Adult Level 3 ICU Business Cases – overall summary

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Executive Summary

Context

The Adult Level 3 ICU project has been in existence since November 2014 and was formed to rapidly develop proposals for relocating level 3 ICU, and affected services, from the Leicester General Hospital (LGH) site. The project has been chaired by Kate Shields, Director of Strategy, as SRO with Andrew Furlong, John Jameson and Chris Allsager as Clinical Leads.

Significant work has been undertaken to identify solutions which are safe, optimal within the parameters of the project and meet with the tight timeframes for delivery. The final enabling solutions have been confirmed and the project is now able to present a number of business cases for consideration and approval.

Four component business cases are being presented to Trust Board, having previously been discussed at Executive Strategy Board (ESB) and the Integrated Finance, Performance and Investment committee (IFPIC). For each business case there is a checklist which provides a summary of the content, strategic fit, financial position and risk assessment. The checklist template was approved at the July 2015 IFPIC.

These cases have been reviewed and authorised by the Adult Level 3 ICU Project Board to ensure that organisational governance processes are adhered to.

It is important to view these cases in the context of both the preceding agreement to relocate Vascular Surgery from the Leicester Royal Infirmary (LRI) to Glenfield Hospital (GH) and also the immediate clinical need to relocate Adult Level 3 Critical Care (and services reliant upon it) by July 2016. The Vascular Business cases were approved by the Trust Board in August 2015 with the business case to create temporary ICU space at both the LRI and GH being approved at CMIC on 14th August 2015. As such these cases are presented in the following order:

Primary Case

1. Adult Level 3 ICU Project - Glenfield ICU Medium Term

Individual Enabling Cases

2. Adult Level 3 ICU Project - Glenfield Beds Enabler
3. Adult Level 3 ICU Project - LRI Beds Enabler
4. Adult Level 3 ICU Project - Glenfield Imaging Enabler

(The checklists for all 4 business cases are attached to this report. The Full Business Case for the Adult Level 3 ICU Project (Glenfield ICU Medium Term) and the Full Business Cases for the individual enabling projects themselves are not attached but are available on the Trust's website using the hyperlinks listed above)

This approach to managing the ICU Business Cases was agreed at IFPIC in July where the rationale for presenting separate Vascular and ICU cases was presented.

The primary case (Adult Level 3 ICU project – Glenfield ICU Medium Term) sets out the case for change and the impact on the Trust (and relevant specialties) of not taking immediate action. This case will increase capacity for ICU level 3 beds at the GH which will be essential to enable affected services at the LGH to be relocated. Without this additional capacity the necessary re-provision of services to the GH will not be possible.

In supporting the case to move sustained Adult Level 3 Critical Care from the LGH there will be an imperative to agree to the three subsequent enabling business cases. This will be crucial as if all cases are not approved simultaneously then the capacity to accept transferring ICU patients from LGH will be created at GH, however the necessary ward space to house the specialties would not be available. This would be the same for services moving to the LRI. Furthermore the specialties relocating to the GH can only do so with access to Interventional Radiology which pertains to the Glenfield Hospital Imaging Enabler case. Without approving all four cases this will leave specialties heavily reliant on ICU level 3 such as HPB, General Surgery, Gynae Oncology and Renal Transplant located on the LGH without sustainable Level 3 critical care support and will require the de-commissioning of their acute services.

As the business cases have progressed through the Trust authorisation process at ESB and IFPIC risks around accessibility of capital funding and bed capacity at GH have been raised. The approach to mitigating these risks is set out in this summary paper below.

Case for Change

As mentioned the ICU project commenced in November 2014 in response to the major organisational risk that sustained Adult Level 3 critical care could not be provided on the LGH past December 2015. The drivers for this situation are as follows;

ICU element

- A gradual movement of high dependency patients from LGH to GH and Leicester Royal Infirmary (LRI) sites and changes in patient flows has restricted opportunities for critical care staff to maintain experience in providing care for critically ill patients at the LGH. An erosion of skill base presents further risk to the most vulnerable patients in the future. These impact 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.

The case for change was communicated to the Overview and Scrutiny committee in March 2015 and received support. The projects leads have more recently met with the committee to discuss the final proposals and secure continued support.

Due to the complexity of the project, number of stakeholders that needed to input to ensure the most optimal solutions were reached, and the capital requirements, it was clear that the December 2015 date would not be achieved. The deadline for the project was moved from December 2015 to July 2016. This has only been made possible by the flexibility of the existing ICU clinicians in providing cross site cover for a limited period of time through a model which is not sustainable past July 2016. As such immediate action is required.

Throughout the project the following principles have been adhered to which were agreed and signed up to by all stakeholders:

1. Any part of a service that is dependent on level 3 Adult Critical Care must be re-located
2. If the above results in parts of a services remaining that are so small as to be destabilised then these parts must also move or have a robust interim solution
3. Any services that do not require Adult Level 3 Critical Care and can move onto the General site to free up the estate foot print must consider moving

Project Governance

Throughout the past twelve months it has been key to maintain a robust project governance process to ensure that control of such a complex project could be maintained. This has been achieved through the setting up of specific work streams (clinical, workforce, estates and communications) that have fed into the, ultimately responsible, project board.

It has been of key importance to provide regular updates to key stakeholders and forums throughout the process. To this end the project has offered updates to ESB, IFPIC and the Trust's Reconfiguration and Bed Programme boards on a monthly basis. This approach has provided an excellent opportunity to communicate key messages, challenges and risks throughout the process and to ensure that key stakeholders have been sighted throughout.

Agreed destinations of services;

- **HPB major complex elective and emergency service** will move to Glenfield. All day case activity will be provided at the General.
- **Renal transplant** will move to Glenfield.
- **Complex elective and emergency general surgery** activity will move to the Royal. All day case activity will be provided at the General.
- **Gynaecology/Gynae-Oncology** activity that requires General Surgical **joint operating** will move to the Royal. All other elective activity will remain at the General.
- The majority of the **Urology** service will remain at the General.

Compatibility with the Trust's longer term strategy

The strategy for the Trust is to become smaller and more specialised in the future. This will enable better configuration of services and more optimal patient experience.

Whilst the primary driver for relocating Adult Level 3 ICU activity (and reliant specialty activity) is based on the immediate clinical imperative described above, the solutions proposed are aligned with the Trust strategy. For example, HpB and Renal Transplant are proposed to move to the GH site which will enable their development into specialist tertiary services. General Surgery will re-locate to the LRI which will see the consolidation of all General Surgical inpatient activity onto one site.

Planning has been undertaken to ensure that, where possible, any proposed developments fit in with the longer term Trust strategy. This will ensure that any costs incurred in converting existing estate will result in the provision of space that, whilst primarily designed to solve the existing ICU problem, will provide clinical spaces that can be utilised by the Trust into the future as it begins to reconfigure other services.

The project is also aligned to the trust's local ICU strategy of working towards the creation of two "super" units that centralise all ICU and HDU care to provide an optimal environment for both patients and staff.

Impact of doing nothing

The Trust has reviewed its overall position in respect of transferring all services related to the LGH critical care 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.

The result of this appraisal is as follows:

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 shown to be significantly more expensive than the proposed developments for Critical Care, including and excluding Vascular services. It reflects the loss of Critical Care income at the LGH. (The Trust would clearly make savings in relation to this reduction in activity; and theses are assumed to be realised over a period of five years. There would also be a decline in inpatient activity as a result of certain procedures (those requiring a close proximity to a Critical Care bed) ceasing. The calculated impact of inaction equates to £7.7m of lost contribution per year.

The impact on the Trust and specialties involved will see a;

- Decline in University Hospitals Leicester's(UHL's) financial position as ICU reliant surgical work is repatriated to local providers;
- Loss of specialist activity, with a resultant impact on staff retention and status for both affected specialties and UHL as a whole;
- Negative impact on culture as staff lose belief in the organisation's ability to deliver change.

