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, 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.

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: programme resourcing, the impact of revised demand and capacity planning in the STP 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.

Questions

1. Does this report provide the Trust Board with sufficient and appropriate assurance of the UHL Reconfiguration Programme, its links to the STP, the delivery timeline and management of risks?

Conclusion

1. This report provides an overview of the STP and Reconfiguration programme, an update on the programme plan and programme risks for escalation. Following feedback from the last Trust Board, 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 2nd February 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)

1. Over recent weeks, we have continued to progress discussions with commissioners and partners (alongside internal analysis / risk assessments) as we work towards a contractual settlement that aligns with the LLR STP as much as practically possible. This is not without its challenges of course, not least because this process requires the translation of what are, in effect, high level assumptions or ambitions (in the STP) into service specific plans in contracts and operational plans.

2. While we are likely to reach contractual agreement, with shared assumptions on key components like demand, it is likely providers will be required to deliver more activity than the STP envisaged. This is, in part, due to the timing / readiness of alternatives services and initiatives that are designed to moderate demand, including a step change in preventative strategies, place based integrated community teams, a new model for primary care, effective and efficient planned care and integrated urgent care services. A key risk here, as previously cited, is the uncertainty around transitional or transformational funding from the Centre.

3. As a result, a key risk emerges for the system's service configuration ambitions and for our own clinical service strategy (and capital programme), which assume / require a significant reduction in demand to allow the Trust to take out the associated capacity in order to facilitate service moves and estate works in vacated space. This is not helped by our relative starting point - the LLR system is not in equilibrium; early 'gains' will restore operational sustainability and help reduce bed occupancy before we start to physically reduce our bed stock.

4. By way of mitigation, we are working with commissioners to ensure incentives and risk arrangements are appropriately aligned.

Reconfiguration Programme

Demand & Capacity: Estates / Development Control Plan (DCP) Refresh & SOC

5. As previously reported, the DCPs, showing which clinical services go where on each of our hospital sites, were previously produced in 2014. These are now being refreshed in light of the STP in order to:
    - Allow for an updated clinical adjacency matrix (showing which services need to sit next to each other) and a refined schedule of accommodation (showing what types of rooms each service needs).
    - Look at timescales, accessibility across the sites and traffic management.
    - Create the UHL "route map" and other useful materials which will be used to talk to staff, patients and other organisations about our plans.
    - Compare the original capital costs for each project with the agreed budget in the October STP submission.

6. The Reconfiguration Programme team are also currently drafting a Strategic Outline Case (SOC), which will explain:
    - what our plans are
    - why we're doing them
    - how we will deliver them
    - how much they will cost
    - when they will be complete

7. A key source of information for the SOC is the refreshed DCPs.

8. Work has started on the DCP refresh, but discussions are ongoing around validation of the capital costs. This has caused a delay, which therefore means there is a chance the SOC will not be ready to go to the Trust Board for approval in February 2017, as planned.

9. We need to try and avoid any delay to the SOC, because NHSI (the external body of the Department of Health which approves our requests for capital funding) will not approve any individual project requests until they have approved the SOC. Therefore, we will look again at our programmes and make sure the delay to the SOC is minimised.

10. At the same time, new guidance "Capital Regime, Investment and Property Business Case approval guidance for NHS Trusts and Foundation Trusts" has been issued from NHS Improvement (NHSI), which merges previous guidance from the NTDA and Monitor.

11. There are a number of key changes in the guidance which the team are taking on board as they work on developing the SOC.

Interim ICU Project Review

12. At their meeting in December, the Executive Strategy Board (ESB) were updated on clinical mitigations to ensure the LGH ICU remains safe and sustainable in the period before Level 3 services move to the LRI and GH. As the ESB were assured of the continuing safety of the Level 3 service; a request was made that the interim ICU scheme was reviewed in its entirety to ensure any expenditure forms part of the long term scheme. An update on this review will come back to a future Trust Board.

Vascular Expenditure Position

13. The Reconfiguration Board received a paper outlining the current expenditure position of the vascular project; with a projected underspend of £927k. The paper also presented the essential requirement for two pieces of equipment originally omitted from the FBC; without which the vascular service cannot complete their transfer to the Glenfield site. The total cost of these two items is £65k.

14. It was agreed that a paper would be prepared and submitted to the Capital Monitoring & Investment Committee (CMIC); outlining the options for the procurement of these two pieces of equipment – whether purchased or procured under the Managed Equipment Service. If purchased, the recommendation will be that this occurs this financial year (allowing £862k to be released to assist with the Trust's overspend on capital this financial year) or pre-committed as expenditure for the beginning of 2017/18 (allowing the full £927k to be released to assist with the Trust's overspend on capital this financial year).

