UHL Reconfiguration – update

Author: Ellie Wilkes, Programme Director, Rhiannon Pepper, Programme Manager
Sponsor: Kate Shields, Director of Strategy paper G

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.

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 paper provides the monthly update on Reconfiguration to the Trust Board, employing the Level 1 dashboard to show an overview of the programme status and key risks, with accompanying focus on one workstream each month. This month, the focus is on those major capital reconfiguration business cases that are in delivery phase – Emergency Floor, ICU and vascular projects.

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

Questions

1. Does the report, with dashboard and risk log, provide the Board with sufficient (and appropriate) assurance of the UHL Reconfiguration Programme and its delivery timeline?
2. Is there any specific feedback/suggestions in relation to the major capital reconfiguration business cases that are currently in delivery phase?

Conclusion

1. The report provides a summary overview of the programme governance, an update from a key workstream, 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 27 January 2016.

2. The major projects in delivery, despite constraints of access to capital as previously planned, are moving forward albeit at a slower pace. The Trust is committed to fully implementing the business cases, and will continue to prioritise these projects once capital is secured.

Input Sought

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

For Reference

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

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

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

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

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

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

Scheduled date for the **next paper** on this topic: March 2016 Trust Board

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

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

Update to the Trust Board 4 February 2016

UHL Reconfiguration Programme

1. This update paper provides a brief summary and overview of the current programme status, and is a reflection of the regular monthly updates provided to the Reconfiguration Programme Board. The executive level dashboard (appendix one) and programme risk log (appendix two) are provided; these reflect the integrated governance structure of the programme. It should be noted that the Reconfiguration Programme Board last met on 27 January. Any issues identified at this meeting, not covered in this update paper, will be provided verbally by the Reconfiguration Director at the Trust Board meeting.

2. Work has been ongoing to re-phase the capital plan; the initial rebasing adds 12 months to the final delivery date for completion of the programme. This has been accepted through the Executive Strategy Board (ESB) but as the best case scenario. Once there is more clarity regarding capital availability for 2016/17 and future years, the programme will be reviewed. This is likely to be in March.

Governance update

3. The dashboard at a glance highlights a number of amber areas. These are flagged as such due to some key risks affecting delivery; however, they are being effectively managed and therefore, at this time, are not deemed to be showstoppers. The RAG is based on progress against delivery, and the % complete gives an indication of overall progress against in year plan, based on the workstream view of progress against individual project milestones.

4. The programme risk log has been updated to ensure the risks are recorded in the right place and attributed to the right people, and accurately reflect the impact on delivery of the programme. To make the register 'live', a 'by when' column has been added to ensure risks are regularly reviewed and mitigations enacted. The top programme risks are aligned with, and reflected in, the Trust's Board Assurance Framework (BAF).

5. A Programme Implementation Document, providing a more detailed overview on the programme in implementation phase, including, governance, current state and how it is supporting delivery of the UHL five year plan, will be presented to ESB in February.

6. The recent Trust Board Thinking Day focused on the reconfiguration programme and how the Trust continues to support delivery of the plan with the current issues facing it – demand management and limited capital availability. A number of key actions came from the session, including:
    - The need to update the Trust narrative to clearly articulate our intention to reduce our acute footprint and increase our provision of specialised services in a meaningful way to reflect the different types of activity: planned/ambulatory; emergency/medicine; and tertiary
    - A need to look at the future health needs of the population with Public Health colleagues
    - Agree priority workstreams aligned with key Trust 'business' areas to maintain progress with reconfiguration, for example, focus on services for frail, elderly patients
    - Looking at alternative sources of funding.

7. Following the departure of the current reconfiguration director from the Trust, interim arrangements are in place to focus on monitoring and tracking progress as the plan moves into year three.

Programme risks

8. The top three UHL reconfiguration programme risks to delivery this month remain as:

Risk: BCT SOC assumed 571 bed closures, 109 of which were predicated on demand management. 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, which has significant impact on delivery of overall plan.