Effect on each service

Each service that currently performs or supports surgical work on the LGH site would be affected by this course of action. This is likely to be seen in the following ways;

- **Renal Transplant** – would see a loss of recognition for transplant surgery, whose service specification mandates co-location with Level 3 Critical Care. This is likely to result in both out of area and local patients being repatriated out of UHL.
- **HPB** – would see the cessation of major elective surgery (including cancers) with tertiary activity being referred back to its originating providers. HPB has a significant tertiary referral volume
- **General Surgery** - All emergency surgical admissions would still be required to re-locate to a site with Level 3 care, together with major elective surgery (including cancers).
- **Other services remaining at LGH (Nephrology, Urology, Orthopaedics, Gynaecology etc)** – Without Level 3 support a variety of tertiary and high risk cases could not be undertaken.

How do the ICU cases support the Trust Five year strategy?

It is important to view the changes suggested through the Adult Level 3 ICU project as consistent with the overall strategic direction of the Trust as a whole. The Trust's five year strategy sees a clear aim to become smaller and more specialised, enabling better configuration of services and more optimal patient experience for patients and staff.

This project can be viewed as the Trust accelerating a number of developments that would have been completed under the banner of the five year plan but that are being delivered more rapidly due to the need to solve a critical, immediate, and wide reaching operational issue.

The proposed locations of services that are set out through this project are entirely consistent with the Trust's view of where these services would be within the five year strategy.

Capital funds invested will provide capacity in areas such as ICU beds and Interventional Radiology which will support future movement of services.

Whilst there will be transitional revenue costs attached with the project these are entirely non-recurrent and will be avoided once separated services are brought back together in line with the five year strategy.

The capital funds requested form part of the Reconfiguration funding that the Trust has been granted access to. If evidence of a movement towards change is not demonstrated rapidly then there is a substantial risk that this money will not remain available in the future to support investment and improvement.

Capital costs by case

Throughout the project there has been the imperative to ensure that capital costs are controlled and are kept as low as possible. This has been completed by;

i) Ensuring that a design brief is set out clearly so that key requirements and interdependencies for each element of the moves are understood

ii) Making the utilisation of existing space the key priority rather than resorting to new build

iii) Challenging the level of refurbishments and changes absolutely required

The key elements of the **£16.5m** capital programme (the element presented for approval) are set out below;

Cases presented for approval:

Business Case	Site	Area	Specialty	Rationale	Value (£m)
Glenfield ICU Medium Term	GH	**11 additional ICU bed spaces**	ICU	Creates capacity for HPB and Renal Transplant to move in July 2017	**4.3**
		ICU Equipment		Equipment to kit out increased bed spaces	**0.3**
		Fees	Overall Case	Fees associated with overall business case (project management and implementation)	**0.1**
		Glenfield ICU Medium Term Total			**4.7**
Glenfield Beds Enabler	GH	**Ward 28 & 29**	HPB	Wards to be vacated and refurbished to allow HPB to move onto GH site	**0.9**
		Renal	Renal Transplant	Respiratory office corridoor to be converted into 10 bedded ward space	**2.3**
		Office solution	Respiratory/Cardiac	Relocated office space to enable construction of Renal transplant Ward	**0.9**
		Theatre Equipment	Multiple specialties	Theatre equipment that cannot be transferred due to specialties splitting site without the ability to transfer kit	**0.1**
		Fees	Overall Case	Fees associated with overall business case (project management and implementation)	**0.1**
		Glenfield Beds Enabler Total			**4.3**
LRI Beds Enabler	LRI	**Ward 7**	General Surgery	Refurbishment of vacant wards (through internal re-organisation of LRI wards and the vacation of Ward 21 when Vascular moves to GH in April 2015) to enable General Surgery to move on to LRI site	**2.7**
		Ward 21			
		Ward 9			
		Theatre Equipment	Multiple specialties	Theatre equipment that cannot be transferred due to specialties splitting site without the ability to transfer kit	**0.1**
		Fees	Overall Case	Fees associated with overall business case (project management and implementation)	**0.1**
		LRI Beds Enabler Total			**2.9**
GH Imaging Enabler	GH	**Conversion of internal space to expand Radiology capacity**	Radiology	Capacity to transfer Interventional Radiology capacity from LGH to GH for HPB and Renal Transplant,	**3.7**
		Enabling relocation of Medical Records	Medical Records	Enables the conversion of the Treatment Centre on the GH site so that Medical Records can be moved by January 2016. This is required to enable the conversion of space into expanded radiology capacity	**0.6**
		Recovery beds	Theatre Recovery	Recovery capacity required for surgical activity moving to GGH	**0.2**
		Fees	Overall Case	Fees associated with overall business case (project management and implementation)	**0.1**
		GH Imaging Enabler			**4.6**
Overall ICU Business Cases Total					**16.5**

Case previously approved at August CMIC:

Business Case	Site	Area	Specialty	Rationale	Value (£m)
Level 3 beds (short term)	**LRI/GH**	**Adult Recovery (LRI) and Ward 34 (GH)**	ICU	Allowing ICU capacity at LRI to allow General Surgery to move on site. Also creates capacity at GH to enable Vascular to move in April 2016	**0.7**
Total					**0.7**

The capital cost of the business cases are as follows:

- Adult Level 3 ICU project – Glenfield ICU Medium Term - **£4.7m**
- Adult Level 3 ICU project – Glenfield Beds Enabler - **£4.3m**
- Adult Level 3 ICU project – Leicester Royal Infirmary Beds Enabler - **£2.9m**
- Adult Level 3 ICU project – Glenfield Imaging Enabler - **£4.6m**
- Level 3 ICU Beds – **Approved** – **£0.7m**
- **TOTAL VALUE OF ALL CASES (including already approved) - £17.2m**

The below summary shows the breakdown of capital costs between years;

Capital Cost Summary	2015/16 (£m)	2016/17 (£m)	Total (£m)
Glenfield ICU Medium Term	1.6	3.1	4.7
LRI Beds Enabler	0.2	2.7	2.9
Glenfield Beds Enabler	1.0	3.4	4.3
Imaging Enabler	1.2	3.4	4.6
Level 3 beds (short term) - **Approved**	0.7	0.0	0.7
Interim Solution	**4.6**	**12.6**	**17.2**

It was requested at ESB that detailed work be undertaken, enabling the phasing of capital commitments to be determined. This will enable the Trust to fully understand timescales at which capital sums are committed and will further inform any discussions around mitigating actions to manage the constrained capital situation that the Trust finds itself within.

Revenue costs by case

Workforce costs driven by this project represent the largest element of revenue expenditure. This expenditure is largely driven by the need to split service across sites and for support services to expand the services offered across sites in response to the required changes;

A robust process has been undertaken throughout planning to ensure that;

i) Only costs directly attributable to the ICU project have been considered (as opposed to costs required to remedy existing issues);

ii) Only elements of a service that are specifically dependent on level 3 Adult Critical Care must be re-located (and only these elements will be able to propose increased revenue costs);

iii) Confirm and challenge has been undertaken by those of relevant experience and standing within the Trust (Medical Director, Deputy Medical Director, Director of Strategy, Chief

Nurse) to ensure that all potential options have been explored and risk assessed prior to a potential cost pressure being agreed

iv) Potential cost pressures agreed through ICU board with strict change control procedures in place

The current level of **Pay and Non-Pay** revenue pressures through each of the four cases and the already approved interim solution case are as follows;

Summary of Business Cases Operational Costs	2015/16	2016/17	2017/18	2018/19	2019/20
	£'000	£'000	£'000	£'000	£'000
Glenfield ICU Medium Term	0	453	641	641	150
LRI Beds	0	269	404	404	0
Imaging	6	261	373	373	60
Glenfield Beds	0	661	837	837	0
LRI/GH ICU beds interim solution – approved		23	0	0	0
Total Critical Care Business Cases	**6**	**1,644**	**2,255**	**2,255**	**210**

The above summary indicates that **all costs are non-recurrent** in nature (past 2018/19) when services are brought back together as part of the Trust's longer term strategy. The exception to this relates to recurrent non-pay costs around Facilities Management and the movement of imaging equipment form the LGH to GH.

The **Pay** costs can be broken down by CMG as follows:

CMG	WTE	16/17 (£'000)	17/18 (£'000)
CSI Total	7.81	289	434
W&C Total	0.15	12	18
CHUGGS Total	18.91	389	583
RRCV Total	4.11	144	182
ESM Total	0.00	0	0
ITAPS Total	18.93	637	827
OVERALL ICU CASE TOTAL	**49.91**	**1,472**	**2,044**

The total pay cost for the Critical Care and Vascular projects was reported to the Trust Board in August at £2.3 million. This cost increased and has subsequently been reported back to IFPIC at £2.8 million. This allows for additional nursing costs arising from a less efficient ward configuration being proposed. Since reporting this figure the solution proposed for Renal has changed with only Renal Transplant moving to the GH, whilst this reduces the capital investment required and the timescales involved, it has led to additional costs relating to the junior doctor rota to ensure adequate cover at Core Trainee grade exists at both GH and LGH.

