# UHL Reconfiguration - update

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# Executive Summary

## Context

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

It has been agreed to provide the Trust Board with a monthly update on Reconfiguration, employing the Level 1 dashboard (recognising the need to improve user-ability) to show an overview of the programme status and key risks, with accompanying focus on one or two topical workstreams each month.

This paper provides an update to the Trust Board on the governance of the programme, progress of a number of selected workstreams and top risks. It ensures that the Trust Board is sighted on key issues that may impact on delivery of key milestones of the programme.

## Questions

1. Does the report, with dashboard and risk log, provide the Board with sufficient (and appropriate) assurance of the UHL Reconfiguration Programme and its delivery timeline?
2. Does the Board agree to the approach to provide an overview accompanied with a focus on one to two workstreams each month?
3. Is there anything else the Board would like by way of update each month or quarter?

## Conclusion

[Summarise your answer to the question above, keeping your Exec Summary to one page]

1. The report provides a summary overview of the programme governance, updates from a number of workstreams, and the top three risks from across the programme that the Board should be sighted on. This summary follows the UHL reconfiguration programme board, which took place on 26 August 2015. Sufficient assurance should be taken from

this given the governance structure underpinning the dashboard which is based on levels of reporting (described in the August Trust Board paper).

2. The approach to reporting to Trust Board (Level 1) has been agreed in principle. This needs to be tested through applicability and then refined as required to be fit for purpose. A 'thinking day' in the autumn will enable further feedback and modifications.

## Input Sought

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

# For Reference

Edit as appropriate:

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

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

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

| | |
|---|---|
| Organisational Risk Register | [Yes /No /**Not applicable**] |
| Board Assurance Framework | [**Yes** /No /Not applicable] |

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

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

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

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

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

# Update to the Trust Board 3 September 2015

# UHL Reconfiguration Programme

## Governance arrangements in place

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

This approach has been shared with the Trust Board previously to gain input and will be fully operational from the next month's Board meeting. It is important to remember that the Programme has a monthly meeting, chaired by Kate Shields as SRO, upon which all aspects of the programme are reviewed and monitored, fundamentally through detailed highlight reports and risk registers.

As the Programme moves into delivery, with some workstreams already there, three layers of reporting with two dashboards have been developed to enable tracking across the overall programme, triangulation of progress and provide assurance to all parts of the Trust governance structure. The differing levels of dashboard will enable tracking at different levels of the programme and therefore to differing degrees of granularity. The level one dashboard (appendix one) provides assurance to Trust Board and Executive Strategy Board.

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

## Workstream updates

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

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

### 1) Models of Care/Future Operating Model

Over the last month a series of workshops have been held with CMGs to develop thinking around their future models of care. This builds upon the work completed last year and will feed into the Trust's reconfiguration tool, which enables known assumptions and also scenario testing for the three main resource/footprint groups of beds, theatres and outpatient activity and capacity. It is recognised that the diagnostics workstream (as a fourth major resource group) will need more

focus over the coming months to enable the same level of modelling to be completed and this will be addressed over the coming months.

Clinical teams are working hard to generate practical ideas that will help shrink the acute footprint to support the reconfiguration programme and support the Trust's vision to become smaller and more specialised (overall). Specialties are beginning to shape new models of care that mean the Trust will only provide, in hospital, the acute care that cannot be provided in out-of-hospital facilities, making better use of technology, new roles, flexible working arrangements etc.

## Reconfiguration Business Cases

### Level three ICU moves

Work continues with affected specialties to confirm final locations, following the move of level three services from the Leicester Royal Infirmary (LRI) to Glenfield Hospital (GH). A final nursing workforce confirm and challenge takes place on 3 September, with the Chief Nurse, to finalise plans for the operationalization of services in their new locations. Discussions with renal colleagues are ongoing to determine a deliverable configuration.

