STP, BCT and UHL Reconfiguration – Update

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Executive Summary

Context

In order to provide a vision for transformation across the whole health economy, this paper provides an update on the LLR Sustainability and Transformation Plan (STP)/Better Care Together (BCT) Programme and the development of UHL's Operational Plan for 2017/18 – 2018/19, which sets the context for UHL's Reconfiguration Programme.

The LLR STP describes how the local health and social care system plans to restore financial balance by 2020/21 through new ways of working. The STP builds on the work developed as part of the BCT programme but with clearer focus on implementing system priorities. Crucially, it makes our case for national/external capital investment and access to transformational funding to support our reconfiguration programme. The latest version of the STP was submitted to NHS England on Friday 21st October 2016, with feedback now received from NHS England and NHS Improvement.

Our Reconfiguration Programme is an ambitious and complex undertaking which has been established in order to deliver the broader system priorities within the STP, the Trust's strategic direction and clinical strategy. It is important that the Trust Board has visibility of progress in delivering the STP, since the assumptions on transformation in the STP underpins the reconfiguration programme, and is able to provide appropriate challenge, to ensure there is sufficient assurance associated with activities undertaken to achieve the desired future state.

The Reconfiguration Programme is currently working through a number of key issues that will enable the development of a re-phased programme plan. These include: the impact of revised demand and capacity planning in a refreshed STP to reflect the Operational Plan for 2017/18 – 2018/19; public consultation and the anticipated availability of capital funding. The re-phased programme plan will provide the Board with a forward view of activities being planned and timescales for delivery. It is anticipated that the re-phased programme plan will be available in early 2017/18.

Questions

1. Does this report provide the Trust Board with sufficient and appropriate assurance of the UHL Reconfiguration Programme, its links to the STP and 2017/18 – 2018/19 Operational Plan, the delivery timeline and management of risks?

Conclusion

1. This report provides an overview of the STP, 2017/18 – 2018/19 Operational Plan and Reconfiguration Programme, an update on the programme plan and programme risks for escalation. Please note that due to the imminent opening of Phase 1, the update on the Emergency Floor Project is now submitted as a separate paper.

Input Sought

The Trust Board is requested to:

- **Note** the progress within the Reconfiguration Programme and the planned work over the coming months.

For Reference

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

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

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

Organisational Risk Register	[N/A]
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 at this stage]

Scheduled date for the **next paper** on this topic: [Thursday 6th April 2017]

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

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

Sustainability and Transformation Plan (STP) and 2017/18 – 2018/19 Operational Plan

1. We have now received feedback on our STP from NHS England and NHS Improvement. Both NHSE and NHSI continue to support the strategy and plans set out in our STP, which they note involves ambitious plans for a left shift of activity and proposals to reduce the number of acute sites from three to two.

2. However, before they can provide the necessary assurance prior to formal consultation and approve capital business cases, a number of questions have been raised about our demand and capacity assumptions. In particular, we have been asked to provide more information about the new/alternative services described in our STP that will see more people cared for and supported in the community (instead of traditional hospital services).

3. A meeting between LLR STP leads and NHSE and NHSI is scheduled for the end of February to discuss our plans further.

4. Ahead of this discussion, we have been working with STP work-stream leads (and the STP PMO) in revisiting/reaffirming our key planning assumptions, including the likely impact of new/ extended services on hospital activity (i.e. integrated community teams) and the timing of any associated benefits, as well as a broader assessment of 'readiness'. This, in turn, is helping frame – locally – a discussion about key priorities and resourcing requirements so that programmes of work are appropriately supported. This includes the bolstering of the STP PMO, the appointment of a Programme Director and clarity around the way partner organisations engage and support delivery on the ground.

5. In addition to the meeting in February, a joint NHSE and NHSI Stocktake will be held over the next 4-6 weeks with all 5 STPs across Central Midlands. Focus will be on ensuring systems are delivering early gains in relation to key priorities outlined within our October submission. We will also be asked to articulate what support we need to move our plans forward i.e. capital, non-recurrent transformation funding etc.