Non-Pay revenue costs have also been identified (as demonstrated below) largely driven by increased Facilities Management costs relating to the expanded GH ICU department and the relocation of Imaging equipment between sites;

2016/17:- £172k
2017/18 onwards :- £210k

Mobilisation and managing pressures

Upon Business Case approval there remains significant work to undertaken to ensure the solutions detailed within the cases are implemented safely and to time. Aside from the more obvious capital works which require progression and monitoring, more detailed consideration as to impacts on operational performance will be key to ensure that mitigations are in place to minimise any adverse impacts.

A discussion has been held with the Operational Delivery Unit to agree the best way to model the transitional impact of site moves upon operational performance (alongside an agreed strategy to mitigate identified impacts). This will be formalised at the Heads of Operations meeting on the 30th November.

The movement towards granular operational planning to support site moves will be delivered through the rapid creation of site based mobilisation teams. These will be both clinically and operational led, to drive forward necessary changes and translate the proposals within the business cases into implementation plans. This process has already begun but an increase in operational input will be required to ensure that all elements have been translated into granular mobilisation plans as quickly as possible.

The primary focus of the Glenfield group will be to continue the progression of work aimed at freeing ward space on site by July 2016. At present several work streams based around;

- the maximisation of ICS;
- exploration of an outreach model at Loughborough;
- the introduction of new models of care and;
- a feasibility study to determine the deliverability of adding additional ward capacity to the site

are progressing. The continuation of rapid planning to enable the delivery of this capacity will involve continued close working between clinicians and management staff.

The project will continue to rely upon such wide ranging involvement from specialties already operating on both the GH and LRI sites. This will be crucial in the formulation of plans which minimise any impacts associated both with increased activity on LRI and GH sites and minimising the impact of the actual moves themselves, keeping any transition periods to an absolute minimum.

Questions

1. Is Trust Board able to approve the business cases?
2. Do the business cases provide a feasible solution to deliver the clinical imperative of moving sustained Adult Level 3 critical care from the LGH by July 2016?
3. Do the business cases also align with the Trust's vision and strategic objectives?
4. Are the business cases financially viable in their own right (in comparison to the "do nothing" option?
5. What are the key risks associated with the ICU business cases that the Trust Board should be sighted on?

Conclusion

- Trust Board has been presented with four checklists, relevant business cases and a summary paper to provide sufficient information to allow the review and approval of the four cases.

- The requirement to move sustained Adult Level 3 critical care from the LGH to GH and LRI is set out in the ICU Medium term business case
- If this case is approved then the following three enabling cases, describing necessary measures to support the re-location of ICU reliant specialties, should also be approved.
- These cases, relating to enabling works undertaken at GH around Imaging, theatres and beds as well as another case describing changes to LRI beds, will be required to progress if specialties reliant on Adult ICU level 3 activity are to be successfully relocated by the end of July 2016.
- The key risks for the ICU project is:
    - Wards 28 and 29 at GH will be required to be vacated by the end of March 2016 to enable the movement of HPB from the LGH
    - Changes required around the application of the space utilisation policy to clear space will be required to free Cardiac offices by the end of December and the Respiratory corridor at GH by end of February.
    - Operational support will be required to move the project rapidly from business case planning to operationalisation.

UHL Strategic Reconfiguration Business Cases

Name of Business Case:	FBC Adult Level 3 ICU Project: Glenfield ICU Medium Term
Forum:	Executive Strategy Board Capital Monitoring and Investment Committee Integrated Finance, Performance & Investment Committee Trust Board
Checklist Completed by:	Anna Fawcett, Business Case Manager, UHL
Project SRO:	Kate Shields, Director of Strategy, UHL

Confirm Commissioner support:	Commissioner are aware of plans within the Adult Level 3 Critical Care business cases and are supportive of the rationale behind the need to remove Adult Level 3 Critical Care from the Leicester General Hospital (LGH) site by July 2016.
Confirm Stakeholder support :	HealthWatch Leicester has been fully involved in the development of this project, with oversight provided by the Health Overview and Scrutiny Committee. Stakeholder involvement has been crucial throughout the ICU project and has relied heavily upon clinicians and managers from affected specialties to inform planning decisions. The Overview and Scrutiny Committee were informed of progress in March 2015 and has been again in November 2015 to ensure that they remain sighted on the absolute clinical need to move Adult Level 3 ICU provision from the Leicester General Hospital (LGH) to the Leicester Royal Infirmary (LRI) and Glenfield Hospital (GH) by the end of July 2016.

		Business Case Section Reference
What is the purpose of this project?	This principal purpose of this project is to create the capacity required at the GH to re-locate Adult Level 3 Critical Care from the LGH by July 2016. It proposes an overall increase at the GH of 11 beds.	Section 1.1 Page 10
Why is it being carried out?	This project must be viewed in the context of the immediate clinical imperative to remove Adult Level 3 Critical Care from the LGH by July 2016. It describes an increase in bed spaces at the GH, which is a crucial enabler to support specialties moving from the	Section 1.2 Page 10

		Business Case Section Reference
	LGH due to the necessary removal of the Adult Level 3 ICU service from this site.	
What are the key assumptions in this business case?	Without approval of this case sufficient capacity will not exist at GH to allow Adult Level 3 Critical Care reliant specialties to re-locate from the LGH by July 2016 and as a result would see those specialties cease surgical activity that required Adult Level 3 ICU support.	Section 2.1 Page 16
Identify how this project fits in the reconfiguration programme?	Whilst not the primary driver for the project it is an enabler for the Trust's five-year strategy to deliver Critical Care services via the creation of two 'super' Critical Care units by 2019 at the LRI and the GH. The first year of the strategy is underway, precipitated by the need to relocate Adult Level 3 beds from the LGH due to ongoing staffing issues. This has driven the need to provide a solution for an increase in Adult Level 3 beds at LRI (addressed in a business case authorised by CMIC in August) and GH. The imperative is to deliver the change as rapidly as possible.	Section 2.1 Page 16

What are the Benefits?		**How will it be measured?**	**Business Case Section Reference**
To the patient	• Access to high quality ICU Level 3 reliant surgery within Leicester • An improved patient experience: high-quality accommodation and facilities meeting national core standards for Level 3 care • A more efficient patient flow for Levels 2 and 3 care and stepdown will enable improved clinical outcomes and reduced length of stay • The additional capacity will minimise the occurrence of cancellations on the day of surgery – improving clinical outcomes and reducing stress for patients • The benefit of being cared for by staff who are highly motivated, well-trained and experienced in caring for patients requiring Level 3 care.	• Patient experience surveys Close monitoring of RTT performance	1.2.1 Page 11
To UHL	• The ability to continue ICU Level 3 reliant surgery	• Feedback from staff	1.2.1 Page 11

What are the Benefits?		How will it be measured?	Business Case Section Reference
	• Enhanced capability of clinical staff to deliver optimal care • Improved staff satisfaction • Optimally efficient flow of patients • Ability to continue complex tertiary work (with ICU support) is in line with the Trust's longer term strategy to become smaller while expanding its provision of specialised, co-located services	Close monitoring of RTT performance	
To LLR	• Delivering better care for patients • Providing a greater focus on specialised care, teaching and research • In line with plans to concentrate acute services on two sites rather than three	As above	1.2.1 Page 11

		Business Case Section Reference
What is the solution?	Construction of an extension around the existing GH ICU Bay B to create an additional 11 bed spaces.	Appendix 3 – Estates Annex
What options have been considered?	The 'Do Nothing' option is shown to be significantly more costly than the proposed developments for Critical Care, reflecting the loss of income at the LGH associated with ICU reliant surgery. It was agreed that co-location of the additional bed spaces with the existing ICU will be crucial to ensure that they are utilised in the most efficient, effective and safe way possible. Due to the restrictions around the current unit on the GH site, as well as the need to retain an efficient and safe reconfiguration, meant that the only options deliverable by winter 2016 were new build options. Site locations assessed were: 1) New Build expansion into courtyard adjacent to current GH ICU Bay B 2) New Build areas at several proposed locations around the outskirts of the current ICU department	Appendix 3 – Estates Annex