15. An update on the outcome of discussions at CMIC will be included in this paper for the February Trust Board.

Private Finance 2 (PF2)

16. As reported last month, Paul Traynor, Nicky Topham and Mike Hotson (Head of Business, Commercial & Contracts) met with representatives from the PFI and Transactions Team (formerly the Private Finance Unit - part of the Department of Health) and the Treasury to explore further UHL's desire to progress the Women's and PACH projects using PF2 as an alternative to Department of Health capital funding.

17. A number of actions were agreed at the meeting and these are being progressed by Nicky Topham, Darryn Kerr and Paul Traynor. In addition, Darryn Kerr and Nicky Topham have held a discussion with the Infrastructure Programme Director from Velindre NHS Trust in South Wales regarding their experience with PF2. Whilst their £300m project is a new build on a green field site, soft market testing has indicated the need for more due diligence to minimise risk to the commercial partner and therefore make funding more attractive. These lessons learnt are under consideration for UHL's plans.

18. A paper is due to be presented at the Trust Board Thinking Day on 9th February 2017 to discuss PF2 further.

Governance, Programme Board membership & the role of SROs

19. Discussions are taking place between the Reconfiguration Programme team and the new STP team to align governance and ensure integrated working. A productive meeting has also been held between the Reconfiguration Project Senior Responsible Officers (SROs) and a review of the Reconfiguration Programme governance has been carried out.

20. The terms of reference including membership of the Reconfiguration Programme Board have been reviewed and updated; these were agreed at the Reconfiguration Programme Board meeting in December and will be presented to the ESB in January.

21. A new sub-group of the Reconfiguration Programme Board (the Reconfiguration Programme Team) has been set up with meetings to be held monthly from January 2017. This sub-group will allow Reconfiguration work-stream personnel meet in between the Reconfiguration Programme Board meetings to confirm/challenge and discuss ongoing cross-cutting work e.g. the SOC development, risk and issues management, and programme.

22. The Reconfiguration Programme Board discussed the need to have more transparency at Project Boards and Reconfiguration Programme Board on the financial position of projects, particularly around the use of contingency budgets. It was therefore agreed that the following would be developed to accompany the recently developed guide to roles and responsibilities of SROs:

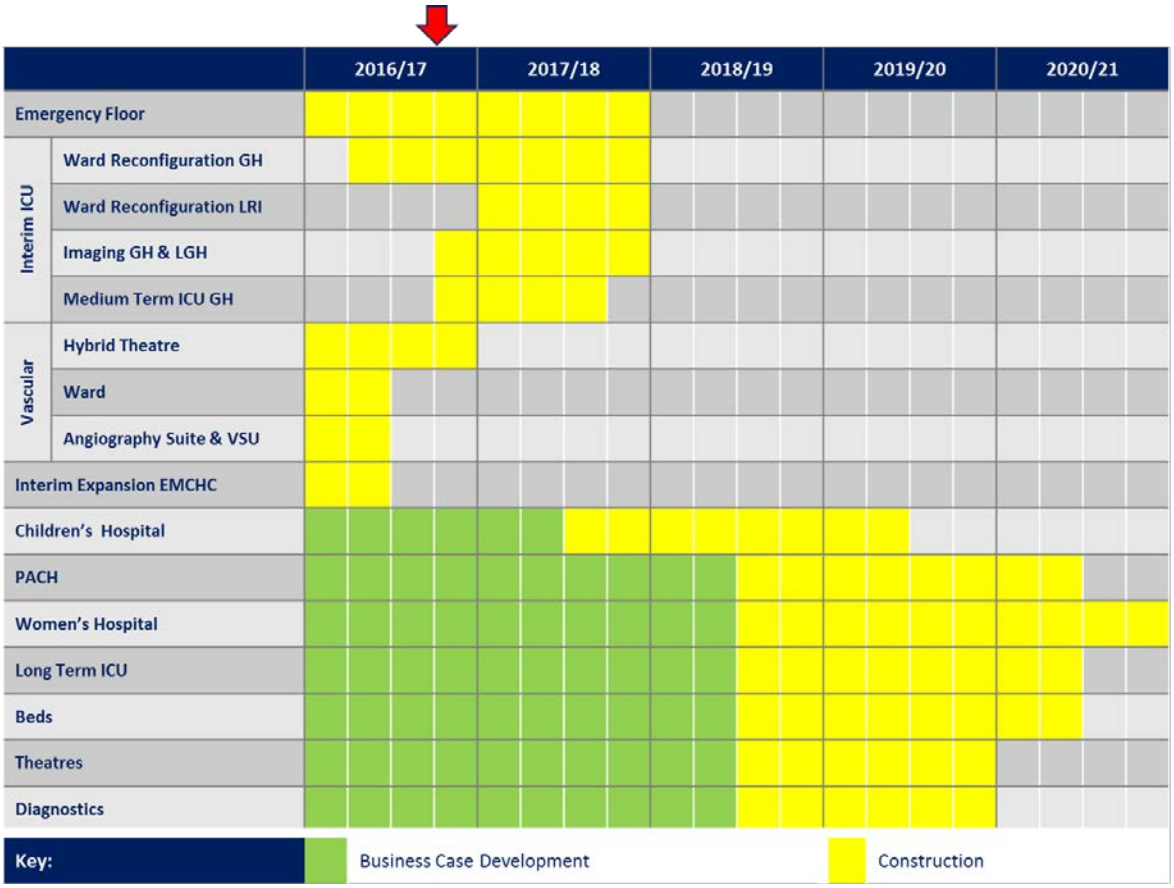
    - reporting mechanism for financial position of projects
    - guide to the delegated authority limits of Project Mangers under the construction contract, and Project Boards.
    - updated terms of reference for the Project Boards