Mitigation: Demand management will need to be reconsidered. Vehicles for delivery are UHL's MOC strategy and the Vanguard MOC. More focus needed on reducing patients admitted four times or more and on readmissions as well.

Action required: Trust Board to discuss and consider additional mitigations**.**

Risk: Capital funding not guaranteed for the estimated £330m, and will affect 3 to 2 site strategy if not secured. Notification received from Department of Health that national capital availability is limited and impact on UHL not yet known.

Mitigation: Limited capital available until end of March 2016. Unclear on implications for 2016/17 as yet; re-phasing plan is ongoing. OBC and FBCs continue to be implemented as per original plans. Options for alternative options of funding are being reviewed.

Action required: For noting

Risk: Consultation timelines significantly impact on business case timelines, and ability to achieve 19/20 target for our preferred option of moving off the General site. Particular impact on planned ambulatory care hub and women's projects moving forward.

Mitigation: Impact of consultation incorporated into refreshed business case timeline. Business cases continue to progress as per plan. Consultation now delayed to late Spring 2016; change control process enacted for capital projects, all reviewed at reconfiguration board.

Action required: For noting

The risk log is reviewed and updated each month.

Workstream update

9. Each month a reconfiguration workstream is selected for inclusion with more detail provided on the current status, progress and any issues. Those selected are 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. There will be the opportunity for all workstreams to be considered.

10. This month, the focus is on providing an update to the Trust Board on the major capital reconfiguration business cases that are in delivery phase.

Recommendation

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.

11. **Workstream update – Major capital reconfiguration business cases (in delivery)**

Following approval of full business cases at the Trust Board, a number of capital projects are in delivery phase as part of the wider reconfiguration plan to move from three to two acute sites and to provide clinically sustainable configuration of services, operating from excellent facilities.

Those projects are:

Vascular relocation from Royal Infirmary to Glenfield: Approved by Trust Board August 2015
The completion of construction for the ward, angiography suite and Vascular Studies Unit has now shifted from 29 April 2016 to 1 August 2016, and the hybrid theatre from December 2016 to February 2017 following the delay in access to capital funding for 15/16. The clinical teams have been fully involved with planned the revised timescales to mitigate any risks.

The operational commissioning programme is now being amended on this basis and will be taken to the February Vascular Project Board for comment and approval.

Moving vascular services is a key enabler to the level three ICY project, and the first move towards reconfiguration of services. There are interdependencies between the vascular and ICU service moves which are being worked through and will need aligning with the revised construction timescales – this includes access to emergency theatre sessions, middle grade doctor rotas and junior doctor rotas.

Top risk: There is currently no agreement of solution for Junior Dr interim solution and final solution linking with ICU service moves. This has been escalated through the CMG and to the project board for resolution.

Level three ICU and dependent specialty moves from Leicester General:

Capital constraints have seen an inability for the project to progress as planned from an Estates perspective in recent weeks. The design sign off for the imaging area at Glenfield is progressing however, and design work on the medical records and office space enablers has started. Both elements are key to maintaining the critical path. The revised timescales currently stand at December 2016.

Work has focused, alongside the vascular project, on determining the revised programme timeframe and the impact of this on delivery of the project. Once the revised timescale is known, detailed planning around the moves is required to finalise operational solutions to Theatre and bed capacity issues.

Site based working groups have been established and will act as the vehicle for operational planning moving forward. The final operational issues around junior doctor cover at Leicester General and Glenfield are to be solved in February.

Top risk: 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. New models of care, as well as a feasibility study for additional bed space at GGH, are being explored to ensure that these beds are free by March 2016.

Emergency Floor:

Following release of funding, construction of the new building continues, with the steel frames recently being erected on site.

Operational policies, detailing how services will operate in the new department, are on track for completion with a plan in place to support this. In addition, a draft commissioning plan is in place that includes the technical, procurement and equipment elements; this will be brought together into an all-encompassing commissioning strategy for the emergency floor.

