# 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 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 2022/23 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 presented to partnership trust Boards at their February 2018 meetings; as well as planning for public consultation.

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.

### Questions

1. What progress has been made since the last Trust Board?

### Conclusion

2. The following progress has been made :

**STP / PCBC Timelines**

1. The Draft LLR STP will be discussed at the Trust Board Thinking Day in January. It is currently planned to be presented to partner Public Boards in February/March 2018.

2. As discussed previously, LLR can go out to consultation in advance of our full capital bid being supported. The partnership is currently planning for consultation to commence in spring 2018.

3. There has been agreement that the pre-consultation business case (PCBC) will be split into three separate cases:

    - UHL: Acute reconfiguration and maternity
    - West CCG : Hinckley Hospital
    - East CCG : Lutterworth Hospital

**Reconfiguration Programme**

- The outcome of the Autumn Budget was announced on the 22nd November.

- We are still waiting to advised on the prioritisation process for access to this capital.

**The Relocation of ICU Capacity and Associated Specialties from the Leicester General Site/ Interim ICU Project ( £30.8m bid)**

- The Outline Business Case (OBC) was approved at the UHL Trust Board on 2nd November and at the CCG Boards on 14th November. Following these meetings, the OBC was formally submitted to NHSI and the team responded to initial queries from the local NHSI team, before the OBC was sent to the National NHSI Finance Team for review on the 24th November. A detailed response document has been developed as an audit trail.

- We have been advised that the name of the project is misleading, and therefore NHSI have renamed it 'the Relocation of ICU Capacity and Associated Specialties from the Leicester General Site'.

- On the 19th December NHSI clarified that Public Dividend Capital (PDC) will be provided to fund this scheme rather than interest bearing loans, which were assumed in the outline business case approved at the November Trust Board. As a result of this clarification, the Trust has been asked to revise the OBC to reflect this. The use of PDC will require the Trust to pay a higher dividend. This increase is only partially offset by the reduction in interest payments .

- The use of PDC creates an additional cost of circa £500k. The Trust will need to deliver a higher CIP to manage this additional cost pressure. The total revised additional cost of the scheme of £3.6 million (including capital charges) needs to put into the context of the Trust's annual CIP programme of circa £30 million. This therefore represents an additional circa 12% in one year of the Trust's annual CIP (0.4% of income).

- The OBC needs to be re-submitted by the end of December for NHSI to re-write their recommendation report to the National Cash and Capital Team for the 12th January. The National Cash meeting at which the OBC will be approved is on the 12th February 2018.

- The impact of this is a month delay on the approval of the Full Business Case, which will now be submitted to the Trust Board in March 2018, taking account of any feedback from the National Capital Team on the OBC.

- **The Trust Board are therefore asked to approve the amendment to the first OBC which was signed off in November 2017.**

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

- The Development Control Plan (DCP) has now been finalised following complete alignment of the associated elements; 2048 Beds, agreed design strategy of new build and refurbishment costs, identification of the major projects that underpin the 5 year Reconfiguration Programme, sequential delivery based on dependencies/clinical safety and a robust cost profile that supports the £397.5m requested in the Trust's capital bid.

- We have commissioned architects to work collaboratively with the DCP Project Manager to develop high level visuals that will depict how the sites will develop throughout the Programme. It will be plain to see the scale of the developments and their impact on both the LRI and the GH.

- The details of the DCP will form part of the refreshed UHL Estates Strategy required for submission with the Full Business Case for the Interim ICU programme of schemes (£30.8m), and the LLR Estates Strategy.