Programme Plan & Availability of Capital

23. The programme plan for major projects currently reflects the assumption that 2016/17 capital requirements are available from September 2016, and capital for the remaining years of the programme will be available promptly after requests are submitted. This is already out of date and no confirmation of capital for 2016/17 has yet been received.

24. The programme will be updated once the Estates/DCP refresh and the STP are complete. At this time, we will ensure the programme reflects the latest information and resolves two issues with the current plan:
    - Many of the projects have been slowed down as there has not been the expected capital funding. This has resulted in individual project programmes catching up with each other, so that multiple projects would be due to start construction at the same time – see diagram below. This would cause problems on a hospital site which must remain open throughout construction work and will therefore require further consideration.
    - Some of our projects are linked to each other, therefore must happen at the same time – we need to double check that the programme reflects this.

25. A high level summary of the current programme plan is shown below.



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

Workstream / Project	Decision	Current deadline	Comment
Reconfiguration	Sign-off updated reconfiguration governance structure including any changes to workstreams / meetings.	~~August ESB~~ ~~December ESB~~ January ESB	Approved at December Reconfiguration Programme Board, to be presented to ESB in January 2017.
Clinical Services Strategy	Sign-off of scope and deliverables for Model of Care (or associated) workstream(s).	~~October ESB~~ ~~December ESB~~ February ESB	To be completed following resource review.
Estates / Programme	Phase 2 Estates Strategy re-fresh including DCPs, realignment of project costs and programme plan.	~~December ESB~~ ~~January ESB~~ February ESB	DCPs have been delayed until the end of January so will be presented to ESB in February.
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	Decision to be made and reported in context of DCP refresh.

Programme Risks

27. 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

28. This month there are no risks which meet these criteria. The top three programme risks are summarised below:

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 reconfiguration programme is not deliverable within the agreed capital funding parameters.	**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.

29. The Reconfiguration Programme team held an initial review of the Risk & Issues Log (Appendix 1) for the programme on Tuesday 25th October. This was presented to the Reconfiguration Programme Board at their meeting on Wednesday 2nd November and the Executive Strategy Board on Tuesday 8th November. This Risk & Issues Log will be developed further at the Reconfiguration Programme Team meetings once these are implemented in January 2017.

