STP, BCT and UHL Reconfiguration – Update

Author: Nicky Topham & Anna Fawcett Sponsor: Paul Traynor & Mark Wightman

Trust Board paper I

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 Partnership (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. Work has continued since then to refine the plan and the aspiration is to bring a revised version back to partner Board's before Christmas ahead of public consultation in Spring 2018.

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.

NHS England announced on 19th July 2017 that our BCT/LLR partnership would receive investment of almost £40m, starting this year. This was the result of capital bids submitted by UHL for £30.8m to deliver the interim ICU scheme; and by LPT for £8m to deliver a new facility for child and adolescent inpatient mental health services at Glenfield.

UHL also submitted a second bid of £397.5m for progressing the whole reconfiguration programme against the 2017 Autumn Budget. Further information requested by NHSI was submitted in September 2017 in advance of an announcement, expected later in the autumn.

Questions

1. Does this report provide the Trust Board with sufficient and appropriate assurance of the UHL Reconfiguration Programme and 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, including high scoring programme risks.

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 November 2017]

Executive Summaries should not exceed **2 pages**. [My paper does comply]

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

Sustainability and Transformation Plan (STP)

1. The LLR STP is in the process of being updated with partners in order to reflect the system-wide impact of increasing the acute bed base. In addition, having taken advice from senior colleagues at NHS Improvement, the timescale for delivery of the reconfiguration programme has been extended to 2022/23, which will also need to be reflected in the next iteration of the STP to ensure consistency with the plan for the wider LLR health economy.

2. Further discussion with NHSE has also identified the need for us to strengthen our maternity case for moving to one acute site. The Women's Project Team are working to develop this narrative for the STP, alongside the Reconfiguration, Strategy and Estates teams who are working closely with the STP team to provide the other information required to update the STP.

3. Discussions have also re-started about public consultation; which previously could not commence until after we had capital support for the programme. There has now been an agreement that as the political landscape has changed, LLR can go out to consultation in advance of our full capital bid being supported.

4. There has also been agreement that the pre-consultation business case (PCBC) will be split into multiple separate cases i.e. acute reconfiguration and maternity will be separate from the community hospitals consultation.

5. The outline process of preparing for public consultation and associated timescales were discussed at the Senior Leadership Team (SLT) meeting in August 2017. The aspiration being to bring a revised STP plan back to boards before Christmas ahead of public consultation in Spring 2018. The precise timescale is still subject to discussion.

6. During their August meeting, the SLT discussed a draft paper entitled '*Moving towards an Accountable Care System in LLR*'. This paper was then taken to CCG, UHL and LPT Boards in September. Each of the NHS partner organisations clearly had their individual views on the direction and pace of the ideas and these will be discussed in detail at the October SLT meeting, in advance of a revised paper being brought back to individual Boards. A strong theme for all partners was that whilst the concept of greater clinical integration, supported by alternative contracting models was broadly welcome, there was much more work required to engage and involve staff, stakeholders and local authority partners.

Reconfiguration Programme

Section 1: Reconfiguration Programme Board Update

Clinical Strategy: Development Control Plan (DCP) & the UHL/LLR Estates Strategies

7. The Development Control (DCP) is now progressing at pace in order to inform the refreshed Estate Strategy. This is needed to manage the longer term control of the sites (including the decommissioning of the LGH), and is needed to support the Full Business Case for the £30.8m scheme. The DCP will be completed by early November 2017 in-line with current timeframes, and will inform the UHL Estates Strategy which will be complete for approval by the Finance Investment Committee in December and Trust Board in January 2018.

8. Work has been undertaken to re-align the 2048 bed requirement in 2020/2021 as per the Bed Bridge with the March 2017 Bed Census to understand and confirm requirements at specialty level. A thorough analysis of current bed supply against future demand has demonstrated the number of new build wards required. The additional beds have been assigned to both the LRI and GH based on the agreed locations of the specialties.