- A number of outstanding clinical issues were identified that need to be resolved in the near future; these are detailed in the main paper. These include:
    - Agreeing the future model of care and location of delivery for ophthalmology
    - Validation of the activity modelling undertaken to size the Planned Ambulatory Care Hub
    - Theatres activity modelling continues to be progressed, with a particular focus on ensuring adequate emergency theatre capacity. This is particularly key during the transitional period following completion of the interim ICU scheme, when some services have moved, but the LGH remains operational.
    - Discussions with Leicestershire Partnership Trust (LPT) leads to progress moving the NRU and Stroke Rehab Unit to a new build facility at the Evington Centre, adjacent to the LGH site. LPT have requested additional clinical assurance from clinical leads that the NRU function sits appropriately with the stroke service.
    - Progressing development of a Surgical Assessment Unit for Vascular, HPB, Urology and Thoracics at Glenfield.
    - Considering the longer term assessment model at the LRI

**Options to Relocate Vascular Outpatients to GH**

- The current option that is being progressed is the potential conversion of a waiting area by the Restorative Dentistry and Orthodontics department. RRCV are in discussion with MSS regarding this.
- The Estates team are looking at the feasibility of the delivery of outpatient space within this area. RRCV have been advised that there is currently no capital allocated to this, and alternate sources of funding are being considered.

**Emergency Floor Project: Phase 2**

- GPAU opened on plan and in budget on 13 November 2017. The model of care is undergoing a Plan Do Study Act (PDSA) cycle to adapt practice as the team orientate to the new area. The Standard Operating Procedure (SOP) for GPAU was approved by the Executive Quality Board in November with the understanding that this will change as the service tests out the model of care.

- Phase 2 of the Emergency Floor will be completed by 10 June 2018 with beds opening from the week commencing 4 June 2018. The capital costs are being controlled and are currently delivering the project within the allocated budget.

- Operational commissioning for phase 2 continues, aligned to the milestones in the masterplan.

- The programme team continue to work with the charity leads to progress plans.

- The Stakeholder and Clinical Reference Group for Phase 2 have reviewed the work programme and proposed a new approach for delivery. This will focus on delivering the vision for the whole of the new floor (phase 1 and phase 2) and embedding a new culture and set of behaviours that will be vital to ensuring the new floor continues to work efficiently.

- A fully costed workforce business case for phase 2 is being developed and a progress report was presented to the EFPB.

- A stakeholder event was held in order to share the vision, knowledge and understanding about the future Paediatric Single Front Door model of care as agreed in the Trust's strategic objectives 2017/18. Discussions during the event showed that there are differing interpretations/perceptions of the agreed model of care that the paediatric single front door describes. The future model of care requires further clarity and so a second stakeholder event will be rearranged for January. ESB have been asked for an update on a monthly basis.

**Programme Risk Register**

- This was reviewed and updated at the Reconfiguration Programme Team meeting on 14th November 2017. A revised risk register will be presented to the next Trust Board.

## Input Sought

The Trust Board is requested to:

- **Note** the progress within the Reconfiguration Programme and the planned work over the coming months
- **Approve** the amendment to the first OBC which was signed off in November 2017 to reflect the use of Public Dividend Capital rather than interest bearing debt; which has a c.£450k revenue impact.

## 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 1 February 2018]

Executive Summaries should not exceed **4 pages**. [My paper does comply]

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

## Section 1: Sustainability and Transformation Partnership (STP)

1. The Draft LLR STP will be discussed at the Trust Board Thinking Day in January. It is currently planned to be presented to partner Public Boards in February / March 2018.

2. As discussed previously, LLR can go out to consultation in advance of our full capital bid being supported. The partnership is currently planning for consultation to commence in spring 2018.

3. There has been agreement that the pre-consultation business case (PCBC) will be split into three separate cases:

    - UHL: Acute reconfiguration and maternity
    - West CCG : Hinckley Hospital
    - East CCG : Lutterworth Hospital

## Section 2: Reconfiguration Programme Board Update

### *Capital Bid for £397.5m – Next Steps*

4. The outcome of the Autumn Budget was announced on the 22nd November.

5. We are still waiting to advised on the prioritisation process for access to this capital.

### *The Relocation of ICU Capacity and Associated Specialties from the Leicester General Site/ Interim ICU Project ( £30.8m bid)*

6. The Outline Business Case (OBC) was approved at the UHL Trust Board on 2nd November and at the CCG Boards on 14th November. Following these meetings, the OBC was formally submitted to NHSI and the team responded to initial queries from the local NHSI team, before the OBC was sent to the National NHSI Finance Team for review on the 24th November. A detailed response document has been developed as an audit trail.