Reconfiguration Programme

Availability of Capital

6. The Trust is still waiting to hear whether capital will be made available to progress the reconfiguration programme as currently planned. It is hoped that this will be articulated in the next few weeks.

7. The Reconfiguration SRO and Reconfiguration Programme Director have met with the Medical Director to discuss the impact that no additional funding is forthcoming. It was agreed that regardless of the availability of capital, the clinical strategy to move to 2 acute sites is still the only option that creates a clinically sustainable future. It was agreed that no further work would be undertaken on a 'no external funding scenario' until such a time that it is necessary.

Alignment of the STP, Operational Plan, Pre-Consultation Business Case (PCBC), Development Control Plan (DCP) and Strategic Outline Case (SOC)

8. The Estates team have almost completed the second phase of the DCP refresh. Discussion and work is on-going to mitigate a significant capital pressure; which will result in a further phase in the DCP refresh programme. The outcome of this may change the fine detail on the reconfiguration programme in the STP.

9. A three-day workshop was held 20th – 22nd February for the wider reconfiguration team (including project managers, the Trust's cost advisor, and representatives from estates, finance and workforce) and senior members of the medical and nursing team to spend dedicated time reviewing the outputs of the DCP refresh, to assess and mitigate the capital pressure and to agree next steps and priority areas of work. The objectives were to:

    - Review how to reduce the capital required to move from 3 to 2 acute sites
    - Reassess how many beds can be accommodated in the retained estate at the LRI & GH
    - Review the assumptions around PF2

10. A number of actions were agreed at the end of the workshop and members of the reconfiguration team will work to complete these within the next few weeks. This information will inform the next phase of the DCP refresh, which will include an indicative programme plan detailing the phasing of projects and their individual budgets.

11. Advice from NHS Improvement to date advises that the Reconfiguration Programme Strategic Outline Case cannot be submitted to NHS Improvement for approval without the inclusion of the Pre Consultation Business Case and the outcome of consultation. Therefore, the delay to the DCP refresh and the requirement for a further phase in the DCP refresh programme is not material, but maybe needed for the next iteration of the STP.

12. To summarise, there are a number of things that need to happen before we are in a position to submit our SOC, including:

    - Confirmation of the availability of capital
    - Alignment of STP to Operating Plan & DCP
    - Alignment of PCBC to STP & Operating Plan
    - Completion of Consultation

Reconfiguration Programme Planning for 2017/18 and Future Years

13. The Reconfiguration Programme needs to be updated to reflect the STP, the availability of external capital, and the refreshed DCP (including phasing of projects).

14. Due to Trust cost pressures during 2016/17, a request was received from CMIC to review essential expenditure for the remainder of 2016/17 and reduce expenditure wherever possible. It is likely some expenditure can be delayed until the start of 2017/18; however, doing so will result in a pre-commitment against the capital plan for 2017/18. Further detail will be included in our paper to the Trust Board meeting in April 2017.

Private Finance 2 (PF2)

15. PWC and Nicky Topham attended the Trust Board Thinking Day on 10th February 2017 to discuss PF2 as an alternative route of external funding to support the reconfiguration programme. It is clear that including any refurbishment in the current estate as part of a PF2 scheme would not be supported owing to the cost impact for transferring risk. The DCP refresh is taking account of this information.

16. Brian Saunders from the PFI & Transactions Team (formerly the Private Finance Unit - part of the Department of Health) and representatives from the Treasury will visit to UHL on March 20th 2017 to gain further understanding of our reconfiguration programme and the potential to use PF2 as a procurement route for some of our projects. It is hoped that Non-Executive Directors will be engaged in this visit. An update will be provided to the April 2017 Trust Board.

