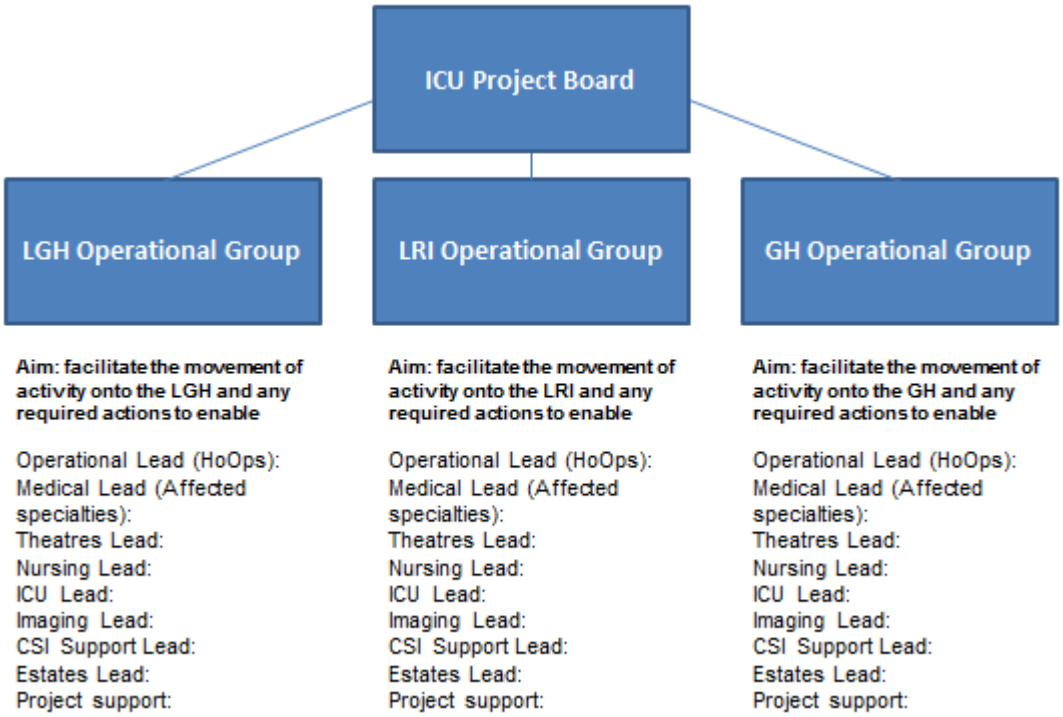
Project Governance arrangements have been established to reflect national best practice guidance and the Trust's own Capital Governance Framework, as shown in the diagram below. As the capital value of this business case is less than £1m; it does not need to be approved at Trust Board and can be approved by the Integrated Finance, Performance & Investment Committee.

Figure 6 Project Governance Arrangements – Project Structure



This structure was used during the strategic planning phase of this investment business case and has ensured that all decisions have been made with appropriate due diligence and rigour. To enable operational delivery it has been changed to the site-based governance arrangements in the figure below.

Figure 7 Project Governance Arrangements – Site-based Delivery Structure



6.2.1 Project Roles and Responsibilities

The ICU Project Board

The project reports to the ICU Project Board. Key roles and responsibilities include:

- Responsibility for delivering the project within the parameters set within the business case;
- Providing high level direction on stakeholder involvement and monitoring project level management of stakeholders;
- Providing the strategic direction for the project;
- Ensure continuing commitment of stakeholder support;
- Key stage decisions;
- Progress monitoring.

The key project roles and responsibilities are outlined below.

Table 32 Project Board

Role	Name	Responsibilities
Senior Responsible Officer	Kate Shields, Director of Strategy	Responsibility to the Executive Trust Board for delivery of the project to meet their terms of reference. Chair of the Project Board.
Project Manager	Chris Green	Day to day responsibility for administration of the development of the project, within the delegated role permitted by Project Board.
Project Clinical Leads	Chris Allsager/John Jameson	Overall clinical responsibility for models produced and structures determined suitable for inclusion within relevant business cases. Also responsible for offering clinical challenge to models put forward.
Clinical Lead	Giuseppe Garcea / George Kenney / Graham Warwick / Jo Bayes	Responsibility for determining clinical requirements, reporting progress to the Project Board and providing clinical challenge to operational plans and designs
Estates Lead – Glenfield beds	Loo Naylor	Responsible for delivering design solution upon receipt of suitable project brief and offering Estates expertise to the project. Responsible for reporting to the project board and delivery of the build stage
Finance Lead	Tim Pearce	Responsible for translating plans into cost and benefits and maintaining financial challenge around assumptions. Responsible for reporting to the project board.
Workforce Lead	Louise Gallagher	Responsible for challenging workforce plans and assumptions and providing strategic workforce context. Responsible for reporting to the project board.

