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. LLR are now working to update this plan which will be published in late summer.

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 trust are awaiting the outcome of two bids for capital which will enable the reconfiguration programme to be progressed; the first is a bid of £30.8m for the interim ICU scheme against the £325m announced in the 2017 Spring budget; the second is a bid of £397.5m for progressing the whole programme against the 2017 Autumn Budget. It is hoped that we will hear the outcome of the first bid in the next few weeks; and that we will hear the outcome of the second bid by the end of the year.

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 3rd August 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. Work to refresh the STP narrative and all the templates is on-going ready for final publication towards the end of the Summer, taking on board feedback from public engagement. Over recent months we have had to limit engagement due to purdah.

2. As we work towards an updated Plan, we are listening to the feedback we have received and expect some aspects of the STP which was published in November 2016 to look different as a result. We will see a greater focus on prevention and early intervention, as well as an increase to our previously planned hospital bed capacity.

3. Some elements of the proposals for our area will require an injection of funding. We estimated that to achieve the right structure for LLR would require a significant capital investment, and have now submitted bids to NHS England to allow us to take forward our plans. The UHL bids are outlined below.

4. We have also been working to establish clear leadership as our partnership across LLR develops. Toby Sanders, Accountable Officer at West Leicestershire CCG has been appointed by the partners of Better Care Together to lead the Strategic Transformation Partnership.

5. The System Leadership Team (SLT) oversees all aspects of the development and delivery of the Sustainability and Transformation Partnership for the Leicester, Leicestershire and Rutland footprint. It met on 22 June 2017. Key points discussed in the June meeting included:

   - An Implementation Plan is being developed that will bring together the key actions from across the different work streams. This will inform the updated plan, due to be shared by the end of the Summer
   - Members of the SLT were updated on recent 'Tiger Team' meetings that have been held to look at the pathways needed to provide more care in the community. The 'Tiger Team' looked particularly at how frail patients could be cared for in community hospitals or in the community and what barriers and challenges would need to be addressed for this to be a success
   - Feedback from engagement events since the publication of the draft Sustainability and Transformation Plan was discussed and the SLT noted the important role that this feedback would now have in informing and shaping the next draft of the plan.
   - The prevention work stream gave an update on the plans across the partnership. It was noted that the growing burden of preventable disease by 2020/21 will cost the LLR health and care system approximately £399m. A priority for the work stream is Making Every Contact Count – working to maximise all opportunities to support people to adopt healthier lifestyles through advice, support and signposting to lifestyle services.
   - An update was given by the medicines management work stream. The medicines management plan covers a number of areas, including medicines supply, antimicrobial resistance and medication safety. It was agreed that a small number of priorities should be selected from across LLR that could achieve the greatest impact for the system

Reconfiguration Programme

Section 1: Reconfiguration Programme Board Update

Capital Bid Submission - Background

6. Over the last few months, the Reconfiguration Programme team have been working through the impact on UHL's Reconfiguration Programme of the increased bed base in relation to the revised demand and capacity planning; and the impact this has on the capital cost of moving from 3 to 2 sites.

7. On April 28th, an initial bid of £30.8m for capital against the £325m announced in the 2017 spring budget was made in order to progress the interim ICU scheme. This is deemed to be the next scheme required in order to deliver our reconfiguration programme. At the same time that this bid was announced, a deadline of the 24th May was announced for any further capital required within the STP.

8. On May 24th, a second capital bid for £397.5m was submitted reflecting the capital required to deliver the whole reconfiguration programme (this includes the £30.8m capital reflected in the first bid). This bid is higher than the capital requested in the original STP, due to providing additional ward capacity to reflect the increased bed base and the supporting infrastructure.

Capital Bid Submission - Content

9. If supported, the first capital bid for £30.8m will facilitate the move of Level 3 ICU and associated services dependent on Level 3 ICU from the LGH to the LRI and GH. This scheme delivers:

    - an increase of 11 bed spaces in Adult Level 3 capacity at the GH, crucial in enabling the transfer of clinical activities reliant on Adult Level 3 care from LGH;
    - additional refurbished bed capacity at the GH and the LRI (crucial to balancing demand and capacity);
    - the provision of a new ward block at the GH (as above);
    - the provision of interventional radiology capacity at GH to support the ICU dependant services moving there.

10. The second capital bid for £397.5m delivers the UHL clinical reconfiguration strategy of moving from 3 to 2 acute sites, therefore allowing the remodelling of the LGH site. Key financial information :

    - The payback period is 13.1 years
    - The Return On Investment is 7.7%
    - The Trust returns to financial balance in 2021/2

11. The programme outlined in this second bid includes capital for the following projects:

Leicester Royal Infirmary (LRI)	Glenfield Hospital (GH)
Women's Hospital	Planned Ambulatory Care Hub
Enhanced ICU facilities	Enhanced ICU facilities
Increased bed base – new build & refurbishment	Increased bed base – new build & refurbishment
Main Entrance including patient & public services	Extension to Clinical Decisions Unit
Infrastructure	Infrastructure
	Increased number of theatres - new build
	EMPATH contribution for Cellular Pathology

12. The Diabetes Centre of Excellence and the Brandon Unit for back office functions will remain on the LGH site with, subject to the outcome of consultation, a standalone Birth Centre. In addition, it is assumed that the stroke rehab unit and NRU are provided in the Evington Centre the costs for which are included in our capital.