Estates continue to identify solutions; a preferred solution for the LRI has now been found. This will be delivered by July 2016. Imaging capacity at the GH will increase via refurbishment of existing estate, as a new build option has been discounted on costs and time delivery. This solution has supported the reduction of costs for the project.

### Vascular

Following approval at the Trust Board in August, construction work is now starting to enable the move of the vascular service from the LRI to GH in April 2016; this development also includes a new hybrid theatre, which will be ready by December next year.

### Consultation

Women's services and Planned Ambulatory Care Hub projects will form part of the Better Care Together public consultation, starting on 30 November. Progress with these business cases is clearly depending on the outcome.

### 2) Estates

The estates workstream has commissioned site surveys across all three sites, which are due in September. This will enable the Trust to confirm the 'as is' state and provide a basis for completing the reconfiguration mapping across the estate and inform the remaining capital business cases. This includes identification of clinical and non-clinical space for potential repatriation.

Over the coming months the workstream will validate the survey with CMGs and ensure all services (clinical/non-clinical/corporate) are captured, and for LGH specifically, all interdependencies between services are known. By November the workstream will be able to confirm the services that are on the LGH and be able to model the residual position once major business cases and the future operating model assumptions have been overlaid. This will ensure all services (that need to be) are captured in the Reconfiguration Programme and inform the modelling/planning work.

A gantt chart of all estates phases, actions and timelines will be presented to the September programme board, and October Trust Board.

A site workstream for the LGH has been establishing, reporting to the programme board, which will work with CMGs to ensure all services and infrastructure are accounted for and all interdependencies are clearly articulated.

## Risks

The top three UHL reconfiguration programme risks, agreed at the August programme board, are as follows:

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

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

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

The risk log is reviewed and updated each month.