		Business Case Section Reference
	3) New Build area that allows the direct expansion of GH ICU Bay B and increases the size of the existing unit.	
Are there any material deviations to recommended standards?	The development team referenced Health Building Note (HBN) 04-02 – 'Critical Care Units' (Department of Health, 2012), applying the recommended room sizes. The DH standards and guidance in this HBN will be utilised and applied where possible, along with others that are deemed applicable. However, due to some restrictions on space, there may be some constraints in terms of achieving full compliance with the HBN. Where compliance is not possible, derogations will be systematically reviewed and approved by the Trust before implementation. Room sizes for this project are denoted by m^2 and have been tested with clinical and managerial stakeholders to assure the Trust that the functional area required to deliver the service against the agreed clinical model and supporting activity and capacity model is functionally adequate.	Appendix 3 – Estates Annex
How will it be implemented?	The new build area will allow direct expansion of GH ICU 34 Bay B and increase the size of the existing unit. There will be some impact on adjacent departments but natural light will be maintained, to a limited extent. From a construction viewpoint the location is challenging, but the best case of all the available options.	Appendix 3 – Estates Annex
Are there any key dependencies?	None – planning permission has been approved.	Appendix 3 – Estates Annex
When will it be completed?	Key dates: • FBC signed off at ESB: 17 Nov 2015 • FBC signed off at CMIC with tendered prices: 20 Nov 2015 • FBC signed off at IFPIC with capital costs: 26 Nov 2015 • FBC signed off at Trust Board: 03 Dec 2015 • Commencement of mobilisation: mid-Dec 2015 • Commencement of capital works: 04 Jan 2016	Section 6.3 Page 70 Table 44
How much will it cost?	£4,712,232	Section 3.2 Page 66

		Business Case Section Reference
Will it be affordable?	The 'Do Nothing' option is significantly more expensive than the proposed developments. The options were 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 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; or • Transitional income is secured to offset these costs; or • The development is funded by the £4m per annum allowance made in the Financial Strategy for annual operating cost pressures.	Section 5.5 Page 71
Is it accounted for in the 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 £452k in 2016/17 and £641k in 2017/18 and 2018/19. The revenue costs will need to be managed and potentially reduced as a result of further investigation.	Section 5.5.1 Page 71

		Business Case Section Reference
How will the project contribute to deficit reduction?	This project is one in a series of business cases supporting the relocation of Adult Level 3 Critical Care services from the LGH by July 2016. The economic appraisal 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. The 'Do Nothing' option is significantly more expensive - due to loss of income (driven by the cessation of ICU reliant surgery) - than the proposed developments for critical care and associated services.	Section 3.2 Page 49
How have patients been involved?	HealthWatch Leicester has been fully involved in the development of these plans, with oversight provided by the Health Overview and Scrutiny Committee. Information on the UHL website informs the public of the wider reconfiguration programme. This year's Annual Public Meeting (18th September 2015) included ICU key messages. The Trust engages patients via local media – the Leicester Mercury Patient Panel is made up of members of the public who provide comment on local issues. 'Services on the move' publicity including staff briefings, leaflets at all three hospital sites, posters and social media / online communications are underway and will continue through to project completion. An article in the Trust's 'Together' newsletter (Feb/ May 2016 edition) will provide an update on the whole programme.	Section 2.5.10 Page38
What external assurance has been obtained?	A combined Health Check Review 3: Investment Decision was undertaken on the ICU project and the vascular enabling moves in July 2015. A Delivery Confidence Assessment of AMBER was issued by the review team, indicating that: *"successful delivery of the project appears likely. However attention will be needed to ensure risks do not materialise into major issues threatening delivery".* Project Governance arrangements have been established to reflect national best practice guidance and the Trust's own Capital Governance Framework.	Section 6.2 Page 66

Risks (scoring over 15) & Mitigations			RAG pre mitigation	Business Case Section Reference
Financial	Any additional increases in revenue costs, as a result of issues as yet undetected, may make the project unaffordable	Rigorous application of the Trust Change control process will be required for any future alterations.	**15 Red**	Section 4.3 Page 57 Table 35
	In the absence of a formal agreement the Trust will need to establish how the capital programme will be managed in order to keep the works to programme and achieve the tight delivery framework.	This is managed through the Capital Monitoring and Investment Committee and ongoing discussions with the TDA. Failing this internal capital will be required to be re-prioritised to fund the ICU project.	**15 Red**	Section 4.3 Page 57 Table 35
Operational	None over 15			
Workforce	Ability to staff vacancies and recruit/retain staff where split site coverage is required may make delivery of services more difficult	There will be a need to go out to recruit to vacancies rapidly. This will be addressed through the workforce work stream determining a critical path for recruitment and progressing high risk areas first	**15 Red**	Section 4.3 Page 57 Table 35
	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	Early engagement through the workforce work stream to build a clear workforce recruitment plan will be required to identify and target likely risk areas rapidly.	**15 Red**	Section 4.3 Page 57 Table 35
Estates	None over 15			

Risks (scoring over 15) & Mitigations			RAG pre mitigation	Business Case Section Reference
Equipment & Procurement	None over 15			
Comms & Engagement	None over 15			
Stakeholder Ownership	None over 15			
Project Delivery	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 and will require the Trust to cease some surgical activity.	Risks to timely delivery are escalated through ICU board and safe operational resolutions found as rapidly as possible	20 Red	Section 4.3 Page 57 Table 35
IM&T	None over 15			
Training	None over 15			

RAG Rating Key for Risks

			Impact				
			Very Low	Low	Medium	High	Very High
			1	2	3	4	5
Probability	Very Low	1	1	2	3	4	5
	Low	2	2	4	6	8	10
	Medium	3	3	6	9	12	15
	High	4	4	8	12	16	20

Very High	5	5	10	15	20	25

UHL Strategic Reconfiguration Business Cases

Name of Business Case:	FBC Adult Level 3 ICU Project: Glenfield Beds Enabler
Forum:	Executive Strategy Board Capital Monitoring and Investment Committee Integrated Finance, Performance & Investment Committee Trust Board
Checklist Completed by:	Anna Fawcett, Business Case Manager, UHL
Project SRO:	Kate Shields, Director of Strategy, UHL

Confirm Commissioner support:	Commissioner are aware of plans within the Adult Level 3 Critical Care business cases and are supportive of the rationale behind the need to remove Adult Level 3 Critical Care from the Leicester General Hospital (LGH) site by July 2016.
Confirm Stakeholder support :	HealthWatch Leicester has been fully involved in the development of this project, with oversight provided by the Health Overview and Scrutiny Committee. Stakeholder involvement has been crucial throughout the ICU project and has relied heavily upon clinicians and managers from affected specialties to inform planning decisions. The Overview & Scrutiny Committee were informed of progress in March 2015 and has been again in November 2015 to ensure that they remain sighted on the absolute clinical need to move Adult Level 3 ICU provision from the Leicester General Hospital (LGH) to the Leicester Royal Infirmary (LRI) and Glenfield Hospital (GH) by the end of July 2016.