7. We have been advised that the name of the project is misleading, and therefore NHSI have renamed it 'the Relocation of ICU Capacity and Associated Specialties from the Leicester General Site'.

8. On the 19th December NHSI clarified that Public Dividend Capital (PDC) will be provided to fund this scheme rather than interest bearing loans, which were assumed in the outline business case approved at the November Trust Board. As a result of this clarification, the Trust has been asked to revise the OBC to reflect this. The use of PDC will require the Trust to pay a higher dividend. This increase is only partially offset by the reduction in interest payments

9. The change in the financial impact on the Trust is as follows:

10. The table below identifies the Loan Funding assumed in the OBC approved in November:

| Impact on Income and Expenditure | 2017/18 £'000 | 2018/19 £'000 | 2019/20 £'000 | 2020/21 £'000 | 2021/22 £'000 | 2022/23 £'000 | 2023/24 £'000 |
|---|---|---|---|---|---|---|---|
| **Total Additional Operating Costs** | **0** | **57** | **1,945** | **2,449** | **2,449** | **2,449** | **499** |
| Capital Charges: | | | | | | | |
| Depreciation | 0 | 0 | 437 | 583 | 583 | 583 | 583 |
| Interest | 6 | 266 | 522 | 526 | 504 | 482 | 461 |
| Return on Assets | 0 | 0 | (429) | (406) | (384) | (361) | (338) |
| Total Capital Charges | 6 | 266 | 530 | 702 | 703 | 704 | 705 |
| **Total Impact on I&E** | **6** | **323** | **2,475** | **3,150** | **3,151** | **3,152** | **1,204** |

11. Taking account of the need to use PDC, the revised OBC assuming PDC Funding

| Impact on Income and Expenditure | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Total Additional Operating Costs** | **0** | **57** | **1,945** | **2,449** | **2,449** | **2,449** | **499** |
| Capital Charges | | | | | | | |
| Depreciation | 0 | 0 | 437 | 583 | 583 | 583 | 583 |
| Interest | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Return on Assets | 25 | 529 | 814 | 614 | 597 | 577 | 557 |
| Total Capital Charges | 25 | 529 | 1,251 | 1,196 | 1,179 | 1,159 | 1,139 |
| **Total Impact on I&E** | **25** | **586** | **3,196** | **3,645** | **3,628** | **3,608** | **1,638** |
| **Change in Impact on I&E as a result of PDC funding** | **19** | **263** | **721** | **495** | **477** | **456** | **434** |

12. The use of PDC creates an additional cost of circa £500k. The Trust will need to deliver a higher CIP to manage this additional cost pressure The total revised additional cost of the scheme of £3.6 million (including capital charges) needs to put into the context of the Trust's annual CIP programme of circa £30 million. This therefore represents an additional circa 12% in one year of the Trust's annual CIP (0.4% of income).

13. The consequence of this is that we have been requested to re-submit a fully revised OBC to NHSI; which includes a response to all the queries as well as the finance section. It does not change the principles approved within the case.

14. The OBC needs to be re-submitted by the end of December for NHSI to re-write their recommendation report to the National Cash and Capital Team for the 12th January. The National Cash meeting at which the OBC will be approved is on the 12th February 2018.

15. The impact of this is a month delay on the approval of the Full Business Case, which will now be submitted to the Trust Board in March 2018, taking account of any feedback from the National Capital Team on the OBC.

16. **The Trust Board are therefore asked to approve the amendment to the first OBC which was signed off in November 2017.**

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

17. The Development Control Plan (DCP) has now been finalised following complete alignment of the associated elements; 2048 Beds, agreed design strategy of new build and refurbishment costs, identification of the major projects that underpin the 5 year Reconfiguration Programme, sequential delivery based on dependencies/clinical safety and a robust cost profile that supports the £397.5m requested in the Trust's capital bid.

18. Race Cottam (Architects) have been commissioned to work collaboratively with the DCP Project Manager to develop high level visuals that will depict how the sites will develop throughout the Programme. It will be plain to see the scale of the developments and their impact on both the LRI and the GH.