Competing Pressures for Beds at LRI

17. Due to the move of Vascular from the LRI to the GH and the Emergency Floor Project, a number of wards are due to become available at the LRI in the future:

Ward	Reason Available	Date Available	Notes
21 (L6 Balmoral)	Vascular moves to Glenfield	May 2017	
7 (L3 Balmoral)	Temporary use for EDU & Winter Pressures	April 2018	
15 (L5 Balmoral)	Phase 2 of Emergency Floor	April 2018	4-month delay from original programme
16 (L5 Balmoral)	Phase 2 of Emergency Floor	April 2018	4-month delay from original programme
33 (L5 Windsor)	Phase 2 of Emergency Floor	April 2018	4-month delay from original programme

18. Owing to the fact that the demand has continued to increase, and that the bed bridge in the STP has yet to come to fruition, there are conflicting pressures on the available ward space, including:

    - the move of EMCHC from the GH to co-locate with other paediatric services (requirement for 4 wards of space)
    - the move of General Surgery from the LGH as part of the Interim ICU move (requirement of 2 wards of space)
    - medical bed capacity

19. This bed pressure and the potential competing priorities were flagged and recognised at the February ESB and Reconfiguration Board, and will be discussed further when the final STP bed bridge is confirmed.

Governance & Reporting

20. A piece of work has been carried out to strengthen the governance arrangements for financial reporting within projects, which also includes a proposal for the level of expenditure a project manager can authorise without seeking additional approval. Following discussion at the Reconfiguration Programme Board in February 2017, the proposal requires altering and expanding to include the level of expenditure the SRO/Project Board can authorise without seeking additional approval. This will be reporting back to the Trust Board in April 2017.

21. The table below outlines some key decisions which will be made by the Executive Strategy Board over the coming months:

Work-stream / Project	Decision	Current deadline	Comment
Clinical Services Strategy	Sign-off of scope and deliverables for Model of Care (or associated) work-stream(s):	~~October ESB~~ ~~December ESB~~ March ESB	Agreement that Gino DiStefano will develop a clinically led process for engaging clinical services on new ways of working (that improve quality and support reconfiguration) that accounts for previous learning and emerging STP governance arrangements.
Estates / Programme	Phase 2 Estates Strategy re-fresh including DCPs, realignment of project costs and programme plan.	~~December ESB~~ ~~January ESB~~ ~~February ESB~~ ~~March ESB~~ April ESB	DCP completion has been delayed due to the requirement for a cost validation exercise and realignment of STP to the Operational Plan.

Work-stream / Project	Decision	Current deadline	Comment
ICU / Beds	Agreement of the status of the interim ICU scheme. Decision on preferred option for Glenfield capacity creation.	~~December ESB~~ ~~January ESB~~ ~~February ESB~~ April ESB	Outcome of DCP required in order to inform work, decision to be made and reported following completion of DCP refresh.

Programme Risks

22. Alex Morrell has undertaken a review of the risk management process within Reconfiguration, liaising with Richard Manton. A report summarising the outcome of the review and the proposed changes to risk management within the Reconfiguration Programme was discussed at the Reconfiguration Programme Board in February. Paul Traynor requested that the report is updated following a further review and validation of the scoring guidance for financial consequences. This will be reporting back to the Trust Board in April 2017.

23. The programme risk register is included at Appendix 1. This was reviewed and updated at the Reconfiguration Programme Team meeting on 7th February 2017.