		Business Case Section Reference
What is the purpose of this project?	The project is a crucial enabler for the strategic reconfiguration of UHL's Adult Level 3 (ICU) care. It proposes the refurbishment of two wards on the Trust's GH site, which are needed to house Hepato-Pancreato-Biliary (HPB) and Renal Transplant services when they are transferred to the GH due to the critical clinical reliance on ICU level 3 services. This move will enable the HPB unit to run as a "stand alone" service providing consultant-led care for patients presenting with emergency biliary pathology	Section 1.1 Page 9

		Business Case Section Reference
	with emergency laparoscopic cholecystectomy undertaken on their index admission.	
Why is it being carried out?	This project must be viewed in the context of the immediate clinical imperative to remove Adult Level 3 Critical Care from the LGH by July 2016. It describes the ward refurbishments required at the GH, which are needed to provide accommodation for specialties moving from the LGH due to the necessary removal of the Adult Level 3 ICU service from this site.	Section 1.2 Page 9
What are the key assumptions in this business case?	There is a strong clinical view that it would be a significant risk to undertake Renal Transplantation and HPB without access to 24/7 Level 3 support (which is part of national service specification from specialised commissioners for renal transplantation). Moving both services 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. The co-location of HPB services with Adult Level 3 Critical Care and Interventional Radiology will enable continuance of tertiary work as well as the development of HPB into a "stand alone" service.	Section 1.2.2 Page 9
Identify how this project fits in the reconfiguration programme?	Whilst not the primary driver for the project, UHL's five-year plan envisages that HPB, Renal and Transplant services will move to the GH site in line with the vision to become more specialised. For this interim solution the proposal is to move all of HPB and inpatient transplant activity, as it is these cohorts of patients who have a critical clinical adjacency requirement with Level 3 ICU care. The imperative is to deliver the change as rapidly as possible. An initial proposal to move Renal Transplant and acute Nephrology to GH in July 2016 was found to be unaffordable. It was subsequently agreed that only the inpatient Renal 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.	Section 1.2.1 Page 9

What are the Benefits?		How will it be measured?	Business Case Section Reference
To the patient	• Improved safety for Renal Transplant and HPB patients requiring Level 3 care, by providing 24/7 access on-site • An improved patient experience: high-quality accommodation and facilities • An efficient and convenient patient flow • Co-location of the departments positions patients on the same site without the need to transfer	• Patient experience surveys • Close monitoring of RTT performance	Section 1.2.2 Page 9
To UHL	• Enhanced capability of clinical staff to deliver optimal care • Improved staff satisfaction • Optimally efficient flow of patients • Critical adjacencies met to facilitate urgent transfers between departments • Increased efficiency of resources, staffing and equipment • In line with the Trust's longer term strategy to become smaller while expanding its provision of specialised, co-located services	• Feedback from staff • Close monitoring of RTT performance	Section 1.2.2 Page 9
To LLR	• Delivering better care for patients • Providing a greater focus on specialised care, teaching and research • In line with plans to concentrate acute services on two sites rather than three	• As above	Section 1.2.2 Page 9

		Business Case Section Reference
What is the solution?	The relocation and provision of 10 Renal Transplant beds and 52 HPB beds on the GH site. This will act as an enabler to the overall relocation of Level 3 beds from LGH to GH. There is no additional bed capacity being delivered through the project; the capacity is being relocated.	Appendix 3 – Estates Annex

		Business Case Section Reference
What options have been considered?	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. For Renal Transplant beds, the options explored included: co-habitation with patients on the Vascular ward; conversion of current office space; and creation of a new-build 10-bedded ward. The Project Board determined that the cost of new build did not provide 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 determined that delivery of the beds should be achieved through refurbishment of existing wards. The Respiratory, Renal, Cardiac & Vascular Clinical Management Group (RRCV CMG) was asked to review their wards to inform the selection of those which would be most suitable for refurbishment. The only combination of wards that would not have a resultant negative impact on remaining specialties was wards 28 and 29.	Appendix 3 – Estates Annex
Are there any material deviations to recommended standards?	The relevant DH Health Building Notes including HBN 04-02 'Critical Care Units' will be utilised and applied where possible. The preferred solution for the wards is refurbishment of an area of the existing estate, adjacent to the existing wards. The project team will work to minimise derogations to HBN standards; however, there are constraints when undertaking capital works within an existing building and the capital allocation may result in the requirement to derogate. The Trust will systematically review and approve each derogation before it is implemented.	Appendix 3 – Estates Annex
How will it be implemented?	The Respiratory corridor at GH must be released for this project to go ahead; consequently the inhabitants of 29 offices located here must be re-housed. Initially the RRCV CMG will aim to deliver this space by applying the Trust's approved Space Utilisation Policy. This will involve identification of staff who 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.	Appendix 3 – Estates Annex

		Business Case Section Reference
	The relocation of HPB to the GH is dependent on the release and vacation of Wards 28 and 29 as they are both fully operational Wards. The responsibility to release and vacate these wards sits with the RRCV CMG and Operations Team.	
Are there any key dependencies?	• Release of the Respiratory corridor following the relocation of 29 offices (required by the end of 2015) • Vacation of wards 28 and 29 (required by the end of March 2016)	Appendix 3 – Estates Annex
When will it be completed?	Key dates: • FBC signed off at ESB: 17 Nov 2015 • FBC signed off at CMIC: 20 Nov 2015 • FBC signed off at IFPIC: 26 Nov 2015 • FBC signed off at Trust Board: 03 Dec 2015 • Update on PTE Capital Costs: 31 Dec 2015 • Area operational: July 2016	
How much will it cost?	£4,314,090	Section 5.2 Page 58
Will it be affordable?	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.	*5.5* *Page 55*
Is it accounted for in the 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. The FBC identifies additional operating costs of circa £661,000 in 16/17 and £837k in 2017/18 and 2018/19 outside the LTFM. The revenue costs will need to be managed as described above and potentially reduced as a result of further investigation.	*5.5.1* *Page 56*
How will the project contribute to deficit	This project is one in a series of business cases supporting the reconfiguration of Critical Care services across the three hospital sites. The economic appraisal compares a 'Do Nothing' scenario (with respect to the Critical Care facilities at	Section 3.2 Page 40

		Business Case Section Reference
reduction?	the LGH) with a scenario that moves Critical Care beds and associated services from the LGH. The 'Do Nothing' option is significantly more costly - due to loss of income - than the proposed developments for critical care and associated services.	
How have patients been involved?	HealthWatch Leicester has been fully involved in the development of these plans, with oversight provided by the Health Overview and Scrutiny Committee. Information on the UHL website informs the public of the wider reconfiguration programme. This year's Annual Public Meeting (18th September 2015) included ICU key messages. The Trust engages patients via local media – the Leicester Mercury Patient Panel is made up of members of the public who provide comment on local issues. 'Services on the move' publicity including staff briefings, leaflets at all three hospital sites, posters and social media / online communications is already underway and will continue through to project completion. An article in the Trust's 'Together' newsletter (February/ May 2016 edition) will provide an update on the whole programme.	Section 2.5.10 Page 33
What external assurance has been obtained?	A combined Health Check Review 3: Investment Decision was undertaken on the ICU project and the Vascular enabling moves in July 2015. A Delivery Confidence Assessment of AMBER was issued by the review team, indicating that: *"successful delivery of the project appears likely. However attention will be needed to ensure risks do not materialise into major issues threatening delivery".* Project governance arrangements have been established to reflect national best practice guidance and the Trust's own Capital Governance Framework.	Section 6.2 Page 64

Risks (scoring over 15) & Mitigations			RAG (pre mitigation)	Business Case Section Reference
Financial	Any additional increases in revenue costs, as a result of issues as yet	Rigorous application of the Trust Change control process will be required for any	**15** **Red**	Section 4.4 Page 52 Table 23

Risks (scoring over 15) & Mitigations			RAG (pre mitigation)	Business Case Section Reference
	undetected, may make the project unaffordable	future alterations		
	In the absence of a formal agreement the Trust will need to establish how the capital programme will be managed in order to keep the works to programme and achieve the tight delivery framework.	This is managed through the capital monitoring and investment committee and ongoing discussions with the TDA. Failing this internal capital will be required to be re-prioritised to fund the ICU project	**15 Red**	Section 4.4 Page 52 Table 23
Operational	**Beds:-** Capacity constraints within system to enable moves (including failure of Left shift to deliver bed space required) could require a costly solution to create capacity or risk increased operational pressure	At present Wards 28 and 29 are being planned to be vacated at GH site. A backup plan is being formulated to ensure that these beds are free by March 2016. Impact of plans to close GH theatre capacity gap is being worked through operationally with service leads	**20 Red**	Section 4.4 Page 52 Table 23
Workforce	Ability to staff vacancies and recruit/retain staff where split site coverage is required may make delivery of services more difficult	There will be a need to go out to recruit to vacancies rapidly. This will be addressed through the Workforce work stream determining a critical path for recruitment and progressing high risk areas first	**15 Red**	Section 4.4 Page 52 Table 23
	Required staffing is costed at substantive rate. If there is an inability to recruit to vacancies then premium pay spend	Early engagement of through the Workforce work stream to build a clear workforce recruitment plan will	**15 Red**	Section 4.4 Page 52 Table 23