19. The details of the DCP will form part of the refreshed UHL Estates Strategy required for submission with the Full Business Case for the Interim ICU programme of schemes (£30.8m). Turner & Townsend (Consultants) has been appointed to support the development of the UHL Estates Strategy. This will be presented to the February trust Board.

20. The LLR Estates Strategy has been updated and will be signed off by partner Trust Boards when the LLR STP is approved. The LLR Estates Strategy reflects the UHL Reconfiguration Programme and the proposals for future use of the community estate across LLR. This document is essential for submission with the Interim ICU schemes Full Business Case in order for us to access capital.

21. The outstanding clinical issues for resolution for the Reconfiguration Programme are as follows:

## *Additional work required to confirm the Scope of Reconfiguration*

22. The procurement process for selecting a P22 partner has commenced. An open day was held on the 7th December to which three of the six potential Principle Supply Chain Partners ( PSCPs) attended. These were IHP, Galliford Try and Interserve construction. A partner will be identified by the beginning of February. Assuming that the UHL reconfiguration programme is supported with capital from the Autumn Budget, the design scope (i.e. models of care, activity models and operational policies) must be drafted to OBC level of detail by the end of January 2018.

23. The activity modelling initially undertaken to size the Planned Ambulatory Care Hub is currently being validated with service leads. Ophthalmology has been identified as an area that requires further work to understand the models of care . A paper on the service's

preferred clinical model will be presented to the December Reconfiguration Programme Board which is delayed to the 9th January. An update will be provided once the model is agreed by ESB on 16th January.

24. Theatres activity modelling continues to be progressed, with a particular focus on ensuring adequate emergency theatre capacity. This is particularly key during the transitional period following completion of the interim ICU scheme, when some services have moved, but the LGH remains operational. The potential to 'lift and shift' day case activity during the reconfiguration programme is being explored, to free up capacity on the LRI and GH.

25. A key opportunity is IM&T. A meeting will be held in January between Nicky Topham, John Clarke, Steve Jackson, Tim Bourne, John Jameson and Andy Carruthers to agree the best way to progress an IM&T reconfiguration work stream which helps scope future opportunities.

*Neuro Rehab Unit (NRU) & Stroke Rehab*

26. Discussions with clinical and management leads for the NRU and Stroke Rehab Unit established the most appropriate environment for patient care was not in the middle of a busy acute hospital site.

27. A meeting has been arranged with Leicestershire Partnership Trust (LPT) strategy and clinical leads to progress moving the NRU and Stroke Rehab Unit to a new build facility at the Evington Centre, adjacent to the LGH site. LPT have requested additional clinical assurance from clinical leads that the NRU function sits appropriately with the stroke service. The assumption is that UHL would continue to manage this service. Discussions are on-going.

28. The capital for this relocation is included in the UHL reconfiguration programme.

*Assessment Model at GH*

29. A meeting was held with Clinical Directors and John Jameson to discuss the assessment model for the GH. It was agreed that there should be a Surgical Assessment Unit for Vascular, HPB, Urology and Thoracics. The model of care and scope of this project is currently being developed .

30. There is currently £3m in the reconfiguration programme for expansion of the Clinical Decisions Unit (CDU). A piece of work is being undertaken to consider the model of care for the CDU, potentially negating the need for immediate expansion.

31. The outcomes of both of these pieces of work will dictate what is required, i.e. the merit of a combined medical and surgical assessment unit, and timescales of delivery. An update will be included within this paper next month.

32. The longer term assessment model at the LRI is also being considered . Whilst assessment is being provided on level 5 in wards 15 and 16 in the Interim ICU project, there is an

opportunity to bring elements of this service down to the assessment floor when clinics 3 and 4 move into PACH.

## *Options to Relocate Vascular Outpatients to GH*

33. Work continues by the CMG to assess the options to move the Vascular Outpatient department from the LRI to the GH.

34. The current option that is being progressed is the potential conversion of a waiting area by the Restorative Dentistry and Orthodontics department. RRCV are in discussion with MSS regarding this.