# Workstream progress report - September 2015

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

| | Workstream | Executive Lead | Workstream Lead | Objectives | On track (RAG) | Complete (%) | Comments |
|---|---|---|---|---|---|---|---|
| 1 | Clinical Strategy (Models of Care) | Andrew Furlong | Gino DiStefano | To ensure all specialties have models of care for the future which are efficient, modern and achieve the 2 acute site reconfiguration with optimal patient care | **Green** | 10% | Discussions with specialties about how we reshape our services and deliver our clinical strategy are well underway and will continue throughout September and October.<br>Clinical teams are generating practical ideas that will help shrink our acute footprint to support our reconfiguration programme and ensure we become smaller more specialised (overall). |
| 2a | Future Operating Model - Beds (internal) | Richard Mitchell | Simon Barton | To deliver bed reductions through internal efficiencies and achieve a 212 total reduction by 18/19 with a footprint capacity requirement by specialty | **Green** | 65% | Sustained progress with agreed bed closures and reductions in LOS. CMGs developing winter bed plans and bed reduction plans. Next steps include review modelled/non-modelled Beds interventions from Future Operating Model / Models of Care workshops and support work-up of prioritised interventions |
| 2b | Future Operating Model- Beds (out of hospital) | Kate Shields | Helen Seth | To increase community provision to enable out of hospital care and reduce acute activity by 250 beds worth | **Amber** | 50% | Good progress with workforce plan - secondment, rotations and recruitment are all part of the solution to enable initial 65 beds to transfer. Contracutual mechanism to support year one not yet agreed - deadline for sign off, to ensure implementation as per plan, by 31.8.15. |
| 2c | Future Operating Model - Theatres | Richard Mitchell | Simon Barton | To articulate the future footprint for theatres in a 2 acute site model including efficiency gains and left shift | **Amber** | 40% | Unbudgeted WLI usage remains low compaed to same time last year; work ongoing with remaining specialties who are main drivers of unfunded usage; Support to ITAPS in MOC sessions to determine how they can work differently to provide theatres and impact on other CMGs. |
| 2d | Future Operating Model- Outpatients | Richard Mitchell | Simon Barton | To articulate the future capacity requirements for outpatients in a 2 acute site model including efficiency gains and left shift | **Green** | 50% | Continue using work on maximum productivity opportunities to identify next cohort of specialties to undertake cross-cutting CIP process and backlog modelling tool; Review modelled/non-modelled OP interventions from FOM/MOC workshops and support work-up of prioritised interventions. |
| 2e | Future Operating Model- Diagnostics | Kate Shields | Suzanne Khalid | To articulate the future capacity requirements for diagnostics in a 2 acute site model including efficiency gains and left shift | **Amber** | #NAME? | Workstream only recently formed, and producing a charter and PID to inform scope and objectives. |
| 2f | Future Operating model- Workforce | Paul Traynor | Emma Stevens | To design the workforce model for a reconfigured organisation bringing in new roles and modern ways of working, achieving an overall headcount reduction | **Amber** | 20% | **CIP:** Ongoing work to review medical job plans and ward budgets and roster variances; premium pay workstream scoped for implementation. **Reconfiguration**: UHL HR director exploring establishing an overarching workforce confirm and challenge, and dedicated delivery board for overall BCT workforce strategy. |
| 3 | ICU Level 3 | Kate Shields | Chris Green | Safe transfer of level three critical care service, and dependent specialties, from LGH to GH and LRI sites. | **Amber** | 60% | Ongoing work with estates colleagues to identify space and meet all clinical co-adjacencies; interim solution presented to Capital Monitoring Group; operational policies to be finalised; remaining confirm and challenges actions on staffing to be agreed with 3 CMGs. |
| 4 | Reconfiguration business cases | Kate Shields | Nicky Topham | To deliver a £320m capital programme through a series of strategic business cases to reconfigure the estate | **Green** | 40% | Vascular FBCs, including hybrid theatre, approved at Trust Board; project team focusing now on operationalisation of plans on the service. Agreement on interim EMCHC solution; ongoing discussion with service and stakeholders on midwifery led offer as part of BCT consultation. |
| 5 | Estates | Darryn Kerr | Richard Kinnersley | To deliver a £320m capital programme through a programme of work around infrastructure, capital projects, property and maintenance | **Amber** | 20% | Timeline and process approved at programme board for LGH site workstream , with LGH site survey scheduled for completion at end of August. Site specific plans to be completed and reviewed at next programme board. |
| 6 | IM&T | John Clarke | Elizabeth Simons | To enact the IM&T strategy and have a modern and fit for purpose infrastructure which supports the 2 acute site model and community provision strategy | **Amber** | 65% | Ongoing dialogue with DH following referral from TDA of EPR financial business case (not yet approved by DH); commencement of EPR early works (ar risk); plan for EDRM full deployment across Trust by end October. |
| 7 | Finance/ Contracting | Paul Traynor | Paul Gowdridge | To achieve financial sustainability by 18/19 and support reconfiguration of services through effective contracting | **n/a** | n/a | Resource requirements for programme delivery identified/process for approval agreed. Reconfiguration spreadsheet providing overarching accountability of all spend to be prestented at monthly programme board meetings. |
| 8 | Communication & Engagement | Mark Wightman | Rhiannon Pepper | Ensure staff, stakeholders, and public are aware of UHL reconfiguration and are able to contribute and feed into discussions. | **Green** | n/a | Communication issued to staff and key stakeholders on approval of vascular business cases; article in local press on progress with demolition for EF; support to consultation on women's services. Further support to preparing for out of hospital shift in coming month. |
| 9 | Better Care Together | Kate Shields | Helen Seth | Realising the UHL elements of BCT within the organisation through new ways of working/pathways and activity reductions | **Amber** | 35% | Session held with key stakeholders to discuss and agree a compelling narrative for pre-consultation business case. Peer review of all clinical workstream plans by East Midlands Clinical Senate carried out. BCT developing system dashboard, with key metrics, to monitor progress. |