Risks (scoring over 15) & Mitigations			RAG (pre mitigation)	Business Case Section Reference
	may be incurred above the originally agreed budget	be required to identify and target likely risk areas rapidly		
Estates	Access to Wards 28 and 29 will be required by the end of March 2016	Will remain dependent upon performance of "Out of Hospital" shift and supporting work streams	**20 Red**	Section 4.4 Page 52 Table 23
Equipment & Procurement	None over 15			
Comms & Engagement	None over 15			
Stakeholder Ownership	None over 15			
Project Delivery	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 and will require the Trust to cease some surgical activity	Risks to timely delivery are escalated through ICU board and safe operational resolutions found as rapidly as possible	**20 Red**	Section 4.4 Page 52 Table 23
IM&T	None over 15			
Training	None over 15			

RAG Rating Key for Risks

			Impact		
	Very Low	**Low**	**Medium**	**High**	**Very High**

		1	2	3	4	5
Very Low	1	1	2	3	4	5
Low	2	2	4	6	8	10
Medium	3	3	6	9	12	15
High	4	4	8	12	16	20
Very High	5	5	10	15	20	25

Probability

UHL Strategic Reconfiguration Business Cases

Name of Business Case:	FBC Adult Level 3 ICU Project: LRI Beds Enabler
Forum:	Executive Strategy Board Capital Monitoring and Investment Committee Integrated Finance, Performance & Investment Committee Trust Board
Checklist Completed by:	Anna Fawcett, Business Case Manager, UHL
Project SRO:	Kate Shields, Director of Strategy, UHL

Confirm Commissioner support:	Commissioner are aware of plans within the Adult Level 3 Critical Care business cases and are supportive of the rationale behind the need to remove Adult Level 3 Critical Care from the Leicester General Hospital (LGH) site by July 2016.
Confirm Stakeholder support :	HealthWatch Leicester has been fully involved in the development of this project, with oversight provided by the Health Overview and Scrutiny Committee. Stakeholder involvement has been crucial throughout the ICU project and has relied heavily upon clinicians and managers from affected specialties to inform planning decisions. The Overview and Scrutiny Committee were informed of progress in March 2015 and has been again in November 2015 to ensure that they remain sighted on the absolute clinical need to move Adult Level 3 ICU provision from LGH to the Leicester Royal Infirmary (LRI) and Glenfield Hospital (GH) by the end of July 2016.

		Business Case Section Reference
What is the purpose of this project?	The project is a crucial enabler for the strategic reconfiguration of UHL's Adult Level 3 (ICU) care. It proposes a series of moves to facilitate the vacation of wards 7 and 21 at the LRI site to enable the co-location of General Surgery and Colorectal services with existing wards when they are transferred to the LRI due to their critical clinical adjacencies with ICU. It will also enable joint Gynaecological / Colorectal cases to be undertaken at LRI using the General Surgery bed base.	Section 1.1 Page 9

		Business Case Section Reference
Why is it being carried out?	This project must be viewed in the context of the immediate clinical imperative to remove Adult Level 3 Critical Care from the LGH by July 2016. It describes the moves required to provide 41 acute beds across two wards on the LRI site for emergency and complex elective surgical patients. These specialties are moving from the LGH due to the necessary removal of the Adult Level 3 ICU service from this site.	Section 1.2 Page 9
What are the key assumptions in this business case?	It is essential for General Surgery to have access to 24/7 Level 3 ICU provision. This necessitates that the service move from the LGH in order for safe care to be provided to patients beyond July 2016. There will be benefits from co-locations with other surgical specialties.	Section 2.3 Page 18
Identify how this project fits in the reconfiguration programme?	Whilst not the primary driver for the project, it is an enabler for the Trust's five-year strategy to deliver Critical Care services via the creation of two 'super' Critical Care units by 2019 at the LRI and the GH. It is also the intention to provide acute services across two sites with emergency activity centred at the LRI. The imperative for General Surgery moving to the LRI is to deliver the change as rapidly as possible due to clinical necessity.	Section 2.1 Page 16

What are the Benefits?		**How will it be measured?**	**Business Case Section Reference**
To the patient	• Improved safety for General Surgical patients requiring Level 3 care, by providing 24/7 access on-site • An improved patient experience: high-quality accommodation and facilities • An efficient and convenient patient flow • Co-location of the departments positions patients on the same site without the need to transfer	• Patient experience surveys Close monitoring of RTT performance	Section 1.2.2 Page 10
To UHL	• Enhanced capability of clinical staff to deliver optimal care • Improved staff satisfaction	• Feedback from staff Close monitoring of RTT	Section 1.2.2 Page 10

What are the Benefits?		How will it be measured?	Business Case Section Reference
	• Optimally efficient flow of patients • Critical adjacencies met to facilitate prompt intervention for patients requiring emergency surgical treatment • Increased efficiency of resources, staffing and equipment • New training opportunities for clinicians • In line with the Trust's longer term strategy to become smaller while expanding its provision of specialised, co-located services and concentrating emergency surgery to one site.	performance	
To LLR	• Delivering better care for patients • Providing a greater focus on specialised care, teaching and research • In line with plans to concentrate acute services on two sites rather than three	As above	Section 1.2.2 Page 10

		Business Case Section Reference
What is the solution?	The provision of Colorectal and General surgery on the LRI site is based on the existing service requirements. Both services require theatre access, elective and emergency, Radiology access – Interventional Radiology, Ultrasound, X-Ray, MRI/CT and Endoscopy. The beds moving to the LRI are not additional to the overall supply of inpatient beds, they are solely a relocation to support the move of Level 3 beds to the LRI site. There is no requirement for an additional theatre to support the shift of the theatre activity – the existing theatre schedules are being maximised to ensure the capacity is available for both Colorectal and General Surgery. The best option for reconfiguration of LRI General Surgery, Colorectal and joint Gynae beds is determined as: • Utilising ward 21 when Vascular relocates to the	Appendix 2 – Estates Annex

		Business Case Section Reference
	GH • Utilising ward 7 following a series of enabling ward moves to vacate this space	
What options have been considered?	**Surgery to utilise Wards 7 and 21 (Preferred option):-** Current Ward 7 moves into Ward 9, Ward 21 is refurbished following the Vascular Surgery move to GH in April 2016 and Ward 7 is refurbished to provide two wards for General Surgery **Adults take ward 14 for 9 months then move to Ward 9:-** CAU remains where it is until it moves to the new ED floor in ~ Jan 2017 requiring adults to take ward 14 for a period of approximately 9 months and then move to ward 9, after which Children's would convert ward 14 into a medical day case and hospital school space. **Adults take ward 14 for 3 years:-** CAU remains where it is until it moves to the new ED floor in ~ Jan 2017 requiring adults to take ward 14 until the final Children's Hospital solution in approximately 3 years; children's then do minimal work on ward 9 to convert to a medical day case and hospital school space.	Appendix 2 – Estates Annex Section 3.4 Page 40
Are there any material deviations to recommended standards?	The relevant DH Health Building Notes will be utilised and applied where possible. The preferred solution for the wards is refurbishment of an area of the existing estate, adjacent to the existing wards. The project team will work to minimise derogations to HBN standards; however, there are constraints when undertaking capital works within an existing building and the capital allocation may result in the requirement to derogate. The Trust will systematically review and approve each derogation before it is implemented.	Appendix 2 – Estates Annex
How will it be implemented?	The design solution for both areas involves refurbishment of the existing estate. Before General Surgery can move onto the site, the wards will need to be refurbished. There are two enabling moves required in order to release the space required by surgery: • To release ward 7: 4 enabling ward moves need to occur, releasing Ward 21 to be refurbished. • To release ward 21: Vascular moves to GH mid-May 2016, releasing Ward 21 to be refurbished. The extent of design and works will be significantly	Appendix 2 – Estates Annex