The Project Board is ultimately responsible for assuring that the project remains on course to deliver the end product or output in line with the Strategic Outline Case. Throughout the life of the project, the Project Board will be responsible for ensuring key elements of the project occur including:

- Sign off the Project Initiation Document
- Ensuring adequate resources are deployed into the project to enable delivery, inclusive of the appointment of a Project Manager and advisors as appropriate
- Receive reports from the Project Manager and monitor progress/ authorise slippage
- Review risks, issues and exceptions and determine appropriate course of action based on recommendations from the Project Manager
- Exercise functional and financial authority to support the project
- Sign off project stages / closure

Regular progress reports are also submitted to the BCT-UHL Reconfiguration Programme Board for onward reporting and management to the Executive Strategy

The project will move rapidly towards the creation of a mobilisation team or teams. This will be constructed of suitable management and clinical representatives to allow the production of detailed implementation plan to operationally deliver the ICU reconfiguration project. The team/s will operate within the existing governance of the project.

The end stage of the project will result in the completion, handover and commissioning of the new facilities. The Project Board is responsible for providing assurance that the project has been delivered in terms of product and quality in line with the business cases.

UHL Reconfiguration Board

This group is a designated committee appointed by the Trust Board, with responsibilities which in summary, include:

- Keeping overall responsibility for reconfiguration activities within the Trust
- Ensuring that developments are consistent with the Trust's strategic direction and BCT plans

The Executive Strategy Board (ESB)

This group is a designated committee appointed by the Trust Board, with responsibilities which in summary, include:

- To advise the Trust Board on formulating strategy for the organisation;
- To ensure accountability by holding each other to account for the delivery of the strategy and through seeking assurance that all systems of control are robust and reliable
- To lead the Trust executively, in accordance with our shared values, to deliver our vision and, in doing so, help shape a positive culture for the organisation

Integrated Finance, Performance and Investment Committee (IFPIC) and Capital Monitoring & Investment Committee (CMIC)

These groups are designated committees appointed by the Trust Board, with responsibilities which in summary, include:

- Ensure that strong financial governance and control is adhered to in business case preparation
- To ensure that capital and revenue implications of all business cases are fully understood
- To ensure that business cases represent best value for the Trust

6.2.2 Work Streams

A number of work streams have been set up to take responsibility for driving the key objectives and to report back to the Project Board on a regular basis.

Key roles and responsibilities will include:

- Day to day responsibility for the delivery of the project to meet the parameters described within the business case
- Provision of appropriate reports on status to the Project Director
- Management of risks and issues and escalation of appropriate matters for executive direction/ approval
- Providing working groups with detailed briefs
- Monitoring, co-ordinating and controlling the work of the Working Groups
- Drawing together the outputs of the Working Groups
- Ensure continuing commitment of stakeholders, both internal and external

6.3 Project Plan

The project will be managed in accordance with the principles of PRINCE2 methodology. The project managers will have support from the capital projects team, and external consultants.

6.3.1 Project Programme

The Project Programme is intended to deliver the project by July 2016. The milestones for the whole ICU redevelopment programme are set out below.

Table 33 Project Milestones

Description	Activity/ Milestone	Start date	End date
Agree Glenfield Theatres solution	Activity	19-Oct-15	10-Nov-15
Conversion of Treatment Centre into Medical Records Space	Activity	19-Oct-15	28-Dec-15
Creation of site based implementation groups	Milestone	26-Oct-15	26-Oct-15
Fortnightly Meeting of Implementation Groups and ICU Programme Board	Activity	26-Oct-15	30-Jul-16
Re-Engage with OSC	Activity	01-Nov-15	31-Nov-15
Business Case signed off at ESB	Milestone	17-Nov-15	17-Nov-15

Description	Activity/ Milestone	Start date	End date
Business Case signed off at CMIC	Milestone	20-Nov-15	20-Nov-15
Business Case signed off at IFPIC	Milestone	26-Nov-15	26-Nov-15
Identify staff in scope for MoC	Activity	01-Dec-15	31-Dec-15
Business Case signed off at Trust Board	Milestone	03-Dec-15	03-Dec-15
Vacation of Medical Records, office space and on-call rooms at GH	Milestone	28-Dec-15	28-Dec-15
Conversion of vacated areas for Interventional Radiology	Activity	29-Dec-15	29-Jul-16
Update on PTE Capital Costs	Activity	31-Dec-15	07-Jan-16
Construction Activities	Activity	Jan 2016	Jul 2016
LIA events at CMG/Specialty Level	Activity	01-Jan-16	31-Jan-16
Draft MoC paper and undertake pre-consultation with staff side	Activity	01-Feb-16	28-Feb-16
Vacation of Respiratory corridor offices	Milestone	TBC	TBC
Conversion of Respiratory offices into Renal Transplant Ward	Activity	TBC	TBC
Wards 28 and 29 to be vacated for refurbishment	Milestone	20-Mar-16	20-Mar-16
Refurbishment of Wards 28 & 29	Activity	14-Mar-16	24-Jul-16
HPB Move into Wards 28 & 29	Milestone	29-Jul-16	29-Jul-16
Expanded Interventional Radiology space becomes operational	Milestone	29-Jul-16	29-Jul-16
Movement of Renal Transplant onto GH site	Milestone	29-Jul-16	29-Jul-16

6.4 Stakeholder Engagement

Methods of communicating information about the project to various stakeholders are listed below. See Appendix 4 ‘Communications Strategy and Action Plan’ for further information.