9. A session with Trust Executives, and CMG Clinical Directors and Heads of Operations had been scheduled for 19th September, at which we had planned to present options on the site layouts. As discussed at the August and September Reconfiguration Programme Boards, this would have involved a complex discussion about the competing need for space – especially at the LRI in light of the EMCHC move and the General Surgery move as part of the ICU project.

10. NHS England wrote to John Adler on 15th August advising that they would do everything possible in order to make a decision regarding the future of the EMCHC at their board meeting on 28th September 2017, three months earlier than the decision making timescale that had previously been provided. Delaying this clinical session would ensure that discussions could take account of the outcome of the NHSE consultation into the future of EMCHC. The session was therefore rescheduled for 3rd October.

11. Unfortunately on 20th September we then received communication from John Stewart, the national lead for the review process, informing us that the decision on the future of the EMCHC service will not be made until their public board meeting on 30th November 2017, rather than 28th September as previously indicated.

12. As the timelines for completion of the ICU OBC are extremely tight; it is not possible to delay the options appraisal for the preferred location of general surgery at the LRI until the EMCHC decision has been made. Therefore, the ICU project team has carried out the general surgery options appraisal in line with the OBC timelines, and the EMCHC project team are reviewing the impact the outcome of this has on the EMCHC preferred option .A further update will be given next month.

13. The Estates Project Team has taken a view on the site locations of new facilities considering the required clinical adjacencies required to ensure functionality, the ability to successfully deliver the construction elements and also to ensure a comprehensive Infrastructure Programme can be developed to support the process. This analysis has supported a concurrent piece of work with the Reconfiguration Team which has resulted in the development of a high level programme of Reconfiguration Projects.

14. Next steps include:
    - The cost advisors will now re-cast the DCP to assess the impact of the potential site location options for both the beds and specific projects to ensure the cost envelope is not affected

- Detailed work to analyse the sites in more detail to include Theatres, Imaging, and other services
- Consideration of the impact of sequential service relocations on the LGH and develop a view of how the site will reduce over the programme
- Ensure on-going Infrastructure assessments are aligned

Capital Bid for £30.8m – Next Steps

15. Confirmation was received at the beginning of September of the requirement to deliver an OBC for the complete project (£30.8 mill) by the end of October 2017, followed by FBC by the end of January 2018.

16. This varied the previous assumption made regarding the delivery of Business cases – which related to the GH beds element only as the other elements had been approved following submission of FBCs to Trust Board in December 2015.

17. A Project Team has been established incorporating work stream leads & other representatives from Estates & Reconfiguration team. A weekly meeting is taking place, reviewing progress against the project plan & agreeing key actions/ deliverables for the coming week.

18. **OBC Milestones** – a project plan has been developed with the Project Team, the table below details the key milestones for delivery.

Milestone	**Date**
Revised activity baselines & modelling	18/09/17
Non-financial option appraisals completed – individual & overall	22/09/17
Finalise capital & revenue costs	06/10/17
Draft OBC completed	16/10/17
Commissioner sign off	20/10/17
Final OBC	23/10/17
IFPIC approval	26/10/17
Trust Board approval	02/11/17

19. **Key Actions** – a number of pieces of work are currently taking place simultaneously with the engagement of CMGs:
    - Clinical Operational Policies & Models of Care are being reviewed and updated. The revision of these will continue to be an iterative process through to operational commissioning of the services.
    - The baseline2014/15 activity from the original Full Business Cases is being updated to 2016/17.
    - Workforce, equipment & revenue assumptions from the previous Business Cases are being required & updated with CMGs
    - Meetings are taking place with clinical support services to ensure we have captured and are clear regarding implications and impact for these services.

20. **Stakeholder Engagement** – both NHSE & CCG commissioners are members of the Project Board, although attendance at meetings has been variable. A meeting took place on 13th September with Leicester City CCG, as lead commissioner, to overview the high level detail from the original STP bid, the background to the interim ICU case & the way forward in facilitating CCG support in the submission of the Business Case.