		Business Case Section Reference
	different between the two areas. The responsibility to release and vacate these wards sits with the CMG and Operations Team. Surgery will move from the LGH into ward 7 and 21. The relocation of surgery will require the displacement of a number of offices. This is being addressed through a separate route as it covers a number of different projects which all require access to office accommodation.	
Are there any key dependencies?	Release and vacation of operational wards and offices. Vascular moving to the GH by mid-May 2016 to release required Ward space at LRI.	Appendix 2 – Estates Annex
When will it be completed?	Key dates: • FBC signed off at ESB: 17 Nov 2015 • FBC signed off at CMIC: 20 Nov 2015 • FBC signed off at IFPIC: 26 Nov 2015 • FBC signed off at Trust Board: 03 Dec 2015 • Update on PTE Capital Costs: 31 Dec 2015 • Ward 7 released for refurbishment: Jun 2016 • Ward 21 released for refurbishment: mid-May 2016	Appendix 2 – Estates Annex
How much will it cost?	£2,898,586	Section 5.2 Page 51
Will it be affordable?	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.	5.5 Page 49
Is it accounted for in the 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. The FBC identifies additional operating costs of circa circa £269,000 2016/17 and £404,000 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.	5.5.1 Page 49

		Business Case Section Reference
How will the project contribute to deficit reduction?	This project is one in a series of business cases supporting the reconfiguration of Critical Care services across the three hospital sites. The economic appraisal 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. The 'Do Nothing' option is significantly more costly - due to loss of income - than the proposed developments for critical care and associated services.	Section 3.2 Page 38
How have patients been involved?	HealthWatch Leicester has been fully involved in the development of these plans, with oversight provided by the Health Overview and Scrutiny Committee. Information on the UHL website informs the public of the wider reconfiguration programme. This year's Annual Public Meeting (18th September 2015) included ICU key messages. The Trust engages patients via local media – the Leicester Mercury Patient Panel is made up of members of the public who provide comment on local issues. 'Services on the move' publicity including staff briefings, leaflets at all three hospital sites, posters and social media / online communications is already underway and will continue through to project completion. An article in the Trust's 'Together' newsletter (February/ May 2016 edition) will provide an update on the whole programme.	Section 2.5.10 Page 31
What external assurance has been obtained?	A combined Health Check Review 3: Investment Decision was undertaken on the ICU project and the Vascular enabling moves in July 2015. A Delivery Confidence Assessment of AMBER was issued by the review team, indicating that: *"successful delivery of the project appears likely. However attention will be needed to ensure risks do not materialise into major issues threatening delivery".* Project governance arrangements have been established to reflect national best practice guidance and the Trust's own Capital Governance Framework.	Section 6.2 Page 64

Risks (scoring over 15) & Mitigations			RAG	Business Case Section Reference
Financial	Any additional increases in revenue costs, as a result of issues as yet undetected, may make the project unaffordable	Rigorous application of the Trust Change control process will be required for any future alterations.	**15 Red**	Section 4.4 Page 46 Table 19
	In the absence of a formal agreement the Trust will need to establish how the capital programme will be managed in order to keep the works to programme and achieve the tight delivery framework.	This is managed through the Capital Monitoring and Investment Committee and ongoing discussions with the TDA. Failing this internal capital will be required to be re-prioritised to fund the ICU project.	**15 Red**	Section 4.4 Page 46 Table 19
Operational	**Beds:-** Capacity constraints within system to enable moves (including failure of Left shift to deliver bed space required) could require a costly solution to create capacity or risk increased operational pressure	Requirement for beds at LRI is dependent upon preceding ward moves but not out of hospital shift.	**20 Red**	Section 4.4 Page 46 Table 19
Workforce	Ability to staff vacancies and recruit/retain staff where split site coverage is required may make delivery of services more difficult	There will be a need to go out to recruit to vacancies rapidly. This will be addressed through the workforce work stream determining a critical path for recruitment and progressing high risk areas first	**15 Red**	Section 4.4 Page 46 Table 19
	Required staffing is costed at substantive rate. If there is an inability to recruit to	Early engagement through the workforce work stream build a clear workforce	**15 Red**	Section 4.4 Page 46

Risks (scoring over 15) & Mitigations			RAG	Business Case Section Reference
	vacancies then premium pay spend may be incurred above the originally agreed budget	recruitment plan will be required to identify and target likely risk areas rapidly.		Table 19
Estates	None over 15			
Equipment & Procurement	None over 15			
Comms & Engagement	None over 15			
Stakeholder Ownership	None over 15			
Project Delivery	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 and will require the Trust to cease some surgical activity.	Risks to timely delivery are escalated through ICU board and safe operational resolutions found as rapidly as possible	**20 Red**	Section 4.4 Page 46 Table 19
IM&T	None over 15			
Training	None over 15			

RAG Rating Key for Risks

			Impact				
			Very Low	Low	Medium	High	Very High
			1	2	3	4	5
Pr o	Very Low	1	1	2	3	4	5

Low	2	2	4	6	8	10
Medium	3	3	6	9	12	15
High	4	4	8	12	16	20
Very High	5	5	10	15	20	25

UHL Strategic Reconfiguration Business Cases

Name of Business Case:	FBC Adult Level 3 ICU Project: Glenfield Imaging Enabler
Forum:	Executive Strategy Board Capital Monitoring and Investment Committee Integrated Finance, Performance & Investment Committee Trust Board
Checklist Completed by:	Anna Fawcett, Business Case Manager, UHL
Project SRO:	Kate Shields, Director of Strategy, UHL

Confirm Commissioner support:	Commissioner are aware of plans within the Adult Level 3 Critical Care business cases and are supportive of the rationale behind the need to remove Adult Level 3 Critical Care from the Leicester General Hospital (LGH) site by July 2016.
Confirm Stakeholder support :	HealthWatch Leicester has been fully involved in the development of this project, with oversight provided by the Health Overview and Scrutiny Committee. Stakeholder involvement has been crucial throughout the ICU project and has relied heavily upon clinicians and managers from affected specialties to inform planning decisions. The Overview & Scrutiny Committee were informed of progress in March 2015 and will has been again in November 2015 to ensure that they remain sighted on the absolute clinical need to move Adult Level 3 ICU provision from the Leicester General Hospital (LGH) to the Leicester Royal Infirmary (LRI) and Glenfield Hospital (GH) by the end of July 2016.

		Business Case Section Reference
What is the purpose of this project?	The purpose of this project is to create Interventional Radiology (IR) capacity required at the GH (required by Hepato-Pancreato-Biliary (HPB) and Renal Transplant) that will enable the re-location of Adult Level 3 Critical Care from the LGH by July 2016. This is a crucial enabler for the Adult Level 3 (ICU) project.	Section 1.1 Page 9
Why is it being carried out?	This project must be viewed in the context of the immediate clinical imperative to remove Adult Level 3 Critical Care from the LGH by July 2016. It describes	Section 1.2 Page 10

		Business Case Section Reference
	the increase in IR capacity at the GH, which is a crucial enabler to support specialties moving from the LGH due to the necessary removal of the Adult Level 3 ICU service from this site.	
What are the key assumptions in this business case?	UHL's HPB and Renal Transplant patients will be transferred to the GH when the Adult Level 3 Critical Care service leaves the LGH The financial appraisal period has been assumed to be 30 years. Whilst this investment addresses immediate clinical need it will also provide Interventional Radiology support in the future for services moving off the LGH site.	Section 1.2.1 Page 10
Identify how this project fits in the reconfiguration programme?	Whilst not the primary driver for the project it is an enabler for the Trust's five-year strategy to deliver Critical Care services via the creation of two 'super' Critical Care units by 2019 at the LRI and the GH. The first year of the strategy is underway, driven by the need to relocate Adult Level 3 beds from the LGH due to ongoing staffing issues. The imperative is to deliver the change as rapidly as possible. As mentioned above, the IR capacity created will support future reconfiguration of the GH site.	Section 2.1 Page 16

What are the Benefits?		**How will it be measured?**	**Business Case Section Reference**
To the patient	• Enabling HPB and Renal Transplant patients to continue accessing a full specialist service, allied with immediately co-located IR support. • An improved patient experience: high-quality accommodation and facilities • An efficient and convenient patient flow • Interventional procedures for HPB, Renal Transplant and Nephrology patients on the same site without the need to transfer • Provision of imaging services at the right times in the right locations	• Patient experience surveys Close monitoring of RTT performance	Section 1.2.2 Page 10