Further activities are ongoing to review the workforce requirements of the emergency floor, alongside a programme for ensuring clinical input into outstanding design elements for the Emergency Decisions Unit, Emergency Frailty Unit, and Acute Frailty Unit in phase two of the construction.

The IT solution for the emergency floor is a risk; clinical workshops will be held to progress a solution for Plan B that will be useable in the new building.

Top risk: Activity increases beyond business case and commissioning assumptions impacting on workforce and shortfall in savings anticipated within the full business case. Activity and workforce assumptions are being revisited, with the Chief Nurse to review nursing assumptions.

Workstream progress report - January 2016

	This month	Last month	Comments
Overall programme progress	**Amber**	**Green**	Programme Implementation Document being developed for ESB in February. Interim PMO arrangements in place following departure of reconfiguration director. Action plan in place following Trust Board January Thinking Day to strengthen programme approach.

*On track against delivery - Progress against delivery. Red = Planned timeline is unlikely to be achieved, Amber = current timeline is at risk of not being achieved but mitigations in place, Green = planned timeline expected to be met or exceeded

** Completion % against in year plan is based on workstream view of milestones within project highlight report.

	Workstream	Executive Lead	Operational Lead	Objectives	On track against delivery (RAG)*	Complete (%) against in year plan**	Brief update on status
1	Clinical Strategy (Models of Care)	Andrew Furlong	Gino DiStefano	To ensure all specialties have models of care for the future which are efficient, modern and achieve the 2 acute site reconfiguration with optimal patient care	**Amber**	40%	CMG modelling not completed as planned to inform 2nd cut of FOM so issue escalated to medical director. Plan in place to commission peer review of planned models of care by Public Health, and letters to be sent to Heads of Service and Clinical Directors outlining what they need to do, including articulation of their clinical visions and future model of care.
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	**Amber**	70%	Agreed bed right sizing methodology including growth and impact of interventions for FY 16/17 and prepared the initial cut for validation; Revised bed challenge for LGH based on latest data and progress on Model of care and future operating model work. Further work to do a refresh of FOM tool to reflect new set of assumptions for implementation of interventions and growth.
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**	40%	Additional 8 ICS beds opened on 11/01, taking total number of ICS beds to 166, 40 of which are new; Ongoing work to ensure ICS capacity being used effectively; in-reach team in place, gold command meetings, discussions with clinicians through Operational Group; contract variations remain unsigned - UHL contract variation to be escalated; actions sit with CCGs but limited progress made.
2c	Future Operating Model - Theatres	Richard Mitchell	Simon Barton	To deliver in year CIP and to articulate the future footprint for theatres in a 2 acute site model including efficiency gains and left shift	**Green**	60%	Ongoing support to improve in session utilisation which will result in additional income for the trust or a shrinkage in theatres footprint- theatre walk throughs, pathway reviews to diagnose problems and progression of owned action plan between CMGs continue. Work ongoing with ITAPs to model impact of other specialities models of care implications on theatres, and to finalise work to determine number of sessions required to deliver 16/17 activity.
2d	Future Operating Model- Outpatients	Richard Mitchell	Simon Barton	To deliver in year CIP and to articulate the future capacity requirements for outpatients in a 2 acute site model including efficiency gains and left shift	**Green**	60%	Streamlining of current process to produce OP dashboard to reduce data errors and therefore increase accuracy; future work to focus on delivery of a data cleansing session for OP with robust actions, timelines and accountability to ensure correct recording of OP data for performance reporting and opportunity estimation in future. Work needed to kick start models of care across the organisation.