Anticipated Feedback on capital bids

13. It is hoped that we will receive feedback on the first capital bid submission for £30.8m for the interim ICU scheme in the next few weeks. We have been advised that Treasury will require a further template to be completed in support of the submission if successful. We are still awaiting the detail on this.

14. With regards to the outcome of the second bid for £397.5m, we are working on the basis that we will hear at the end of November / early December following the Autumn Statement.

Capital Bid Submission - Next Steps

15. The Reconfiguration Team will now spend the coming months undertaking all the required background work on the individual projects to ensure we are ready to appoint design teams and start high level design work at the beginning of December. During this time we will be limiting time consuming activities with clinical and CMG teams clinical engagement to ensure we are not using up precious resources unnecessarily.

16. Alongside the activities to be undertaken on specific projects, there is also a requirement to fully review the Reconfiguration Programme as a whole:

    - Reaffirm project split, including priorities (ICU)
    - Assessment of 2017/18 capital requirement from internal CRL in light of two scenarios where we do or do not receive capital this year
    - Refresh the Development Control Plans (DCP) across all sites to outline future locations for specialties and the sequencing of moves within the new budget
    - Review the draft programme submitted as part of the capital bid (included as Appendix 2) to validate assumptions and deliverability

17. There is also a requirement to refresh the STP with partners (timescales TBC), to reflect the system-wide impact of increasing the acute bed base to 2048.

Vascular Outpatients

18. An option was developed by the outpatient General Manager in November 2016 which facilitated the move of vascular outpatients to GH, alongside orthopaedics moving to LGH, some internal shifts at GH, & clinics moving from LGH to LRI to enable space for orthopaedics at LGH. This was all to be delivered within existing sessions, with no job plan changes required.

19. A meeting was held on 5th June with orthopaedic colleagues, who support the principle of a single site elective orthopaedic service at the LGH, but who have also highlighted a number of issues in relation to the proposed relocation – in terms of office space requirements and additional space for pre-assessment clinics at LGH. In addition, a solution will need to be put in place for the breast pre-assessment service which will remain at GH, currently delivered from the combined Surgical & Orthopaedics Pre-Assessment Clinic (SOPAC).

20. The proposed solution developed by the outpatient General Manager is also being revalidated with the other impacted services in CHUGGS & ESM predominantly.

21. Meetings have taken place with all impacted specialties – Orthopaedics, Colo-rectal Surgery, Rheumatology and Dermatology. At these meetings, the previous plans have been reviewed and validated, with issues raised as below.

22. Now all meetings are complete, the team are in the process of confirming: the validity of the original plan, given it is now six months since it was first proposed; the issues that need resolution; and the revised cost for delivering a solution.

23. The issues from Orthopaedics, who are the most impacted specialty, are listed below:

    - **X-rays/Imaging** – approximately 50% of patients attending clinic at GH require an X-ray on arrival; this increased demand could not be absorbed by the LGH imaging department.
    - **Plaster room** – it is envisaged that the plaster technician support from GH would move to LGH – but currently there is no spare capacity in the LGH plaster facilities to accommodate the additional workload.
    - **Pre-assessment** – there are currently 8 sessions provided at GH. The pre-assessment space at LGH is utilised 10 sessions per week - with additional space needing to be found particularly for the arthroplasty surgeons. There will also be an impact on the remaining surgical pre-assessment clinics left at GH.
    - **Office space** – there are issues with both Consultant and admin office space. The Consultant body currently shares on the basis of 6/7 Consultants per office. There is inconsistency across the Trust as to how office space is allocated for Consultants which causes some ill feeling with colleagues, particularly when being asked to make further changes. It was confirmed that Consultants do not currently have any office space allocated at GH, but have access to hot desks on an ad hoc basis. Office space had been identified for maximum 8 staff for orthopaedics linked to the move – this has now been reduced to 6 as one office has been reallocated by Space Utilisation team. The orthopaedic consultant numbers have increased over recent years, with no associated increase in available office accommodation.
    - **Clinic accommodation at LGH** – this is far from ideal & it is many years since any money was spent on these areas to maintain and/or improve the environment for both patients and staff. There is also a current issue in LGH clinics related to a lack of IT availability for all clinicians working in LGH clinics.

24. The view of the MSS Clinical Director is that these are some major challenges which need to be addressed if Orthopaedics outpatients are going to move to the LGH. The service at GH is very large and there are already capacity issues at the LGH within the existing Orthopaedics footprint. While there is not an expectation of a major refurbishment to solve long standing problems, the view is that it would not be possible to 'shoehorn' the service into what is already a very tired and overcrowded environment/estate.

25. RRCV CMG is also considering three possible alternative solutions at GH, which would provide additional clinic rooms at GH through the conversion of existing office spaces. The costs for these options have not yet been confirmed as the detail is still being worked through. An options appraisal will be carried out once the costs have been identified. If it was possible to create new outpatient space at GH for Vascular, this would create some manoeuvrability across GH outpatients as a whole as there is currently no in-hours flexibility in the outpatient space.

Section 2: Programme Risks

26. The programme risk register was reviewed and updated at the Reconfiguration Programme Team meeting on 13th June 2017.

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. 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.