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

V1 25/10/16

Risk ID	Risk Category	RISK	CAUSES	CONSEQUENCES	Likeli-hood	Impact	Current RAG	Previous RAG	Raised by	Date Added	Risk Mitigations	Target RAG	Risk Owner	Date for Review	Last updated	Issue	Risk Status	Date Closed
DC1	Demand & Capacity	There is a risk that the external work required to enable UHL bed reductions as per the STP is not acheivable.	The level of detail in the plan is variable, therefore some bed closures may be significantly more challenging that others. Demand may rise at a level over and above that planned for in the STP, which prevents bed reductions	Failure to downsize in total, or in line with phasing requirements, as required to achieve 3 to 2 site strategy.	4	4	16		Reconfiguration Programme Team	25/10/2016	Expectation management via Reconfiguration Programme Board. DCPs to inform detailed programmes per project. Alignment between CMG Clinical Strategies, 2 year plans and Reconfiguration Programme - strong clinical leadership. Governance over STP delivery. Beds STP Board (chaired by Richard Mitchell and Rachel Billsborough) 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.	8	Richard Mitchell	31/12/2016	25/10/2016	No	Open	n/a
DC2	Demand & Capacity	There is a risk that the internal transformation plans for bed reductions as per the STP are not achievable.		Failure to downsize in total, or in line with phasing requirements, as required to achieve 3 to 2 site strategy.	3	3	9		Reconfiguration Programme Team	25/10/2016	Expectation management via Reconfiguration Programme Board. DCPs to inform detailed programmes per project. Alignment between CMG Clinical Strategies, 2 year plans and Reconfiguration Programme - strong clinical leadership. Governance over STP delivery. Beds STP Board (chaired by Richard Mitchell and Rachel Billsborough) 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.	6	Simon Barton	31/12/2016	25/10/2016	No	Open	n/a
DC3	Demand & Capacity	There is a risk that the bed reductions are delivered but are on the wrong sites and/or in the wrong speciality.		Delivery of Clinical Strategy is not achievable (clinical adjacencies)	4	3	12		Reconfiguration Programme Team	25/10/2016	Early CMG ownership of specialty numbers through engagement process. Transformation to be reflected in CMG 2 year planning. Stong clinical leadership and OD will be required to enable change - delivery of the agreed plan without deviating from assumptions.	6	Richard Mitchell	31/12/2016	25/10/2016	No	Open	n/a
F1	Finance	There is a risk that capital funding (£284.1m in total) is not available when it is required to maintain the reconfiguration programme	National capital availability at risk and not known for 16/17 or subsequent years. PF2 funding is hard to access and process is not well tested (new for UHL) Capital receipts not realised	3 to 2 site strategy will be affected if capital not secured. Sequencing of moves at risk. Interdependencies / phasing impacted.	4	5	20		Reconfiguration Programme Team	25/10/2016	Robust plans and programmes in place. Engagement with DH and Treasury.	15	Paul Traynor	31/12/2016	25/10/2016	No	Open	n/a
F2	Finance	There is a risk that the reconfiguration programme is not deliverable for the agreed capital funding parameters		3 to 2 site strategy is not affordable.	4	5	20		Reconfiguration Programme Team	25/10/2016	DCP refresh, delivery strategy Holding projects to their scope, budgets and programme - value engineering	10	Darryn Kerr	31/12/2016	25/10/2016	No	Open	n/a
O1	Overall	There is a risk that the complex internal dependencies between reconfiguration projects are not delivered in the required timescales		Delays to individual projects and/or the programme as a whole. Revenue consequences via double running etc.	4	5	20		Reconfiguration Programme Team	25/10/2016	Monitoring by the Reconfiguration Programme Board via the interdependencies chart. Ensure the baseline is understood so can monitor against an agreed position.	15	Nicky Topham	31/12/2016	25/10/2016	No	Open	n/a
O2	Overall	There is a risk that there are not enogugh resources to support the programme in line with required timescales		Delays, lack of ownership, loss of skills/resource/quality, processes impacted.	4	4	16		Reconfiguration Programme Team	25/10/2016	Changing organisational culture to ensure strategy, reconfiguration and transformation is part of "day job". Resource management to ensure the right skills are in the right place at the right time. Clinical leaders will share lessons with other clinical leaders to ensure lessons are learnt between projects.	12	Nicky Topham	31/12/2016	25/10/2016	No	Open	n/a
P1	Programme	There is a risk that the outcome of consultation is not aligned to our clinical strategy, with particular impact on PACH and Women's projects.		Impact on programme for Women's and PACH projects and therefore reconfiguration programme as a whole.	3	5	15		Reconfiguration Programme Team	25/10/2016	Public engagement Work with STP PMO	10	Mark Wightman	31/12/2016	25/10/2016	No	Open	n/a
P2	Programme	There is a risk that delays to consultation or the external approvals process delay business case development timescales.		Sequencing of moves at risk. Interdependencies / phasing impacted. Programme as a whole delayed.	3	5	15		Reconfiguration Programme Team	25/10/2016	Engagement with NHSI, Taunton, Holding projects to their scope, budgets and programme - value engineering Effective programme management	10	Nicky Topham	31/12/2016	25/10/2016	No	Open	n/a