2e	Future Operating Model- Diagnostics	Kate Shields		To articulate the future capacity requirements for diagnostics in a 2 acute site model including efficiency gains and left shift	**N/A**	5%	Diagnostics cross-cutting workstream aligned to capital business cases being set up to ensure Trust wide perspective of diagnostics in the coming years. Suzanne Khalid, Clinical Director for CSI, to lead.
2f	Future Operating model- Workforce	Louise Tibbert/Paul Traynor	Richard Ansell; Louise Gallagher	To design the workforce model for a reconfigured organisation bringing in new roles and modern ways of working, achieving an overall headcount reduction	**Amber**	40%	Ongoing support to CMGs to complete medical and nursing job plans (CIP). ED workforce plans to be agreed to inform finance, OD and IT planning. First cut of complete operational plans to be submitted to TDA incorporating detailed workforce plans for 16/17 , which will inform all of the longer term planning across the FOM. OD plan/support to business case defined.
3	ICU Level 3 business case	Kate Shields	Chris Green	Safe transfer of level three critical care service, and dependent specialties, from LGH to GH and LRI sites.	**Amber**	70%	Work underway (alongside Vascular project) to determine revised programme timeframe (due to capital availability) and any effects; First meeting of site based working groups, who will act as the vehicle for operational planning; Progression of solution to re-house offices and on-call rooms to progress; Final operational issues to be solved around Junior Doctor cover at LGH/GH
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	**Amber**	50%	**Emergency Floor** - draft commissioning policy developed; **Women's** - continued development of models of care and associated activity levels as well as continued review of information concerning women's services for BCT Pre-Consultation Business Case; **Planned Ambulatory Care Hub**: Individual meetings planned with services to confirm models of care, baseline activity to be provided by informatics department; **EMCHC** - mobilisation of contractor to begin for interim works.
5	Estates	Darryn Kerr	Mike Webster	To deliver a £320m capital programme through a programme of work around infrastructure, capital projects, property and maintenance	**Amber**	30%	Work concluded on office space surveys at LGH, and now starting at LRI; Space Management Team to set out a clear programme of vacated space and recommendations for its re-use in line with the Space Allocation and Space Utilisation Policies and the Estates Strategy . Route map near completion, and will go to ESB In February. Refresh of estates strategy by April.
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**	40%	Ongoing meetings with TDA to discuss funding and approvals mechanism for EPR system; EDRM for Adults deferred to 16/17 subject to capital and outcome of the Paeds EDRM project; Project manager appointed to look at Plan B for EPR (particularly for emergency floor), with timetable for next steps due in January.
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	Continuation of work to fully understand the implications of the re-phasing and how any capital funding will be used post April.
8	LGH Rationalisation	Darryn Kerr	Jane Edyvean	To review and rationalise services at LGH to deliver UHL clinical and estate strategies and wider 3 to 2 Trust vision.	**Green**	25%	Service moves where, when complete and being validated by Heads of Ops. Wiring diagram of moves and changes to be presented to February ESB; workshop to be held in February; options appraisal due in April.
9	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	**General**: Network of Know-it-alls briefings continue to be issued; **Women's** - mini comms plans developed and presented to BCT comms team meeting for feedback; **MSCP -** Planning for official opening of new cark; **Programme** - update communications plan for 16/17.
10	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**	40%	Programme 'wicked issues' - To add further depth to impact assessments already undertaken, health and social care clinicians, commissioners and providers are engaged in evidence-based discussions on the programme's most challenging aspects which include the impact on primary care and on social care, plus how to best deal with increasing demand.

Note: The RAG and % complete is based on workstream lead evaluation and detail provided in highlight reports.