## UHL Reconfiguration Programme Board - 24 August

## Risk log

### Top 10 risks across all workstreams

| Risk ID | Workstream | Risk description | Likelihood (1-5) | Impact (1-5) | Risk severity (RAG)- current month | Risk severity (RAG)- previous month | Raised by | Risk mitigation | RAG post mitigation | Risk Owner | Last updated | Alignment to BAF |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Overall programme | Capital funding not guaranteed for the estimated £330m | 3 | 5 | 15 | 15 | PT | NTDA fully cited on capital programme and in support. Regular meetings with NTDA. ITFF application submitted for emergency floor. OBC and FBCs continue to be implemented as per original plans. | 12 | Paul Traynor | 30-Jul-15 | |
| 2 | Overall programme | Transitional funding required to deliver programme (PMO/business case support/FOM) not available | 4 | 5 | 20 | 20 | EW | Resource requirements identified and process for internal management (ahead of external approval) agreed with central tracking in place. Monthly updates to programme board on costs committed. | 12 | Paul Gowdridge | 30-Jul-15 | |
| 3 | Out of hospital beds | Workforce- Overall staffing numbers required may not be available in the short term to reach the target occupancy level | 4 | 5 | 20 | 20 | HS | Joint workforce plan agreed with LPT for the out of hospital community service. A similar approach will need to be considered project by project | 12 | Helen Seth | 30-Jul-15 | |
| 4 | Internal beds | Unmitigated growth in activity from demand management failure demographic growth exceeding planning | 5 | 5 | 25 | 25 | EMS | Dashboard development being undertaken for LLR Bed reconfiguration group to manage all parts of the system. Escalation process in place to BCT Delivery Board to hold system to account. | 12 | Kate Shields | 30-Jul-15 | |
| 5 | Overall programme | Consultation timelines significantly impact on business case timelines | 4 | 4 | 16 | 16 | RP | Discussions with BCT programme lead on consultation timelines and process, and seeking legal advice on options moving forward. | 12 | Mark Wightman | 30-Jul-15 | |
| 6 | Level three ICU | Current revenue and capital implications may not be affordable and therefore have significant impact on other business cases. | 3 | 4 | 16 | #NAME? | CG | Confirm and challenge, led by medical director and team, of revenue and estate assumptions and impact moving forward. | 12 | Kate Shields | 30-Jul-15 | |
| 7 | Level three ICU | Risk of delivery of out of hospital beds could jeopardise ability to provide additional bed base at Glenfield. | 4 | 5 | 20 | #NAME? | CG | The Executive team are cited on the risk of moving 52 beds of activity from Glenfield site by March 2016 to enable refurbishment works to be completed in line with the July 2016 deadline. This will be delivered through a combination of Out of Hospital shift, internal efficiencies and revisions to the model of care being undertaken on the site. | 12 | Kate Shields | 30-Jul-15 | |
| 8 | Workforce reconfiguration | Workforce plans exceed cost envelope | 4 | 5 | 20 | #NAME? | Finance/Workforce | Robust arrangements for confirm and challenge and clarity about planning 'rules'. | 12 | Relevant project board | 01-Aug-15 | |
| 9 | Capital reconfiguration business case: Emergency floor | EPR will not be available ahead of ED build. | 4 | 4 | 16 | #NAME? | John Clarke | Monitoring plan with NTDA. Ensure timely responses to TDA and DH. Develop plan B to support ED paperless environment. | 9 | JC | 01-Aug-15 | |
| 10 | Internal beds | There is a risk that some bed closures may not be achievable as there are no clear plans for 109 beds worth of demand management where the BCT SOC assumed this would occur. | 5 | 5 | 25 | #NAME? | EMS | Continued monitoring of actual vs. planned activity and clear escalation route through UHL-BCT programme board, LLR Service Bed Reconfiguration board and IFPIC. Risk remains a concern whilst partner plans remain absent and to be formally escalated to LLR Bed Service Reconfiguration group. | 12 | Kate Shields | 15-Aug-15 | |

### Risk Matrix

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