STP, BCT and UHL Reconfiguration – Update

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Executive Summary Paper K

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 underpin 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; 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 1st June 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 2017-19 Operational Plan

STP Governance

1. Following the publication of the NHS Delivery Plan (Next Steps for the Five Year Forward View), consideration will be given locally as to what 'form' we take in the future and how that plays into the governance arrangements already established. The Delivery Plan provided a range of options for local systems to consider as they look for future organisational / joint working arrangements going forward that help bolster delivery of STP plans.

2. We are developing a 'LLR way' introduction for staff to be used at induction and a toolkit to support delivery of system change, new models and pathway redesign.

3. Work to refresh the STP narrative and all the templates is on-going ready for final publication later this year, taking on board feedback from public engagement. However, we do not have any more public engagement events planned in the short-term due to purdah.

2017-19 Operational Plan

4. On the 15th March, NHSI offered provider trusts the opportunity to refresh operational plans for 2017-19 to correct any errors, ensure our planning assumptions reflect our most recent thinking and to ensure NHSI in-year monitoring is against the right set of figures.

5. Two weeks later, in line with the national deadline, we submitted a final plan after discussion / agreement at IFPIC (due to the short turnaround).

6. Like our January submission, our March submission proposed a £29.8m and £24.9m deficit plan for 2017/18 and 2018/19, replacing the December plan of £26.7m and £21.7m respectively. However, NHSI did not accept our March submission as it did not comply with the rules associated with the refresh process i.e. there must be no deterioration in the bottom line financial position - as our January submission was not formally accepted; NHSI compared our latest financial plan to our December submission. As a result, we were asked to resubmit our plan in line with the December bottom line of £26.7m and £21.7m, which we did.

7. Around the same time, NHSI and NHSE published a document entitled Next Steps on the NHS Five Year Forward View - a Delivery Plan for the coming years. This specified / mandated new performance requirements for ED, which we have had to reflect in our local performance trajectories. These do not align as closely with our demand and capacity assumptions as our previous trajectories, which makes delivery / compliance highly risky.

Reconfiguration Programme

Availability of Capital

8. The Spring Budget included "£325 million of capital to allow the first selected [STP] plans to proceed". In the autumn, a further "multi-year capital programme to support implementation of approved high quality STPs" will be announced. Previous conversations have indicated that the LLR STP is in the top 5 nationally.

9. On April 18th, formal notification was received on the process to bid for the £325m capital announced in the Spring Budget and the potential future capital funding to be announced in the Autumn Budget.

'The initial £325m will be made available to those schemes which can demonstrate a robust plan (with a clear case for how the capital will support STPs plans for transforming

services through managing demand and financial sustainability). Consideration will be given in evaluating the bid as to whether funding is available from other sources (for example ETTF).'

10. In order to ensure we reflect what we have identified in our Annual Operating plan as externally funded for 2017/18, UHL are bidding to progress the interim ICU project which was approved by the Trust Board in December 2015; and a new 2 ward block at Glenfield, at a total capital cost of £30.8m.

11. The interim ICU scheme has 4 approved business cases as follows:
    - Glenfield additional 11 ICU beds (£4.7m)
    - Glenfield beds enabler – includes 10 transplant beds and the originally planned ward 28 and 29 upgrade for HPB (£4.3m)
    - LRI beds enabler – moves general surgery to the LRI ward 7 and 21 (£3m)
    - GH imaging enabler (£4.6m)

12. Since these cases were approved in 2015, we plan to validate the content of each case.

13. The 2 new ward development at the GH will need a business case developing, since originally the assumption was that the beds would be provided within existing bed capacity in the Glenfield beds enabler business case.

14. A summary of our bid for part of the £325m capital announced in the Spring Budget was submitted on 21st April, followed by the full submission on 28th April.

15. STPs which would like to have further capital bids considered beyond the £325m timescale must complete a first draft of the template by 24 May 2017.

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

16. The estates and reconfiguration teams have completed the second phase of the DCP refresh. This first version of the DCP reflected 1697 beds, and identified a significant capital pressure against the agreed plan of £300m.

17. We held a clinical validation meeting on April 5th with the senior medical team to ensure the assumptions included in this first version of the DCP are clinically appropriate and robust. A meeting with Clinical Directors and Heads of Operations was also held on April 25th to discuss the reconfiguration programme.

18. The team are now looking at the options for including additional bed capacity in the LLR estate (to respond to the revised STP bed bridge); however, this will be extremely challenging within the existing capital parameters.

19. A further three-day workshop has been arranged for the first week of May, in order to progress the work required around providing additional bed capacity. This will be subject to a further clinical validation session and will effectively become DCP Version2, reflecting an increased number of beds.

20. The STP needs to be supported; and the external capital position known, before the consultation process can commence. Unless something changes, this will be autumn. This does have a material impact on the progressions of our business cases.

Governance & Reporting

21. 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, the proposal required altering and expanding to include the level of expenditure the SRO/Project Board can authorise without seeking additional approval. The revised version was signed off at the Reconfiguration Board in April.

22. 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~~ July ESB	This will now follow the conclusion of the Corporate Resources Review (CRR) Whilst the organisation is reviewing its priorities, clinical services strategy is not specifically referenced. This may determine how the Models of Care work stream is managed in the future.

Programme Risks

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, and the next review meeting was organised for 7th April 2017. The updated risk register will be appended to this update paper in June once ESB has been sighted to it.

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.
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.
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

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	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

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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