Paper A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE RECONFIGURATION AND TRANSFORMATION COMMITTEE (RTC) MEETING HELD ON THURSDAY 31 MARCH 2022 AT 11.30AM, VIRTUAL MEETING VIA MICROSOFT TEAMS

Present:
Mr B Patel, Non-Executive Director (Chair of meeting)
Mr A Carruthers, Chief Information Officer (non-voting)
Ms G Collins-Punter, Associate Non-Executive Director
Miss M Durbridge, Director of Quality Transformation and Efficient Improvement
Mr A Furlong, Medical Director
Ms L Hooper, Chief Finance Officer
Ms H Kotecha, Healthwatch Representative
Ms S Prema, CCG Executive Director of Strategy and Planning
Prof T Robinson, Non-Executive Director
Ms N Topham, Reconfiguration Programme Director
Mr M Williams, Non-Executive Director
Mr J Worrall, Associate Non-Executive Director
Ms R Vyas, CCG Executive Director for Integration and Transformation

In Attendance:
Ms B Cassidy, Director of Corporate and Legal Affairs
Ms D Green, Head of Health Planning
Mr J Jameson, Deputy Medical Director
Mr S Pizzey, Head of Strategy and Planning
Ms S Taylor, Assistant Director of Operations (Planned Care)
Ms A Moss, Corporate and Committee Services Officer

RESOLVED ITEMS

08/22 APOLOGIES

Apologies for absence were received from Dr A Haynes, RTC Chair, and Mr J Hammond, Head of UHL Reconfiguration PMO.

09/22 DECLARATIONS OF INTERESTS

There were no declarations of interest.

10/22 MINUTES

Resolved – Resolved – that the Minutes of the 27 January 2022 Reconfiguration and Transformation Committee be confirmed as a correct record.

11/22 KEY ISSUES FOR ASSURANCE

11/22/1 Reconfiguration Programme Director Update on LRI Design

The Reconfiguration Programme Director presented paper C which recapped on the current position in relation to the New Hospital Programme; progress with the design of the new building at the Leicester Royal Infirmary (LRI); restated the communication, engagement and patient involvement strategy; and updated the Committee on the LRI enabling case.

The Reconfiguration Programme Director reflected on the current position noting that a capital allocation of £450m for UHL had been announced in September 2019. In Spring 2020, the NHS had established the New Hospitals Programme with the objective of delivering all the new hospitals in a programmatic way, and to address agendas for net zero carbon and digital hospitals. The New Hospital Programme which was responsible for delivering 40 new hospitals (with 8 additional new hospitals expected to be announced) was working with HM Treasury, Cabinet Office, Infrastructure

and Projects Authority to determine the final allocation for all the schemes and timelines. The assessment of the case would be made in May 2022, after which it would be reviewed by Ministers of State. It was hoped that a decision would be known in July 2022. However, it could be delayed until Autumn 2022

The Reconfiguration Programme Director reported on the work undertaken with the Trust's architectural partner, Building Design Partnerships, to design the new buildings at the LRI. She noted that it was the most densely built site with key interdependences to be taken into account. There was a need to co-locate specific services, for example, the Intensive Care Unit needed to be next to the theatres and Emergency Department to ensure quick access.

The brief would consider the activity to be delivered, the number of rooms and functionality. The clinical engagement would start in the next two weeks and the design process would take around five months. This would be incorporated in the Outline Business Case which was currently planned for presentation to the Trust Board in January 2023.

The Deputy Medical Director reported that the Trust was keen to work with the New Hospital Programme and achieve a standard design that would be appropriate for the trusts in the following cohorts. The New Hospital Programme intended to co-ordinate the procurement.

Prof T Robinson, Non-Executive Director, noting that the Trust delivered clinical services, research and education, provided assurances that that research and education was reflected in the programme and that there was appropriate dialogue. There followed a conversation about the new requirement to increase the percentage of single rooms. The impact on the workforce was being assessed. In respect of the ICU, the clinicians who had visited Bristol Hospital acknowledged that good design would mitigate some of the concerns.

The Deputy Medical Director noted that the Reconfiguration Programme addressed the key clinical risks facing the Trust, particularly by increasing the beds for neonates and ITU. In the interim, the risks would be kept under review by the Risk Committee. Ms G Collins-Punter, Associate Non-Executive Director, considered that the Trust should invest in the 'best in class;' for the ICT infrastructure in order to future-proof provision. The Chief Information Officer agreed but acknowledged the need to ensure it was affordable.

The Reconfiguration Programme Director presented the Communication and Engagement Strategy which had been shared at the last meeting. She restated the commitment to co-production and inclusive design. Each project would have its own communications plan. The engagement plan would be presented to the next meeting.

Ms H Kotecha, Healthwatch Representative, thought the Trust should be clear, when engaging with patients and the public, what was being presented as information and the scope to influence change. She proposed that the CCG Patient and Public Involvement Group should be involved in the process.

The Reconfiguration Programme Director recapped on the progress made with the LRI Enabling Case which sought to relocate staff from a number of buildings referred to as the Knighton Street Campus. At the request of the City Council, planning consent to demolish the vacated buildings would not be sought until the business case for the new build was well progressed, thereby being able to clearly articulate the reason for the demolition of Victorian buildings.

In response to a question from Prof T Robinson, Non-Executive Director, the Reconfiguration Programme Director noted that staff had been consulted and were aware of where they would be sited. Planning permission for the extension to the Windsor building would be submitted in the next few weeks.