21. **Patient Partner Engagement** – David Henson from HealthWatch previously provided input to the ICU Project Board. However, he has now stepped down from his role, so is no longer able to contribute. Martin Caple, Patient Partner, will now sit on this board whilst he agrees with his colleagues who will lead individual components of this project.

Capital Bid for £397.5m – Next Steps

22. Our second capital bid was submitted in May 2017, for £397.5m to deliver the reconfiguration programme as a whole. On 17th August 2017, a letter was received from Dr Paul Watson, Regional Director at NHS England (Midlands and East) and Dale Bywater, Executive Regional Managing Director at NHS Improvement (Midlands and East) outlining the next steps in the process.

23. Assessment criteria have now been circulated, which will be utilised by the Department of Health to determine whether an application is successful or not. The key criteria are:

    - Leadership to deliver
    - Service / demand management
    - Transformation and patient benefit
    - Financial sustainability
    - Value for money
    - Optimising estates utilisation, including consideration of surplus land disposal opportunity

24. We were given the opportunity to update our original capital bid document submitted in May to ensure complete alignment with the assessment criteria. There was also a compulsory requirement for all capital bids to complete an additional value for money template.

25. Our original bid reflected the STP which was the delivery of a five year Reconfiguration programme first described in the 2014 LLR Better Care Together SOC; completing by 2020/21. The impact of the STP process and lack of availability of capital has delayed the commencement of this programme, making delivery in this timescale impossible.

26. On further consideration, and having taken advice from senior colleagues at NHS Improvement, we have revised the timescales for delivery within our bid to reflect the delays we have experienced and to ensure that the programme is realistic and deliverable. The capital programme will conclude in 2022/23, with the Trust returning to a surplus financial position from April 2023. This will be reflected in the next iteration of the LLR STP to ensure consistency with the plan for the wider LLR health economy.

27. ESB discussed the extension to the reconfiguration programme, and acknowledged that an assessment needs to be carried out to understand and mitigate the clinical risk associated with services remaining on the LGH site for 2 years longer than originally intended.

28. Our current Bed Bridge, and therefore our Reconfiguration Programme, is based on the 2020/21 end state of 2048 beds. Our bid recognised that our timelines are now extended by 2 years and therefore work will be required to mitigate an additional 2 years-worth of growth to ensure that the bed number remains valid.

29. The updated bid documents were returned by the deadline of Wednesday 6th September 2017.

30. The letter received on 17th August 2017 suggests that we will be informed whether or not our bid is successful later this autumn, following the announcement of the 2017 Autumn Statement.

Options to Relocate Vascular Outpatients to GH

31. The Reconfiguration & Estates team have explored, with RRCV CMG, a number of options for the conversion of space at Glenfield Hospital to create clinic rooms & support space to facilitate the relocation of vascular outpatients from LRI to GH.

32. Five options have been assessed for deliverability, cost and issues; resulting in the identification of a preferred option which has been agreed with the RRCV Head of Operations. However, when this option was discussed with the Vascular Head of Service, it was recognised that this would require a compromise from the current "suite" model of care provided in LRI outpatients.

33. The team are therefore exploring a variant of the preferred option which would provide additional space at the GH and enable the "suite" model to be continued after the service relocates from the LRI.

Emergency Floor Phase 2 – Update from Last Month

34. The operational and construction programme remains on track for opening the GPAU on 13 November 2017 and the assessment beds in May 2017. The capital costs are being controlled and are currently delivering the project within the allocated budget.

35. The clinical teams continue to work on developing the models of care for each area. The Standard Operating Procedure (SOP) for GPAU has been drafted and will be finalised by the end of October 2017.

36. Stakeholder engagement events are planned for internal staff on 12 October and external staff on 7 November. Both events will be facilitated by Organisational Development (OD) colleagues, and will be an opportunity for colleagues to discuss how the new floor will work in the future and inform any required changes to SOPs.