35. Whilst the Estates team are looking at the feasibility of the delivery of outpatient space within this area, it was discussed and agreed at the Reconfiguration Programme Board that this issue would no longer be routinely reported at the Reconfiguration Programme Board since the CMG are owning delivery of the outcome.

36. RRCV have been advised that there is currently no capital allocated to this, and alternate sources of funding are being considered.

## *Emergency Floor Phase 2 – Update from Last Month*

37. GPAU opened on plan and in budget on 13 November 2017. The model of care is undergoing a Plan Do Study Act (PDSA) cycle to adapt practice as the team orientate to the new area. The Standard Operating Procedure (SOP) for GPAU was approved by the Executive Quality Board in November with the understanding that this will change as the service tests out the model of care.

38. Phase 2 of the Emergency Floor will be completed by 10 June 2018 with beds opening from the week commencing 4 June 2018. The capital costs are being controlled and are currently delivering the project within the allocated budget.

39. Operational commissioning for phase 2 continues, aligned to the milestones in the masterplan.

40. The finalised and costed the equipment list for the whole of phase 2 will be presented at the January Emergency Floor Project Board (EFPB). This has been factored into the construction timeline .

41. The programme team continue to work with the charity leads to progress plans. A protocol is under development for allocation of funds and delivery. A dementia social space is under design led by a clinical task and finish process. The protocol and social space design will be issued to EFPB for approval in January 2018.

42. The Stakeholder and Clinical Reference Group for Phase 2 have reviewed the work programme and proposed a new approach for delivery. This will focus on delivering the vision for the whole of the new floor (phase 1 and phase 2) and embedding a new culture and set of behaviours that will be vital to ensuring the new floor continues to work efficiently. Revised SOPs will be a product from this approach with clinicians continuing to work on developing the models of care for each area. A paper is presented under separate cover for EFPB approval this month.

43. A fully costed workforce business case for phase 2 is being developed and a progress report was presented to the EFPB. This includes plans for the medical, nursing and administrative workforces. Linked to this, work is on-going to review the activity

requirements of the new hot floor, to ensure the new ways of working are reflective of the staffing models. This work will be presented to EFPB in January 2018.

44. The benefits realisation process, led by the East Midlands Academic Health Science Network, is being taken forward by the Organisational Development (OD) team and progress will also be presented at the January EFPB.

45. A stakeholder event was held on the 24th October 2017 in order to share the vision, knowledge and understanding about the future Paediatric Single Front Door model of care as agreed in the Trust's strategic objectives 2017/18. The event was designed to start the process of service development, engagement of the key team members and commence priority actions in good time for opening on the 1st April 2018.

46. The event was facilitated by Dr Ian Scudamore, Clinical Director Women and Children; and Sharon Smeeton, Organisational Development Specialist. 25 colleagues attended the event.

47. Discussions during the event showed that there are differing interpretations/perceptions of the agreed model of care that the paediatric single front door describes. Although some of the differences were subtle they demonstrated a lack of a service model that was clearly understood by all at this time. The future model of care requires further clarity and detail and so a second stakeholder event was arranged for 22nd November 2017 between the Children's Hospital and Paediatric ED Heads of Service. Unfortunately this had to be postponed at the last minute due to operational pressures. This will be rearranged for January. ESB have been asked for an update on a monthly basis.

## Section 2: Programme Risks

48. 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

49. The latest risk register was reviewed and updated at the Reconfiguration Programme Team meeting on 14th November 2017 and is included at Appendix 12. This was discussed at the Reconfiguration Programme Bard and agreed that a further update is required in light of some of the interdependencies described earlier in the paper. This will be presented to a future meeting.

50. 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. |

| Risk | Current RAG | Mitigation |
|---|---|---|
| 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. |

## Input Sought

The Trust Board is requested to:

- **Note** the progress within the Reconfiguration Programme and the planned work over the coming months
- **Approve** the amendment to the first OBC which was signed off in November 2017 to reflect the use of Public Dividend Capital rather than interest bearing debt; which has a c.£450k revenue impact.