Resolved – that the contents of this report be received and noted.

11/22/2 Principles Underpinning Reconfiguration: Outcome of Consultation

The CCG Executive Director for Strategy and Performance presented the 20 themes which had emerged from the public consultation in 2020. It was noted that all the themes would be addressed within specific work plans or cross-cutting work streams. Ms R Vyas, CCG Executive Director for

Integration and Transformation confirmed that the principles were embedded in pathway transformation and there was a direct read across. The Committee acknowledged its role in ensuring that all the themes were addressed.

Mr B Patel, Non-Executive Director, added that the public should be made aware of how the responses to the consultation had been taken into account.

Resolved: – that the contents of the report be received and noted.

11/22/3 Principles Underpinning Reconfiguration: Working Practices

The Assistant Director of Operations (Planned Care) presented the clinical and operational principles for reconfiguration. The key principle of the Programme was to move all acute clinical activity and associated services off the Leicester General Hospital site to LRI and the Glenfield Hospital. This would enable a separation of emergency and elective care.

The clinical and operational principles had been revised in 2020. These needed to be refreshed, specifically in relation to the use of the Jarvis and Victoria buildings, operational assumptions for beds, theatres and outpatients, and the Children's' hospital project. The Reconfiguration Programme Director cautioned on the need to plan for the longer term and ensure the buildings could be used flexibly.

There was a discussion about the bed bridge and new models of care. The bed bridge identified a requirement for 783 additional beds by 2031/32. This was based on assumptions around demographic and activity growth. The activity models would be reviewed in the next few months. The plan to increase theatre sessions was noted and Mr J Worrall, Associate Non-Executive Director commented on the need to maximise the use of the theatres. The Director of Quality Transformation and Efficiency Improvement noted that transformation was key and considerable work was in train. The Deputy Medical Director noted the need to review pathways across the whole of the patient journey and develop virtual wards so that patients were only admitted to the LRI if that added value. There was a need to transform care, regardless of the reconfiguration programme.

The Committee noted that a Task and Finish Group would be established to refresh the principles and report in three months' time.

Resolved: – that (A) the report be received and noted, and

(B) to receive a further report in three months' time. **ADO(PC)**

11/22/4 Principles Underpinning Reconfiguration: Room Sizes/Spatial Assumptions

The Head of Health Planning, reported on the approach for determining room sizes and spatial assumptions for the new build which would determine the size of the building and cost. There were national mandates for standardised and repeatable designs. There was a need to pandemic-proof the accommodation which meant an increase in single rooms and the ability to cohort patients. The Health Building Notes which provided guidance on best practice were adopted for the majority of spaces and only derogated in five instances. The Committee noted the key interdependency as transformation, including new models of care and agile working.

The Committee sought and received assurances about physical accessibility which was an integral part of the Health Building Notes. Mr M Williams, Non-Executive Director, highlighted the need for good design and the consideration of aesthetics including artwork. It was noted that the requirements for net carbon zero had not affected room size apart from the plant rooms which needed to be slightly bigger.

Recommended – that the report be received and noted.

11/22/5 Principles Underpinning Reconfiguration: IT Principles underpinning design

The Chief Information Officer outlined the principles on which the digital element of the Outline

Business Case had been based. The presentation set out the approach to prioritising funding for new technologies to align with the New Hospital Programme expectations. The Committee noted the need to consider how new technologies would be rolled out in the retained estate, the clinical value of the technology and additional revenue and capital implications for the Trust and the System.

Ms G Collins-Punter, Associate Non-Executive Director, noted the need to consider the total cost for IT projects including a skills framework and training requirements.

Ms H Kotecha, Healthwatch Representative, reflected on the need to offer patient choice as not everyone was IT literate. She highlighted the need for systems to be compatible so there was a seamless service and improve the network availability for visitors. The Chief Information Officer acknowledged the need for digital inclusivity noting that patient groups would be involved in the Programme. There was an LLR Strategy, he added, to address the issues around compatibility.

The role of IT as an enabler for transformation was acknowledged.

Recommended – that the report be received and noted.

12/22 ANY OTHER BUSINESS

There was no other business.

13/22 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

There were no issues to refer to the Trust Board.

14/22 DATE OF THE NEXT MEETING

Resolved – that the next meeting of the Reconfiguration Transformation Committee be held on Thursday 26 May 2022 at 11.30am (virtual meeting via MS Teams).

The meeting closed at 1.06pm

Alison Moss - Corporate and Committee Services Officer

Cumulative Record of Members' Attendance (2021-22 to date):-

Voting Members

Name	*Possible*	*Actual*	*% attendance*
A Haynes (Chair)	2	1	50
I Crowe (until February 2022)	1	0	0
G Collins-Punter (from February 2022)	1	1	100
A Furlong	2	1	50
L Hooper	2	2	100
A Johnson (until February 2022)	1	0	0
B Patel (from February 2022)	1	1	100
T Robinson	2	1	50
M Williams (from February 2022)	1	1	100
J Worrall (from February 2022)	1	1	100

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*
A Carruthers	2	2	100
M Durbridge	2	2	100
J Hammond	2	1	50
D Kerr (until February 2022)	1	0	0
H Kotecha	2	2	100
J Jameson	2	1	50
S Prema	2	2	100

N Topham	2	2	100
R Vyas	2	1	50