37. A fully costed workforce business case for phase 2 is being developed and a progress report will be presented to the Emergency Floor Project Board (EFPB) on 10 October with specific focus on the GPAU Transitional Plan. The final report will be produced for the end of October. This will describe a 'do nothing' option and options for changing the ways of working and additional investment with benefits for each option.

38. The OD and Culture plan for phase 2 will include the lessons learned from the September surge fortnight to inform further workforce and OD actions.

39. Benefits realisation is being facilitated by the East Midlands Academic Health Science Network and will take place on the 24 and 31 October. This will include phase 1 and phase 2. The outcome will be presented to the EFPB in January 2018 for further consideration.

40. The IT plan is on track to deliver GPAU and the whole of phase 2 on time and within budget.

41. Operational commissioning continues, aligned to the milestones in the master plan. The team have finalised and costed the equipment list for the whole of phase 2. This has been factored into the construction timeline and is reported in the construction highlight report.

Emergency Floor Phase 2 – Acceleration of GPAU build

42. Construction work remains on track for handover to UHL on 31 October. The operational commissioning period will then begin, with the new space opening to patients on 13 November.

43. All the key operational commissioning milestones are being met and activities continue to be monitored within the project plan.

Emergency Floor Phase 2 – Charities

44. In August 2017 the Charities Committee approved enhancements funds of £360,475.86 for phase 2.

45. The project team have met with the committee and capital accountants responsible for reporting against spend. To date no costs have been incurred.

46. During October the operational commissioning will start to order equipment for GPAU. This will be submitted direct to the charity accountant to ensure VAT exemption is applied. The remaining

47. Construction items will be part of the overall evaluation but will provide invoices to evidence spend against the charity allocation.

48. The benefits realisation exercise will consider how the benefits from the investment can be measured and this will be reported as point 6 above.

Emergency Floor Phase 2 – Paediatric single front door

49. Both CMGs met on 18 August 2017 and agreed to run an initial stakeholder event 24 October 2017 for Paeds ED and Children's Hospital colleagues to collectively agree and approve the future model of care. It is likely that follow up event and additional actions will be required to implement any changes.

50. Sharon Smeeton and OD colleagues will provide support to facilitate the event and will report on the outcome in November.

Section 2: Programme Risks

51. The programme risk register was reviewed and updated at the Reconfiguration Programme Team meeting on 15th August 2017. The next update is scheduled for 10th October 2017 at the Reconfiguration Programme Team meeting. This will include the new risk around the clinical impact of the extension to the delivery of the Reconfiguration Programme to 2022/23.

52. 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

53. The highest scoring programme risks are summarised below:

Risk	Current RAG	Mitigation
There is a risk that estates solutions required to enable decant of construction space are not available.	**20**	The overall programme is reviewed and progressed with the space planning team, significant decant space is available (e.g. Brandon Unit, Mansion House) and project work-stream to be identified.
There is a risk that the reconfiguration programme is not deliverable for the agreed capital envelope.	**20**	Further work assessing assumptions used to develop the capital envelope. Rigorous change control processes in place and ensure any increases in cost are mitigated by appropriate savings. Review of procurement and innovative solutions to reduce costs.
There is a risk that delays to consultation / external approvals delay the programme, which is already challenging.	**20**	If Women's and/or PACH are progressed through PF2, business case timescales will be longer and delay caused by consultation will have less impact.
There is a risk that the complex internal dependencies between reconfiguration projects are not delivered in the required timescales.	**20**	Clinical services will not be moved until all services on which they are dependent are available with appropriate capacity. Development of Reconfiguration Programme SOC will identify sequencing and interdependencies between projects.
There is a risk that there is not enough internal CRL to provide sufficient resources to develop the business cases during 2017/18 in line with the required timescales.	**20**	Prioritise CRL against those projects which need to deliver early in the programme. Explore alternative ways of funding business case development.

Input Sought

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