24. Each month, we report in this paper on risks which satisfy the following criteria:
    - New risks rated 16 or above
    - Existing risks which have increased to a rating of 16 or above
    - Any risks which have become issues
    - Any risks/issues which require escalation and discussion

25. Following the review of the risk register, there are two risks rated 16 or above:

Risk	Current RAG	Mitigation
There is a risk that delays to consultation or the external approvals process delay business case development timescales.	**20**	Engagement with NHSI, Taunton and the DH to discuss and agree the process for delivery of the SOC. Women's and PACH (which are wholly dependent on consultation) will be progressed through PF2 procurement which will require a more robust OBC than through other procurement processes so delay to consultation is less likely to cause a material impact.
There is a risk that the external work required to enable UHL bed reductions as per the STP is not delivered to its full extent.	**20**	DCP to align with up-to-date bed reductions. Governance over STP delivery. Monitored through Beds Project Board. Monitored via Interdependency Chart at Reconfiguration Programme Board Monitored by the Reconfiguration team to determine extent of deviation from planned reductions. Changes to BCT/STP management including introduction of accountable offices and SROs. Action plans to deliver bed reductions. Development of communications plan with CMGs.

26. There are three additional risks rated 20:

Risk	Current RAG	Mitigation
There is a risk that capital funding is not available when it is required to maintain the reconfiguration programme.	**20**	Robust plans and programmes in place. Engagement with DH and Treasury.
(BAF Risk 13) There is a risk that the limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations	**20**	Holding projects to their scope, budgets and programmes – value engineering where required. DCP refresh will inform delivery strategy.

Risk	Current RAG	Mitigation
There is a risk that the complex internal dependencies between reconfiguration projects are not delivered in the required timescales.	**20**	Interdependencies monitored by the Reconfiguration Board via the Interdependencies Chart.

Input Sought

The Trust Board is requested to **note** the progress within the Reconfiguration Programme and the planned work over the coming months.