UHL Reconfiguration Programme Board - January 2016

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	By when?	Risk Owner	Last updated	Alignment to BAF
1	Internal beds	BCT SOC assumed 571 bed closures, 109 of which were predicated on demand management. 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, which has significant impact on delivery of overall plan.	5	5	**25**	**20**	EMS	Demand management will need to be reconsidered. Vehicles for delivery are UHL's MOC strategy and the Vanguard MOC. More focus needed on reducing patients admitted 4 times or more and on readmissions as well. Escalation re demand management through BCT Delivery Board. **ACTION**: Need response from BCT re next steps.	**16**	Jan-16	Kate Shields	21-Dec-15	
2	Overall programme	Capital funding not guaranteed for the estimated £330m, and will affect 3 to 2 site strategy if not secured. National capital availability at risk and impact known for 15/16 but not yet for future years.	4	5	**20**	**15**	PT	Limited capital available until end of March 2016, has been modelled and timelines for delivery being rephased. Scenarios for future years discussed at ESB in January. Options for alternative sources of funding are being reviewed. Delivery of ICU and vascular business cases delayed until April 2016.	**20**	N/A	Paul Traynor	21-Dec-15	
3	Overall programme	Consultation timelines significantly impact on business case timelines, and ability to achieve 19/20 target for moving off the General site. Particular impact on PACH and women's projects.	4	4	**16**	**16**	RP	Discussions with BCT programme lead on consultation timelines and process, and seeking legal advice on options moving forward. Consultation now delayed to Spring 2016; change control process enacted for capital projects, all reviewed at reconfiguration board in December and approved; potential delay of between 4-6 months.	**12**	Feb-16	Mark Wightman	26-Nov-15	
4	Overall programme	Operational delivery/pressures may be negatively impacted by requirements of reconfiguration i.e., operational resource/input, space.	3	5	**15**	**15**	RM	Each FOM workstream has a dashboard where operational risks are identified. Operational representation on the programme board and business case meeting to ensure strategy and operations better align and issues addressed early.	**12**	Feb-16	Simon Barton	24-Sep-15	
5	Level three ICU	Risk of non- delivery of out of hospital beds capacity could jeopardise ability to provide additional bed base at Glenfield, which is required to relocate HPB.	4	5	**20**	**20**	CG	There is a 'change team' now in place at Glenfield to develop new models of care; work underway includes a combination of Out of Hospital shift, internal efficiencies and exploration of out reach provisions. Feasibility study into additional ward space also being carried out.	**12**	Feb-16	Kate Shields	26-Nov-15	
6	Capital reconfiguration business case: Emergency floor	EPR will not be available ahead of ED build which impacts on required space estimated within business case, and therefore has cost implications.	4	4	**16**	**16**	John Clarke	Monitoring plan with NTDA. Ensure timely responses to TDA and DH. John Clarke developing plan B to support ED paperless environment, update due in January.	**12**	Overdue	John Clarke	22-Dec-15	
7	Out of hospital beds	UHL not fully utilising available capacity through the opening of ICS beds (now 32).	3	4	**12**	**20**	HS	Dashboard created to monitor utilisation of increased capacity. Oversight group in place to oversee usage. Comms plan in place to raise awareness of service. Utilisation currently at 90.1%.	**9**	Feb-16	Helen Seth	15-Dec-15	
8	Overall programme	There is not enough capacity in the system to create headroom to fully implement reconfiguration plans and cope with winter pressures and increased demand.	4	4	**16**	**16**	EW	Feasibility study on additional ward space at Glenfield being carried out; clinical change team in place at GH reviewing patients suitable to be looked after in the community; additional ICS beds open.	**9**	Jan-16	Kate Shields	15-Dec-15	
9	Workforce reconfiguration	Culture of organisation needs to embrace reconfiguration and recognise need to do things differently. This has not been addressed previously and OD programme not yet in place.	3	4	**12**	**15**	KS	Director of HR and Workforce reconfiguration sits on programme board and is developing a proposal for Trust wide OD. Draft plans aligned to all business cases being developed, and will align with UHL way (launch 3/12). OD resource for business cases being secured.	**9**	N/A	Louise Tibbert	26-Nov-15	
10	Overall programme	Ongoing transitional funding required to deliver programme beyond 15/16 will need to be secured to ensure ongoing delivery. In year resource requirements identified and on track but future years at risk in connection with limited capital.	3	4	**12**	**15**	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. Resource requirements will be reprofiled once rephasing of capital plan finalised.	**9**	Jan-16	Paul Gowdridge	28-Oct-15	