6.4.1 Internal

- Face to face briefings: These should be used as the primary source of communication with staff
- INsite pages

- Display boards/ Hoardings around building work
- Hospital Hopper: Information can be displayed aboard and on the exterior of the Hospital Hopper buses, which travel between the three UHL hospital sites
- Factsheet-style newsletter
- Blueprint & Chief Executive's Briefings: Utilise Blueprint reconfiguration newsletter for staff (bi-monthly) to update staff on progress

6.4.2 External

- Social media: Utilising the Trust's Twitter and Facebook accounts
- Website: A section on the Glenfield Beds project can be included on the UHL website, with a link from the homepage
- Local media
- Leicester Mercury Patient Panel: Panel made up of members of the public who provide comment on local issues
- Annual public meeting (September): an opportunity to share what has been accomplished and what is planned next
- Patient information leaflets

6.4.3 Infection Prevention, Health & Safety, Fire and Privacy and Dignity

Representatives from UHL's Infection Prevention (IP) team have been fully engaged throughout the design development. IP representatives have provided guidance on all relevant aspects of the design.

Representatives from UHL's Health & Safety team were consulted on the project and design solution. The size and layout of rooms throughout were reviewed in specific detail to ensure compliance for patient and staff safety.

Infection Prevention, Health & Safety, Fire Officer and Privacy & Dignity teams have signed-off the detailed design and fully support the business case.

6.5 Outline arrangements for Change & Contract Management

Change management associated with the project will be managed through Project Board, under the chairmanship of the Senior Responsible Owner (SRO). Day to day change management issues will be discussed at the Project Team level and any resultant contract and/or cost changes will need to be approved by the Project Board.

The Trust has introduced a new Change Management process to promote consistency and deter changes outside of the governance structure of each project. This will impact upon all business cases where there is a need to:

- Change assumptions in an approved business case;
- Change costs impacting the capital plan;
- Change the reconfiguration delivery programme;
- Change scope which impacts upon another project.

This process will require any changes detailed above to be authorised by the Project Board, Business Case team meeting and then the Reconfiguration Board.

6.6 Outline Arrangements for Benefits Realisation

The delivery of benefits will be managed through the Project Board. The Benefits Realisation Plan sets out who is responsible for the delivery of specific benefits, when they will be delivered, and how achievement of them will be measured. The key opportunity is presented by the new design for facilities, which will ensure capacity meeting demand, efficiencies in service delivery, compliance to standards and minimised disruption to overall Trust operations.

6.7 Contingency Plans

The Trust has a framework for Business/Service Continuity. The Trust's framework ensures the Trust can comply with the business continuity provisions of the Civil Contingencies Act 2004. Contingency plans have been developed to ensure the Trust can continue to deliver an acceptable level of service of its critical activities in the event of any disruption.

In terms of financial contingency, section 5 highlights the planning contingency, including fees and equipment, for short-listed options.

6.8 Conclusion

This business case justifies the GH Beds project which has the primary aim of providing sufficient ward bed and emergency theatre capacity on the GH site to allow HPB and General Surgery to relocate from the LGH site by July 2016. This will be a clinical necessity as by July 2016 sustained Adult Level 3 Critical Care will not be available on the LGH site.

Aside from the immediate clinical need to undertake this project it is also consistent with the Trust's overall strategic direction to become smaller and more specialised. The development will enable the creation of a "stand" alone HPB service leading to

more efficient treatment and improved clinical outcomes. It will also support the delivery of a number of benefits.

- Support the Trust's longer term strategy to become smaller while expanding its provision of specialised, co-located services
- Be an enabler for the transfer of services from LGH and GH and access to IR and Level 3 support there. HPB requires Interventional Radiology (IR) to deliver Endoscopic Retrograde Cholangio-Pancreatography (ERCP) procedures and Renal Transplant/Vascular Access patients need Level 3 care for their patients. This project will be an enabler for the transfer of these services from LGH to GH and access to IR and Level 3 support there
- Enhance UHL's HPB service through the creation of a specialist tertiary service separate from General Surgery
- Enable the co-location of facilities to care for patients requiring interventions for both renal and cardiac diseases (there are commonly occurring interrelationships between the patient pathways). This will eliminate the current need to transfer patients between the Trust's hospitals and lead to improved patient pathways, safer care and optimal clinical outcomes
- By introducing HPB surgery at GH, improve the level and capacity of clinical expertise on the site. This will be beneficial for GH inpatients who develop conditions requiring surgery. This business case will provide the full suite of surgical services in one co-located area
- Support the Trust's longer term strategy to become smaller while expanding its provision of specialised, co-located services
- Ensure that Renal Transplant are co-located with Adult Level 3 Critical Services (as set out in service specifications)

Appendices

Appendices are attached as separate documents and consist of the following:

Appendix 1	What is Intensive Care?
Appendix 2	Operational Policies
Appendix 3	Estates Annex
Appendix 4	Communications Strategy and Action Plan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