Reconfiguration Programme Risk Register

V2 07/02/17

	Risk Category	RISK	CAUSES	CONSEQUENCES	Likeli-hood	Conse-quence	Current RAG	Previous RAG	Date Added	Risk Mitigations	Target Likeli-hood	Target Conse-quence	Target RAG	Risk Owner	Date for Review	Last updated	Issue	Risk Status	Date Closed
C1	Consultation	There is a risk that the outcome of consultation is not aligned to our clinical strategy.	Public are unhappy with UHL's preferred option.	Impact on programme for 3 to 2 site strategy, Women's and PACH projects and therefore reconfiguration programme as a whole.	3	5	15	15	25/10/2016	Ensure there is thorough clinical case for change. Public engagement (including pre-engagement), ensuring that strong reasoning and detailed plans are communicated. Work with STP PMO	2	5	**10**	Mark Wightman	11/04/2017	07/02/2017	No	Open	n/a
DC1	Demand & Capacity / STP	There is a risk that the external work required to enable UHL bed reductions as per the STP is not delivered to its full extent.	The level of detail in the plan is variable, therefore some bed closures may be significantly more challenging than others. Demand may rise at a level over and above that planned for in the STP, which prevents the planned bed reductions.	Failure to downsize in total, or in line with phasing requirements, as required to achieve the 3 to 2 site strategy.	4	5	20	16	25/10/2016	Expectation management via Reconfiguration Programme Board. DCP to align with up-to-date bed reductions. Governance over STP delivery. Monitored through Beds Project Board. Monitored via Interdepedency Chart at Reconfiguration Programme Board Monitored by the Reconfiguration team to determine extent of deviation from planned reductions. Changes to BCT/STP management including introduction of accountable offices and SRO's. Action plans to deliver bed reductions. Development of comms plan with CMG's.	2	5	**10**	Richard Mitchell	11/04/2017	07/02/2017	No	Open	n/a
DC2	Demand & Capacity / STP	There is a risk that the internal transformation plans for bed reductions as per the STP are not delivered to its full extent.	Demand may rise at a level over and above that planned for in the STP, which prevents the planned bed reductions.	Failure to downsize in total, or in line with phasing requirements, as required to achieve the 3 to 2 site strategy. Desire to reduce the bed occupancy to ensure capacity to meet winter pressures is not achievable.	3	5	15	9	25/10/2016	Expectation management via Reconfiguration Programme Board. DCP to align with up-to-date bed reductions. Governance over STP delivery. Monitored through Beds Project Board. Monitored via Interdepedency Chart at Reconfiguration Programme Board. Monitored by the Reconfiguration team to determine extent of deviation from planned reductions. Changes to BCT/STP management including introduction of accountable offices and SRO's. Action plans to deliver bed reductions. Development of comms plan with CMG's.	2	5	**10**	Simon Barton	11/04/2017	07/02/2017	No	Open	n/a
DC3	Demand & Capacity / STP	There is a risk that the bed reductions are not realised in the specialties/site that are required.	The level of detail in the plan is variable, therefore some bed closures may be significantly more challenging than others. Demand may rise at a level over and above that planned for in the STP, which prevents the planned bed reductions.	Delivery of Clinical Strategy is not achievable (clinical adjacencies)	4	4	16	12	25/10/2016	Thorough engagement process and CMG ownership of plans once bed reductions by specialty are confirmed as robust. Reviewing trajectory of bed reductions in STP to reflect the agreed operaitonal plan and the identified programmes within each STP workstream. Stong clinical leadership and OD will be required to enable change - delivery of the agreed plan without deviating from assumptions.	2	3	**6**	Richard Mitchell	11/04/2017	07/02/2017	No	Open	n/a
E1	Estates	(BAF Risk 12) There is a risk that the existing estates infrastructure capacity may adversely affect major estates reconfiguration.	The scope of the reconfiguration programme is such that it has requirements over and above the existing site infrastructure.	The reconfiguration programme is not deliverable in its entirety whilst remaining within an affordable capital envelope.	4	4	16	NEW	15/02/2017	Reconfiguration investment programme demands linked to current infrastructure. Estates work stream to support reconfiguration established. Five year capital plan and individual capital business cases identified to support reconfiguration	3	4	**12**	Darryn Kerr	11/04/2017	07/02/2017	No	Open	n/a
F1	Finance	There is a risk that capital funding required for the reconfiguration programme to continue as scheduled (£300.1m) is not available when it is required	Lack of capital availability nationally, and is unknown for 2016/2017 or subsequent years. PF2 funding process is not well tested (new for UHL). Capital receipts not realised.	Reconfiguration Programme delay. 3 to 2 site strategy will be affected if capital not secured indefinitely. Sequencing of moves at risk. Interdependencies / phasing impacted.	4	5	20	20	25/10/2016	2016/17 - Mitigated by reduction in capital spend and slowed progress in delivery of projects. 2017/18 - Capital programme plan recognises different scenarios. Robust project management and programmes in place. Engagement with DH, Treasury and PF2 advisors.	3	5	**15**	Paul Traynor	11/04/2017	07/02/2017	Yes	Open	n/a
F2	Finance	(BAF Risk 13) There is a risk that the reconfiguration programme is not deliverable for the agreed capital envelope	The assumptions used in initial calculations in 2014 were high level. Recent DCP work indicates pressure on the budget following a robust activity profile in the STP	3 to 2 site strategy is not affordable.	4	5	20	20	25/10/2016	DCP refresh, delivery strategy Holding projects to their scope, budgets and programme - value engineering where necessary Reviewing scope of PF2	2	5	**10**	Darryn Kerr / Nicky Topham	11/04/2017	07/02/2017	No	Open	n/a
P1	Programme	There is a risk that delays to consultation or the external approvals process delay business case development timescales.	Delays to consultation (caused by wider system delays or referral to the IRP) or delays to business case approval.	Sequencing of moves at risk. Interdependencies / phasing impacted. Programme as a whole delayed.	4	5	20	15	25/10/2016	Engagement with NHSI, Taunton and the DH to discuss and agree the process for delivery of the SOC. Effective programme management Women's and PACH (which are wholly dependent on consultation) will be progressed through PF2 procurement which will require a more robust OBC than through other procurement processes so delay to consultation is less likely to cause a material impact.	2	5	**10**	Nicky Topham	11/04/2017	07/02/2017	No	Open	n/a