What are the Benefits?		How will it be measured?	Business Case Section Reference
To UHL	• Provision of IR capacity that will support the continued operating of HPB and Renal Transplant. • Enhanced capability of clinical staff to deliver optimal care • Improved staff satisfaction • Optimally efficient flow of patients • Critical adjacencies met to facilitate urgent radiological response to emergencies • Increased efficiency of resources, staffing and equipment • In line with the Trust's longer term strategy to become smaller while expanding its provision of specialised, co-located services	• Feedback from staff Close monitoring of RTT performance	Section 1.2.2 Page 10
To LLR	• Enablement of tertiary service development • Delivering better care for patients • Providing a greater focus on specialised care, teaching and research • In line with plans to concentrate acute services on two sites rather than three	• As above	Section 1.2.2 Page 10

		Business Case Section Reference
What is the solution?	Conversion of existing Medical Records and Office space which is adjacent to the existing Imaging department and is required to re-locate to create necessary space for conversion. The solution will provide a complete re-model of all areas and services regardless of existing physical function or condition. It will maintain all key adjacencies to the existing department.	Appendix 6 – Estates Annex
What options have been considered?	• New build outside of Imaging • New build at Ivydene House	Section 3.3 Page 44 Appendix 6 –

		Business Case Section Reference
	• New Build in the South Entrance car park • Refurbishment of medical records and offices The preferred option scored most highly when appraised against the following benefits: • clinical quality and configuration • efficiency and effectiveness • staffing • quality of the patient environment • achievability • accessibility	Estates Annex
Are there any material deviations to recommended standards?	Room sizes are denoted by m^2 and have been tested with clinical and managerial stakeholders to assure the Trust that the functional area required to deliver the service against the agreed clinical model and supporting activity and capacity model is deliverable. The works to develop the IR department are all refurbishment works; there is no new build within this project. The project team will work to minimise derogations to HBN standards; however, there are constraints when undertaking capital works within an existing building and the capital allocation may result in the requirement to derogate. The Trust will systematically review and approve each derogation before it is implemented.	Appendix 6 – Estates Annex
How will it be implemented?	The area requiring refurbishment is currently occupied and in use. A key element of the project will be the timely relocation of the existing occupants and services. The departments / functions that will be displaced are: • Medical Records Notes Store • Office Accommodation • On Call Rooms The Medical Records notes store is the main store on the GH site. The department has capacity to store 80,000 sets of regularly used patient notes, which	Appendix 6 – Estates Annex

		Business Case Section Reference
	need to be relocated. Options for the relocation of the offices and on-call rooms are being explored; the respective CMGs are aiming to identify locations within their existing estate to re-provide this accommodation. The Trust's Space Utilisation Team is supporting with this task.	
Are there any key dependencies?	Without this investment, Adult Level 3 Critical Care cannot be effectively moved from LGH as specialties such as HPB and Renal Transplant (which will be located on site from July 2016) rely heavily upon IR to undertake their work. Failure to provide this capacity would result in substantial elements of activity being provided away from the bed bases of affected specialties. The only alternative would be to cease those activities due to the lack of suitable Interventional Radiology provision.	Section 1.2 Page 10
	The affected Medical Records and Offices will require transfer to alternative accommodation within the required timescales.	Appendix 6 – Estates Annex
When will it be completed?	Key dates: • FBC signed off at ESB: 17 Nov 2015 • FBC signed off at CMIC: 20 Nov 2015 • FBC signed off at IFPIC: 26 Nov 2015 • FBC signed off at Trust Board: 03 Dec 2015 • Update on PTE Capital Costs: 31 Dec 2015 • Stage 3 Design and Generation of the MP: Dec 2015 • Construction activities including 5 weeks to relocate equipment: Jan to Jul 2016	Section 6.3 Page 66 Table 31
How much will it cost?	£4,550,479	Section 5.2 Page 60
Will it be affordable?	The operating cost revenue impact of this scheme is affordable as it enables the Trust to retain income, which outweighs the additional costs.	Section 5.5 Page 62
Is it accounted for in the LTFM?	Non-operating costs have been allowed for in the Trust's Long-Term Financial Model (LTFM), leaving the additional operating costs of circa £267,000 in 2016/17 and £373,000 per annum in 2017/18 and 2018/19 outside the LTFM.	Section 5.5.1 Page 62

		Business Case Section Reference
How will the project contribute to deficit reduction?	This project is one in a series of business cases supporting the reconfiguration of Critical Care services across the three hospital sites. The economic appraisal 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. The 'Do Nothing' option is significantly more costly - due to loss of income - than the proposed developments for critical care and associated services.	Section 3.2 Page 44
How have patients been involved?	HealthWatch Leicester has been fully involved in the development of these plans, with oversight provided by the Health Overview and Scrutiny Committee. Information on the UHL website informs the public of the wider reconfiguration programme. This year's Annual Public Meeting (18th September2015) included ICU key messages. The Trust engages patients via local media – the Leicester Mercury Patient Panel is made up of members of the public who provide comment on local issues. 'Services on the move' publicity including staff briefings, leaflets at all three hospital sites, posters and social media / online communications are underway and will continue through to project completion. An article in the Trust's 'Together' newsletter (February/ May 2016 edition) will provide an update on the whole programme.	Section 2.5.10 Page 31
What external assurance has been obtained?	A combined Health Check Review 3: Investment Decision was undertaken on the ICU project and the vascular enabling moves in July 2015. A Delivery Confidence Assessment of AMBER was issued by the review team, indicating that: *"successful delivery of the project appears likely. However attention will be needed to ensure risks do not materialise into major issues threatening delivery".* Project governance arrangements have been established to reflect national best practice guidance and the Trust's own Capital Governance Framework.	Section 6.2 Page 62

Risks (scoring over 15) & Mitigations			RAG pre Mitigation	Business Case Section Reference
Financial	In the absence of a formal agreement the Trust will need to establish how the capital programme will be managed in order to keep the works to programme and achieve the tight delivery framework.	This is managed through the capital monitoring & delivery group and ongoing discussions with the TDA. Failing this internal capital will be required to be re-prioritised to fund the ICU project.	**15 Red**	Section 4.4 Page 54 Table 24
	Any additional increases in revenue costs, as a result of issues as yet undetected, may make the project unaffordable	This is managed through the Capital Monitoring and Investment Committee and ongoing discussions with the TDA. Failing this internal capital will be required to be re-prioritised to fund the ICU project.	**15 Red**	Section 4.4 Page 54 Table 24
Operational	3-day service for GH and LGH during an interim period - no on site provision for 4 days a week (however out of hours on call on each site)	Expansion of hours will come at an increased financial cost.	**15 Red**	Section 4.4 Page 54 Table 24
	Specialties utilising IR do not abide by agreed model of usage. This will result in unacceptable pressure being placed on the staff providing the service and would bring additional risks around quality and safety	The Imaging Department Operational Policy will set out the hours of service. Specialties must be encouraged to live within these.	**15 Red**	Section 4.4 Page 54 Table 24

Risks (scoring over 15) & Mitigations			RAG pre Mitigation	Business Case Section Reference
Workforce	Ability to staff vacancies and recruit/retain staff where split site coverage is required may make delivery of services more difficult	There will be a need to go out to recruit to vacancies rapidly. This will be addressed through the workforce work stream determining a critical path for recruitment and progressing high risk areas first	**15 Red**	Section 4.4 Page 54 Table 24
	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	Early engagement through the workforce work stream build a clear workforce recruitment plan will be required to identify and target likely risk areas rapidly.	**15 Red**	Section 4.4 Page 54 Table 24
Estates	None over 15			
Equipment & Procurement	None over 15			
Comms & Engagement	None over 15			
Stakeholder Ownership	None over 15			
Project Delivery	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 and will require the Trust to cease some surgical activity.	Risks to timely delivery are escalated through ICU board and safe operational resolutions found as rapidly as possible	**20 Red**	Section 4.4 Page 54 Table 24

Risks (scoring over 15) & Mitigations			RAG pre Mitigation	Business Case Section Reference
IM&T	None over 15			
Training	None over 15			

RAG Rating Key for Risks

Probability		Impact: Very Low	Low	Medium	High	Very High
		1	2	3	4	5
Very Low	1	1	2	3	4	5
Low	2	2	4	6	8	10
Medium	3	3	6	9	12	15
High	4	4	8	12	16	20
Very High	5	5	10	15	20	25