Reconfiguration Programme Risk Register

V2 07/02/17

R1	Reconfiguration	There is a risk that the complex internal dependencies between reconfiguration projects are not delivered in the required timescales	Lack of capital availability means that business cases are not approved in a timely manner, and once approved, capital may not be forthcoming.	Delays to individual projects and/or the programme as a whole. Revenue consequences via double running etc.	4	5	20	20	25/10/2016	Monitoring by the Reconfiguration Programme Board via the interdependencies chart. Clinical services will not be moved until all services on which they are dependent are available with appropriate capacity. Engagement with NHSI, Taunton and the DH in order to ensure they are aware of the reconfiguration programme, the timescale, interdependencies and funding requirements.	2	5	**15**	Nicky Topham	11/04/2017	07/02/2017	No	Open	n/a
R2	Reconfiguration	There is a risk that there are not enough resources to develop the business cases to support the programme in line with required timescales on the basis that business case development must be funded from CRL	Lack of capital available for resources. It is very expensive to deliver a PF2 business case.	Delays to delivery of approved business case with consequential impact of programme delay	4	4	16	16	25/10/2016	Prioritise resources against those projects that need to deliver early in the programme and against those being procured through PF2.	3	4	**12**	Nicky Topham	11/04/2017	07/02/2017	No	Open	n/a
R3	Reconfiguration	There is a risk that there are not enough clinical resources to support the reconfiguration programme	Operational pressures mean that clinical teams do not have the time to commit to the programme. Lack of capital resources to support clinical backfill.	Delay to reconfiguration programme, lack of ownership, impact on quality of the deliverable, processes impacted	4	4	16	NEW	07/02/2017	Changing organisational culture to ensure strategy, reconfiguration and transformation is part of "day job Advanced notice of meetings. Early communication with CMG's to identify and negotiate clinical input required in future projects. Clinical leaders will share lessons with other clinical leaders to ensure lessons are learnt between projects. Identification of capital for clinical backfill.	2	4	**8**	Nicky Topham	11/04/2017	07/02/2017	No	Open	n/a
WF1	Workforce	Lack of supply and retention of the right staff, at the right time, in the right place and with the right skills that operates across traditional organisational boundaries	Not enough workforce supply for some staff groups, e.g. Registered nurses or lack of certain key skills in appropriate roles	Inability to staff key services effectively or sustainably	4	4	16	NEW	15/02/2017	Develop an integrated workforce strategy that aligns with new models of care and new ways of working. Provide workforce planning toolkit to meet and support the changing needs of service	2	4	**8**	Louise Tibbert	11/04/2017	07/02/2017	No	Open	n/a
WF2	Workforce	Lack of system wide consistency and sustainability in the way we manage change and improvement impacting on the way we deliver the capacity and capability shifts required for new models of care	Change management methodology and significant change in culture required to meet changing demands	Disaffected staff leading to higher turnover, increased sickness and lower morale. Hearts and minds are not changed and cultural change not achieved	4	4	16	NEW	15/02/2017	Develop implementation plan for the UHL Way and develop an LLR Way. Utilise Local Workforce Action Board (LWAB) and sub groups on staff mobility, attraction and retention, staff capability, OD & Strategic Workforce Planning	2	4	**8**	Louise Tibbert	11/04/2017	07/02/2017	No	Open	n/a
WF3	Workforce	Alignment with STP and the changing demand for numbers impacting negatively on future supply, which in turn undermines new models of care	Radical changes to models and settings of care (moving care closer to home, shifting capacity into the community)	Inability to staff key services effectively or sustainably. Demand and Supply of trained workforce does not align.	4	4	16	NEW	15/02/2017	Develop LLR wide process including Strategic Workforce Planning, OD, training and education and staff mobility. Assure allignment with strategic and operaational planning through reconfiguration programmes and alignment with BAU.	2	4	**8**	Louise Tibbert	11/04/2017	07/02/2017	No	Open	n/a